

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

PRINTED: 04/10/2015
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 03/27/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 A Recertification Survey and an Abbreviated Survey investigating KY00022990 was initiated on 03/24/15 and concluded on 03/27/14. Deficiencies were cited with the highest Scope and Severity of a "E". KY00022990 was unsubstantiated with no deficiencies.	F 000	<p>Disclaimer; Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.</p> <p>1. A physical restraint consent form consent form was obtained and signed by the resident #6 4/24/15 while the annual survey was being conducted. Resident #6 has muscular dystrophy and Fredreichs Ataxia which is severely compromises this resident's ability to sit up, loss of coordination and control. This resident is alert and the device is used per</p>	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure one (1) of two (2) residents (Residents) reviewed for physical restraints was free from physical restraints out of a total of fifteen (15) sampled residents. Resident #6 was observed to have an over the shoulder halter restraint; however, there was no documented evidence of a pre-evaluation assessment prior to the restraint being placed. In addition, there was no documented evidence the risks versus benefits was explained to the resident or the responsible party, or of a consent obtained for the use of the restraint. The findings include: Review of the facility's policy titled, "Use of	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE ADMINISTRATOR (X6) DATE 05/22/2015

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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40068	
(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 221	<p>Continued From page 1</p> <p>Restraints" dated December 2008, revealed restraints should only be used for the safety and well-being of residents, and only after other alternatives had been tried unsuccessfully. In addition, the Policy stated restraints should only be used to treat the resident's medical symptom(s), never for discipline or staff convenience, or for the prevention of falls. Further review revealed restraints were to have written Physician's Order after obtaining consent for the restraint from the resident and/or representative.</p> <p>Review of Resident #6's medical record revealed the facility readmitted the resident on 05/28/14, with diagnoses which included Friedreich's Ataxia (a rare inherited disease which causes nervous system damage, movement problems and leads to impaired muscle coordination), Congestive Heart Failure, Primary Cardiomyopathy, and Cerebrovascular Accident. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 01/21/15, revealed the facility assessed Resident #6 to be cognitively intact, and not to have a restraint.</p> <p>Review of the Social Service Notes, dated 05/20/14, revealed Resident #6 was up in his/her electric scooter after "therapy provided shoulder straps to help with" positioning of the resident. Review of the Physician's Orders revealed on 05/26/14, an order was received for use of the electric scooter "with safety harness to enable to be out of bed safely".</p> <p>Review of the Nursing Notes dated 02/18/15 at 3:12 PM, revealed an Interdisciplinary Team (IDT) meeting was held related to "restraint usage" for Resident #6 regarding the use of a safety belt</p>	F 221	<p>1. resident's choice, which enables his quality of life to be able to use the motor scooter without falling forward. Other alternatives were reviewed prior to survey by skilled therapy and were identified not to be as safe. All residents with assistive devices have the potential to be at risk. Current in house residents identified with a possible restraint will be reviewed by IDT meeting weekly process to ensure the resident and or the responsible party has given informed consent for the device explaining the risks and benefits. Education was provided by the DON to the IDT Team regarding the Physical Restraint Consent form and the importance of obtaining this consent which educates risks and benefits. EDT will continue the education with the current process. Nursing admin will continue the education, pre-assessment evaluation will be done before restraint</p>	

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
F 221	<p>Continued From page 2</p> <p>used for positioning when up in his/her motorized wheelchair. Continued review of the Note revealed Resident #6 was unable to self release the safety belt, therefore the IDT was to consider the use of a restraint vest for more positioning and quality of life regarding the resident's desire to propel self. Although th facility's IDT considered the device a restraint, continued record review revealed no documented evidence of a written consent obtained from the resident or representative for the use of the restraint. Additionally, record review revealed no documented evidence the risk versus benefits of the restraint had been explained to the resident or representative.</p> <p>Interview with Certified Nursing Assistant (CNA) #12 and CNA #13 on 03/24/15 at 4:39 PM, revealed Resident #6 was unable to remove the restraint vest/safety harness on his/her own, and had to be assisted by staff with removing the device.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 03/27/15 at 3:15 PM, revealed the restraint use should have triggered on the MDS Assessment. The ADON revealed a written consent also should have been obtained for use of the restraint.</p> <p>Interview with the Director of Nursing (DON), on 03/25/15 at 10:52 AM, revealed there was no documentation of a written consent obtained for the use of the restraint vest/safety harness. She stated the facility did not consider the use of the safety harness as a restraint initially upon use on 05/20/14. She stated it was not until the IDT reviewed the device for restraint usage on 02/18/15, that the device was identified as a</p>	F 221	<ol style="list-style-type: none"> 1. application. These will be reviewed per RAI process ongoing. Staff education of the restraint process for obtaining consent and for the appropriate education of whether the device is a restraint or enabler will be given on 4/23/2015 by ETD. 2. The facility IDT Team will review with the resident and or responsible party alternative uses to restraints as per current practice. If a physical restraint is deemed the safest alternative a Physical Restraint Consent will be reviewed with the resident and or responsible party which explains risks and benefits of the device and completed for signature. On going education to new nurses in orientation will be given about restraint protocols and usage. Monthly during the facilities IDT meeting the Director of Nursing will ensure that any physical restraint has a signed physical restraint consent form within the plan of care

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 221	Continued From page 3 restraint. The DON stated she should have identified the restraint sooner and thus obtained a written consent for use of it from the resident or representative; however, had failed to do so. She also stated the Social Worker did not obtain written consent for the use of the restraint from the resident or representative.	F 221	ongoing. Prior to the evaluation of the device consent will be obtained from the resident's responsible party and prior to accepting a physicians order for a restraint. The IDT will determine the consent is signed prior to the evaluation of the device.	
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, clean, comfortable and homelike environment for one (1) of fifteen (15) sampled residents (Resident #6). On 03/24/15, a yellow liquid substance was observed on the floor in the room of Resident #6 from 11:10 AM to 2:54 PM. In addition, observation of the ceiling vents in the bathrooms on the East and West units revealed there was a build up of dust and cobwebs hanging from the vents. The findings include: 1. Interview with the facility's Environmental Services Supervisor, on 03/24/15 at 4:28 PM, revealed the facility did not have a housekeeping policy.	F 252	1. All resident rooms cleaned including all floors moped and all bathroom vents cleaned by April 17, 2015. Rooms for resident #6 and bathroom vents in room # 1, 3, 5, 6, 4, 7, 9, 11, 13, 12, 10, 15, 17, 16, and 14. 2. All resident rooms have the potential to be affected. Education will be provided to the nursing staff on mopping, cleaning and identified spills on April 23-30 th ETD. 3. House keeping director has been educated by ETD that each room and hall will be cleaned each day and house keepers will spot check for spills Room check form and results will be reported to	5/5/15

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 252	Continued From page 4 Observation of Resident #6's room on 03/24/15 at 11:10 AM and 12:25 PM, revealed a yellow liquid on the resident's floor on the right side of the bed, with a urinal observed tilted sideways hanging on the siderail of the bed. Observation at 12:44 PM, revealed the urinal had been removed from the bed; however, the yellow liquid remained on the floor by the bed. Further observation at 2:54 PM, observation revealed the yellow liquid on the floor had dried. Interview with Certified Nursing Assistant (CNA) #1 on 03/24/15 at 2:54 PM, revealed Resident #6 used a urinal and the facility's process was for the CNAs to empty the urinal for the resident after each use. She stated the CNAs were to check the urinal after meals or when they did rounds at 8:00 AM, 10:00 AM, 12:00 PM and 2:00 PM, every two (2) hours. CNA #1 stated, housekeeping completed rounds during the day shift at 7:00 AM to 8:00 AM and 9:00 AM to 11:30 AM to clean as necessary. CNA #1 observed the yellow liquid on the floor in Resident #6's room, and stated the substance was urine. Per interview, housekeeping should have observed the spilled urine and need for it to be cleaned up during their rounds that day. CNA #1 revealed the urine should have been cleaned up from the floor before 2:54 PM. Interview with CNA #14 on 03/27/15 at 2:46 PM, revealed Resident #6 told the CNAs when he/she had urinal spills. She stated it was the responsibility of the CNAs to clean up the urine spills and contact Housekeeping to disinfect the area. Interview with the Environmental Services	F 252	3. QA Committee each week for 12 weeks .Administrator or member of IDT will report to QA Committee finding from room audits monthly. Administrator and/or Director of Housekeeping, Director of Nursing or IDT member will check each room for spills and vent cleaning 2 times per day 5 times per week for 4 weeks, then daily 5 times a week for 4 weeks and then weekly for 4 weeks. Results will be recorded on room check form and discussed 5x/week during the morning meeting with the Director of Housekeeping to determine any further system changes needed. Continued inspections be done by the administrator or designee, monthly to ensure no recurrence and reported in monthly QA. Spills will be corrected immediately and vents cleaning instantly and follow-up actions and audits will be brought to weekly QA for review.	5/5/15	

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

PRINTED: 04/10/2015
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 03/27/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 252 Continued From page 5

Supervisor on 03/24/15 at 4:28 PM revealed cleaning started at 7:00 AM; however, resident rooms were not attended to until after breakfast. He stated the housekeeping staff were to walk through the facility at 2:00 PM to check for areas that needed cleaning, and he checked to ensure the staff's tasks were completed at the end of the shift at 2:30 PM or 3:00 PM. Continued interview revealed the urine should not have been in the floor at 2:54 PM, because he told one of his housekeeping staff to clean the spill up at lunchtime after being notified of the spilled urine by a CNA. The Environmental Services Supervisor stated he cleaned the urine spill up himself after 3:00 PM. Per interview, the spilled urine was a safety concern due to the potential of a possible fall injury.

Interview with the Assistant Director of Nursing (ADON) on 03/27/15 at 3:15 PM, revealed her expectation for staff to clean up urine spills as soon as possible. She stated nursing staff should cover the urine spill with a towel and notify housekeeping to clean it up. Per interview, it was her expectation that staff clean the spilled urine up within thirty (30) minutes. The ADON indicated the spill was a safety concern related to the potential of causing a fall, and was also an infection control concern.

2. Interview on 03/26/15 at 4:35 PM, with the Laundry/Housekeeping Manager, revealed the facility did not have a cleaning policy stating how often the vents were to be cleaned. However, there was a cleaning schedule the facility staff followed.

Review of the facility's document titled, "Job To Be Done", dated 01/01/2000, revealed vents were

F 252

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 252	<p>Continued From page 6</p> <p>to be cleaned with a germicide, most vents should be cleaned daily and if necessary maintenance was to remove covers to clean inside of the vents.</p> <p>Review of the facility's document titled, "Project Schedule" dated, March 2015 revealed vents were to be cleaned every Tuesday.</p> <p>However, observation on 03/25/15 at 2:00 PM of the bathroom vents on the East Unit, single resident rooms #1, #3, #5, and bathroom vents for six (6) shared bathrooms for resident rooms Room #6, #4, #7, #9, #11 #13, #12, #10, #15, #17 and #16 and #14 revealed the vents were dusty with cobwebs observed. Observation of the West Unit single resident rooms #24, #26, #32 and four (4) shared bathrooms for resident rooms #23, #25, #27, #29, #35, #37, #36, and #38 revealed the vents were dusty with cob webs hanging from the vents.</p> <p>Interview, on 03/25/15 at 3:15 PM, with the Laundry/Housekeeping Manager revealed vents were to be cleaned every Monday by housekeeping staff. Per interview, he did observe the dust and cob webs and the vents were not clean; however, should have been. He stated the cleaning schedule was not being followed by housekeeping staff.</p> <p>Interview, on 3/25/15 at 8:00 PM, with a Housekeeper revealed housekeeping would clean the vents if they were dusty, but it was maintenance's responsibility to clean them. Further interview revealed she had worked for the facility for eighteen (18) years and it had always been maintenance's responsibility to clean the vents in the bathrooms.</p>	F 252		

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 252	Continued From page 7	F 252			
F 258 SS=E	<p>Interview the Maintenance Supervisor was attempted, however, unsuccessful related to his being off.</p> <p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS</p> <p>The facility must provide for the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, Individual and Group Interview, it was determined the facility failed to provide for maintenance of comfortable sound levels for three (3) of fifteen (15) sampled residents (Residents #6, #9 and #11) and five (5) unsampled residents (Unsampled Residents I, J, K, L and M).</p> <p>The findings include:</p> <p>Interview with the facility's Corporate Nurse, on 3/27/15 at 4:15 PM, revealed the facility did not have a policy or procedure to ensure comfortable sound level were maintained for residents.</p> <p>1. A Group Interview was conducted by the Surveyor on 03/24/15 at 3:30 PM, in the dining room of the facility. Residents present included three (3) sampled (Residents #6, #9 and #11) and five (5) unsampled residents (Unsampled Residents I, J, K, L and M). Review of the facility's list of residents with a Brief Interview for Mental Status (BIMS) greater than eight (8) revealed all eight (8) residents present for the</p>	F 258	<p>All carts were checked for noise from wheels April 17, 2015. None were noted. All staff have been inserviced on April 21, 2015 by ETD, Education and Training Director, that all drawers, lids and doors are to be closed slowly and as quietly as possible. The call light enunciators in the hallways were silenced April 21, 2015, to reduce noise at night, the main boxes in the nurse stations still sound. As of April 21, 2015 the CNA's now do a "Background Noise Check" on the floor to take into account ambient sounds so they do not have to speak as loud. Dietary staff now delay dishwashing until residents have finished eating and left the dining room. In addition, the doors that close the windows will be closed at all time when the dishwasher</p>		

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 252	Continued From page 7	F 252			
F 258 SS=E	<p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS</p> <p>The facility must provide for the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, Individual and Group Interview, it was determined the facility failed to provide for maintenance of comfortable sound levels for three (3) of fifteen (15) sampled residents (Residents #6, #9 and #11) and five (5) unsampled residents (Unsampled Residents I, J, K, L and M).</p> <p>The findings include:</p> <p>Interview with the facility's Corporate Nurse, on 3/27/15 at 4:15 PM, revealed the facility did not have a policy or procedure to ensure comfortable sound level were maintained for residents.</p> <p>1. A Group Interview was conducted by the Surveyor on 03/24/15 at 3:30 PM, in the dining room of the facility. Residents present included three (3) sampled (Residents #6, #9 and #11) and five (5) unsampled residents (Unsampled Residents I, J, K, L and M). Review of the facility's list of residents with a Brief Interview for Mental Status (BIMS) greater than eight (8) revealed all eight (8) residents present for the</p>	F 258	<p>Resident #6, 11 and 15 will be audited 5 days per week for 4 weeks for comfortable sound levels by Activities Director. All residents will be addressed through resident council regarding comfortable sound levels. Other residents at risk will be evaluated through resident interviews by Activities Director. In Resident Council Meeting 5/21/15, residents attending reported an overall improvement in sound comfort. All carts were checked for noise from wheels April 17, 2015. None were noted. All staff have been inserviced on April 21, 2015 by ETD, Education and Training Director, that all drawers, lids and doors are to be closed slowly and as quietly as possible. The call light enunciators in the hallways were silenced April</p>		

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 258	<p>Continued From page 8</p> <p>Group Interview had a BIMS greater than eight (8) indicating all were interviewable. During the interview, the Surveyor questioned the residents about the noise level in the facility. Continued interview revealed all eight (8) residents agreed the facility was noisy, especially at night. Per interview, the residents' sleep was disrupted at night due to staff talking loudly in the hallways and carts being rolled up and down the hallways. Additionally, during the Group Interview as the Surveyor was asking questions, the Surveyor observed it was hard for the residents to hear what was being said due to the noised coming from the kitchen where staff were moving dishes and talking loudly over kitchen machinery. Resident #9 revealed he/she was having a difficult time hearing the Surveyor's questions due to the noise coming from the kitchen. Resident #9 stated the ringing of the call lights was also disrupting. The Surveyor also observed Certified Nursing Assistants (CNAs) were wearing headsets and talking loudly during the Group Interview.</p> <p>2. Review of Resident #11's medical record revealed the facility re- admitted the resident on 08/25/14. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 02/22/15, revealed the facility assessed Resident #11 as being cognitively intact with a BIMS score of fourteen (14).</p> <p>Interview on 03/27/15 at 10:00 AM, with Resident #11 revealed at night staff's loud talking in the hallways, the rolling and screeching of carts up and down the hallways and staff's slamming doors made it difficult for the resident to sleep at night. Per interview, the resident had complained about the staff talking loudly in the hallways at</p>	F 258	<p>21, 2015, to reduce noise at night, the main boxes in the nurse stations still sound. As of April 21, 2015 the CNA's now do a "Background Noise Check" on the floor to take into account ambient sounds so they do not have to speak as loud. Dietary staff now delay dishwashing until residents have finished eating and left the dining room. In addition, the doors that close the windows will be closed at all time when the dishwasher is use. We will continue to use the accunurse headset as it is our facility and cooperation way of documentation, however education will be done by EDT to decrease noise levels during documentation and use of back ground noise check system thru accu nurse.</p> <p>All residents have the potential to be affected..</p> <p>On 4/23/15 through 4/30/15 we had Licensed nurses, CNA's, Dietary staff,</p>		

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 258	<p>Continued From page 9</p> <p>night to a CNA, whose name he/she could not recall. However, Resident #11 reported being told staff had to talk through the head set and couldn't help being loud as that was how they communicated for residents' care.</p> <p>Interview, on 03/27/15 at 10:50 PM, with CNA #6 revealed the room doors on the hall did not shut quietly and the lids on the dirty linen carts would slam shut, if not let down manually by the staff. CNA #6 further revealed, she didn't think the CNAs realized how loud it sounded by allowing the line cart lid to drop on it's own.</p> <p>Interview, on 03/27/15 at 11:00 AM, with CNA #3 revealed residents had complained of the noise on the unit, loud talking and doors being slammed shut before. Per interview, the residents had also complained about the CNAs talking loudly on the headsets. CNA #3 stated the CNAs had to talk on the head set in order to do their documentation. Continued interview revealed sometimes the information coming through the headset interrupted what was being said by staff or residents causing her to have to speak in a louder voice. CNA #3 further revealed CNAs had no place to document through the headset except in the hallway, because the CNAs were not allowed to sit at the nurse's station.</p> <p>Interview, on 03/27/15 at 2:10 PM, with Licensed Practical Nurse (LPN) #7 revealed the noise level was louder than what it should be. Per interview, the call light system was extremely loud and if the call light system had a softer tone that would help decrease the noise level. LPN #7 stated the CNAs documented their work through the head sets and the residents didn't understand why they were talking so loud.</p>	F 258	<p>Activities staff and IDT team (consisting of Administrator, DON, ADON, Unit Manager, MDS Coordinator, Staffing Coordinator, Education and Training Director, Social Services, Activities Director, Dietary Director, Housekeeping Director, Maintenance Director, Business Office Manager, Medical Records and HR were educated by EDT on the call light system silenced and to look for the call lights and answer appropriately. This education will occur April 23-30 2015. The noise issue will be brought up resident council and they will advise they can report issue to activities director. The Activities Director and staff member will interview 5 interviewable residents 1 times per day for 5 days for 4 weeks then 1 time per week for 4 weeks to determine if sound levels are acceptable. Resident will be encouraged to fill out concern reports</p>		

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 258	Continued From page 10 Interview, on 03/27/15 at 9:15 PM, with the Administrator revealed the facility had taken measures to quiet things down by removing alarms from residents' beds and chairs which was to decrease falls, as well as, decrease the noise level. Continued interview revealed placing an extended wall between the dining room and the lobby with a coated material which would absorb the noise was being looked at by the facility, but was not finalized at this time. The Administrator indicated at night staff should attempt to be quiet so residents could sleep.	F 258	with any staff member to report noise level, Concern reports will be address and followed with by administrator or IDT member. Concerns reports are reviewed in morning meeting for IDT sugesstions as well. Results will be reported to the weekly QA meeting for 8 weeks. Any sound level grievances brought to the administrator, administration and/or resident council will receive prompt resolution by the administrator ongoing monthly and discussed in QA.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	Resident #6 care plan and Accunurse system were audited for correct level of assistance and updated. All nursing staff was inserviced on 4/21/15to reflect the preference to be put in bed at 4:00 PM. The care plan was also updated for toileting before and	4/30/15	

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

PRINTED: 04/10/2015
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 03/27/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was revised for one (1) of nine (9) sampled residents (Resident #6), who were reviewed for care plans out of a total of fifteen (15) sampled residents.</p> <p>Interviews with the resident and staff revealed the resident's preference was to be assisted back to the bed at 4:00 PM, so the resident would be ready for dinner service. However, observation revealed the resident was not assisted back to bed as preferred at 4:00 PM. Record review revealed the resident became anxious when he/she was not assisted to bed per his/her request. However, Resident #6's Comprehensive Care Plan was not revised to reflect the resident's preference to be assisted to back to bed at 4:00 PM.</p> <p>In addition, Resident #6's Comprehensive Care Plan was not revised to address the trunk restraint utilized by the resident or for the resident's history of constipation.</p> <p>The findings include:</p> <p>Review of the facility's, "Care Plans-Comprehensive" Policy, dated December 2010, revealed care plans were to be revised, developed and maintained by the facility's Care Planning/Interdisciplinary Team (IDT) in coordination with the resident, and his/her family or representative, by identifying the highest level of functioning the resident might be expected to</p>	F 280	<p>after meals, upon rising and before going to bed at night and as needed during which the trunk halter will have to be removed and the resident's skin will be observed for any signs of rubbing or breakdown. If any areas are noted the nurse will be notified for further assessment at that time. Nursing staff We will have a care plan meeting with Resident #6 to determine agreeable time to provide care as he desires.</p> <p>IDT began auditing resident plan of care 4/27/15 and completed 5/11/15 for bowel preferences, level of assistance and AM and PM care times. Residents with assistive devices have the potential to be at risk. All residents or responsible party will be interviewed by nursing administration for preferences for bedtime, wakeup times. Updates will be made to care plans and accunurse to reflect the</p>	
-------	---	-------	--	--

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	<p>Continued From page 12</p> <p>attain. Continued review of the Policy revealed each resident's Comprehensive Care Plan should be designed to reflect the resident's expressed wishes regarding care and treatment goals.</p> <p>1. Review of Resident #6's medical record revealed the resident was readmitted to the facility on 04/28/14, with diagnoses which included Cerebrovascular Accident and Friedreich's Ataxia (a rare inherited disease which causes nervous system damage, movement problems and leads to impaired muscle coordination). Review of the Quarterly Minimum Data Set (MDS) Assessment dated 01/21/15, revealed the facility assessed Resident #6 to have a Brief Interview for Mental Status (BIMS) of fifteen (15) out of fifteen (15), which indicated the resident was cognitively intact. Continued review of the MDS revealed the facility assessed Resident #6 to require extensive physical assist of two (2) persons for transfers and bed mobility. Review of Resident #8's Comprehensive Care Plan dated 10/02/14 and 02/25/15, revealed the facility had care planned the resident for self care deficit related to diagnoses including Muscular Dystrophy (a disease which causes progressive weakness and loss of muscle mass) with interventions in place. Continued review revealed the interventions included to adjust daily routine as needed to promote independence, provide assistance of two (2) staff for bed mobility and transfers.</p> <p>Review of the facility's, "Nursing Assistant Assignment Worksheet", which was utilized as a Nurse Aide Care Plan for Resident #6, dated 03/20/15, revealed the resident was to be assisted up after breakfast, to bed before lunch, up after lunch and back to bed around 5:00 PM.</p>	F 280	<p>resident's needs or wishes. Non verbal residents will be addressed through their families during care conferences and updated as needed to the plan of care. 5 ADL care plans will be updated per day until all are complete.</p> <p>Education by ETD will be done for all licensed nurses and CNA's staff on April 23-30 on toileting resident before and after meals, skin observation, bowel protocol and notification of the finding to the nurse for further assessment. Accunurse system/CNA care plan and ADL documentation will be updated to reflect toileting needs by IDT member on a daily basis 5 days per week. All existing residents will be assessed to determine if they could also be considered to restrain or be a restraint. If so, assessments will be done by the Interdisciplinary</p>		

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

PRINTED: 04/10/2015
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 03/27/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	<p>Continued From page 13</p> <p>Review of the Social Services (SS) Note dated 03/19/15 at 8:33 AM, revealed on 03/14/15 Resident #6 had been yelling at staff with the root cause determined to be the resident became easily upset when he/she had to wait on the Certified Nursing Assistants (CNAs) to lay him/her down or get him/her up. Continued review of the Note revealed the intervention was for staff to provide reassurance they would lay him/her down "as soon as they can".</p> <p>Interview with Resident #6 on 03/24/15 at 11:22 AM, revealed the resident expressed a preference to be assisted to bed by staff at 4:00 PM, in order to ready for dinner when it was served. Resident #6 stated when he/she asked staff for assistance to bed at 4:00 PM, staff always told the resident they had to wait for someone to assist them, which usually would take thirty (30) to forty-five (45) minutes. Per interview, Resident #6 was unable to get in and out of bed on his/her own and required help from the CNAs. Continued interview revealed all the staff knew Resident #6 wanted to go to bed at 4:00 PM each day. According to Resident #6, he/she was in a verbal altercation with one of the CNAs before because she would not help the resident to bed. Further interview revealed Resident #6 went to the Administrator with complaints regarding not being assisted to bed, and the Administrator had another staff person assist with helping him/her to bed.</p> <p>Interview with CNA#1 on 03/24/15 at 2:54 PM, revealed Resident #6 preferred to be put in the bed at 4:00 PM each day for supper. She stated sometimes the CNAs couldn't get Resident #6 to be at 4:00 PM in because they were in other</p>	F 280	<p>Team and the care plan will be updated accordingly for Needs for Restraints, Bowel protocol and care preferences.</p> <p>Going forward, we will discuss this during quarterly care plan meetings for all other residents. All new admissions will have a 72 hour care plan conference to discuss their preferences and desires. IDT will also be review care plans for correct level of assistance and care plans adjusted. All nurses will be educated on proper bowel movement protocol, returning to again offer intervention in case of non-compliance and proper charting of non-compliance</p> <p>Results of all assessments will be given to DON to report to QA Committee. QA committee will decide if further system changes are needed to be made or further education is needed. Staff will monitor ongoing and audit resident preferences and bowel protocol through the RAI process (quarterly,</p>	
-------	---	-------	---	--

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	<p>Continued From page 14</p> <p>residents' rooms or doing rounds. Per interview, Resident #6 required two (2) person assist for transfers, and sometimes the resident had to wait for other staff to be free to assist with transferring.</p> <p>Observation of Resident #6 on 03/24/15 at 4:25 PM, revealed the resident was in his/her room and was upset because he/she had asked the CNAs if they would assist the resident to bed at 4:15 PM, but was still waiting. Continued observation revealed Resident #6 was not assisted to bed until 4:39 PM, by CNA #12 and CNA #13. Interview with CNA #12 and CNA #13, as they were putting Resident #6 to bed, revealed they had been busy with another resident. However, they stated they did not explain this to Resident #6 when they were not able to assist him/her at the time the resident requested.</p> <p>Further review of Resident #6's Comprehensive Care Plan revealed no documented evidence of revisions to reflect the resident's preferences to be assisted to bed at 4:00 PM.</p> <p>Interview with the Director of Nursing (DON) on 03/25/15 at 10:52 AM, revealed Resident #6's Comprehensive Care Plan should have been revised to include the resident's preferences. She stated Resident #6 had complained to her and the Assistant Director of Nursing (ADON) about the CNAs not helping the resident to bed at the time requested. Per interview, she was trying to monitor the CNAs providing assistance and monitor the resident's behaviors.</p> <p>Interview with the ADON on 03/27/15 at 11:30 AM, in the absence of the DON, revealed Resident #6's Comprehensive Care Plan should have been revised to include the resident's</p>	F 280	<p>annually and as needed by resident request). Daily monitoring by IDT members for changes in preferences will be done through the RAI process. BM list will be addressed daily and will be reported to DON or IDT member by the end of day for resident results</p>	4/30/15	

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	<p>Continued From page 15</p> <p>preferences regarding wanting to go to bed at 4:00 PM. Per interview, it was her expectation staff follow the expressed and documented preferences of Resident #6. The ADON revealed she was unsure why the Nurse Aide Care Plan reflected 5:00 PM instead of 4:00 PM, as Resident #6's preferred time for going back to bed.</p> <p>2. Review of the facility's policy titled "Use of Restraints" dated December 2008, revealed care plans for residents in restraints would reflect interventions which addressed not only the immediate medical symptom(s) but the underlying problems possibly causing the symptom(s). Per the Policy, care plans should also include the measures taken to systematically reduce or eliminate the need for restraint use.</p> <p>Observation of Resident #6 on 03/24/15 at 11:10 PM revealed the resident wore a trunk halter restraint when up in his/her wheelchair.</p> <p>Review of the Social Services (SS) Note dated 05/20/14, revealed Resident #6 was provided with "shoulder straps" by therapy, to help with positioning for the resident when up in his/her electric wheelchair.</p> <p>Continued review of Resident #6's Comprehensive Care Plan dated 02/25/15, revealed no documented evidence the care plan was revised to include the use of the resident's trunk halter restraint or interventions relate to the restraint.</p> <p>Interview with Resident #6 on 03/25/15 at 12:03 PM, revealed the resident was unable to release the straps on the trunk halter restraint, and the</p>	F 280			

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

PRINTED: 04/10/2015
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 03/27/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	<p>Continued From page 16</p> <p>nurses did not release the restraint to check his/her skin. Per interview, the nursing staff only released the restraint to put Resident #6 back to bed.</p> <p>Interview with the DON on 03/25/15 at 10:52 AM, revealed Resident #8's Comprehensive Care Plans had not been revised regarding the use of the restraint which began on 05/20/14. She stated when the halter was first implement the facility had not considered it a restraint. Per interview, an Interdisciplinary Team (IDT) meeting had been held on 02/18/15, and that was when the halter was first considered as a "restraint". The DON revealed Resident #8's halter should have been care planned, and as the resident was unable to remove the belts on the halter/vest, it should have been considered a restraint upon implementation.</p> <p>Interview with the ADON, in the absence of the DON, on 03/27/15 at 3:15 PM, revealed Resident #6's Comprehensive Care Plan should have been revised to include the use of the restraint. Per interview, her expectations were that a Restraint Evaluation should have been completed and the Comprehensive Care Plan revised to include the details of the evaluation. Further interview revealed there was a potential of harm for Resident #6 related to the facility's failure to revise the care plan for the restraint, and staff might not adequately meet the care needs of the resident.</p> <p>3. Further record review revealed Resident #6 had a history of constipation, and experienced episodes of going for four (4) days, 02/17/15 to 02/20/15, and five (5) days from 03/08/15 to 03/12/15, with no documented evidence of a</p>	F 280		

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 280 Continued From page 17
bowel movement. However, further review of Resident #6's Comprehensive Care Plan dated 02/25/15, revealed no documented evidence it had been revised to include the resident's history of constipation with interventions in place to prevent further episodes. Even though review of Resident #6's archived Comprehensive Care Plan dated 10/02/14, revealed the resident had been care planned for constipation.

Review of Resident #6's Comprehensive Care Plan dated 02/25/15 does not address concern for the resident's frequent episodes of constipation that met and exceeded the three (3) day period nor have interventions been put into place to address relationship between the resident's problem areas with regard to infrequent BM and their causes.

Interview with the DON on 03/25/15 at 2:50 PM, revealed Resident #6's Comprehensive Care Plan dated 02/25/15, should have been revised to include the resident's constipation concerns with interventions in place.

Interview with the ADON, in the absence of the DON, on 03/27/15 at 11:30 AM, revealed it was her expectation Resident #6's Comprehensive Care Plan was revised to include the resident's constipation problem with interventions in place to prevent further episodes.

F 280

F 282
SS=D
483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

F 282

on 04/21/15
Resident #6 care plan and Accunurse system were audited for correct level of assistance and updated. All nursing staff was inserviced on 4/21/2015 regarding following care plans

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

PRINTED: 04/10/2015
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 03/27/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 282	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure residents' Comprehensive Care Plans were followed for one (1) of fifteen (15) sampled residents (Resident #6).</p> <p>Review of Resident #6's Comprehensive Care Plan revealed the interventions included for two (2) staff to assist the resident with transfers and bed mobility. However, record review revealed Resident #6 experienced a fall on 09/03/14, while being provided assistance by one (1) nurse.</p> <p>The findings include: Interview with the Director of Nursing (DON) on 3/25/15 at 2:30 PM, revealed the facility had no policy related to staff following residents' care plans. Record review revealed the facility readmitted Resident #6 on 04/28/14, with diagnoses including Atrial Fibrillation, Cerebrovascular Accident, Congestive Heart Failure and Friedreich's Ataxia (a rare inherited disease which causes nervous system damage, movement problems and leads to impaired muscle coordination). Review of the 01/21/15 Quarterly Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #6 to be cognitively intact, and to require the physical assistance of two (2) staff for transfers and bed mobility. Review of the resident's archived Comprehensive Care Plan dated 10/02/14 and current care plan dated 02/25/15, revealed the facility had care</p>	F 282	<p>including the number of assistance for care by ETD, Education and Training Director. Verbal education was given to ETD regarding following the plan of care for transfers, number of assist, bed mobility and ambulation by the DON. Written education will be given and documented by the DON for failure to follow plan of care.</p> <p>All residents have the potential to be affected. IDT will also be review care plans for correct level of assistance and care plans adjusted.</p> <p>DON, ADON, ETD, IDT member or UM will observe care of 5 residents per day for 5 days per week for 4 week., 1 time per day five days per week for 4 weeks then 1 time per week for 4 weeks using care plan follow form</p> <p>Results will be reported to QA Committee for 12 weeks by DON. QA committee will decide if further system</p>	
-------	--	-------	--	--

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 282	Continued From page 19 planned Resident #6 to require extensive physical assistance of two (2) persons for transfers and bed mobility. Review of Resident #6's Fall Incident Reports revealed an Incident Report dated 09/03/14, which noted the resident had experienced a fall at 12:31 PM. Continued review revealed Interview, on 03/25/15 at 2:20 PM, with Registered Nurse (RN) #1 revealed she was present when Resident #6 experienced the fall on 09/03/14. She stated she tried to change Resident #6's bed sheets due to spilled urine from the resident's urinal, and had no one to assist her. Per interview, Resident #6 grabbed the enabler bar on the bed and pulled too hard and fell to the floor from the bed. RN #1 revealed Resident #6 was care planned for an assist of two (2) persons for care; however, there had been no one to assist her on 09/03/14. She stated there should have been two (2) staff assisting the resident, and she had failed to follow Resident #6's care plan interventions, which resulted in his/her fall. Interview with the Assistant Director of Nursing, in the absence of the Director of Nursing (DON), on 03/27/15 at 11:30 AM and at 7:35 PM, revealed her expectation was for staff to follow residents' care plans. She revealed Resident #6's fall of 09/03/14 could have been avoided if the nurse had followed the resident's Comprehensive Care Plan intervention regarding providing two (2) person assist when she was changing the resident's sheets.	F 282	changes are needed to be made or further education is needed	5/11/15	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309			

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 309	Continued From page 20 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being for one (1) of fifteen (15) sampled residents (Resident #6). Resident #6 had a history of constipation with bowel medications ordered. However, there was no documented evidence Resident #6 received the bowel medications as ordered when the resident experienced no bowel movements (BMs) from 02/17/15 to 02/20/15, and from 03/08/15 to 03/12/15. The findings include: Review of the facility's "Bowel List" Protocol, undated, revealed if a resident had no BM for three (3) days the facility was to contact the Physician or Nurse Practitioner for orders for Milk of Magnesium (MOM) 30 cc or laxative of choice. Continued review revealed if the resident continued to have no BM for four (4) days the facility was to contact the Physician or Nurse Practitioner for an order for Dulcolax suppository	F 309	An immediate review of the daily BM list for March and April shows that Resident #6, name appeared several times where the bowel protocol was followed except for the days the resident refused the protocol which is documented on the BM list sheet. Resident #6 care plan was updated on 4/21/15 to include a goal that resident will have a normal BM every 3 days with an intervention to follow the bowel protocol. Residents with hx of constipation, at risk due to medications, decreased mobility or disease process are potentially at risk. ETD will provide education to nurses regarding bowel protocol, running BM list, actions taken, and documentation of non-compliance and daily results. Nursing Administration (DON, ADON, Unit Manager, MDS Coordinator, Education and Training		

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40089		
(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 309	<p>Continued From page 21</p> <p>or laxative of choice. Further review revealed if the resident had no BM for five (5) days the facility was to contact the Physician or Nurse Practitioner for referral for an x-ray of the resident's Kidneys, Ureter and Bladder (KUB) and notify the Physician or Nurse Practitioner of the results and further orders.</p> <p>Medical record review revealed the facility readmitted Resident #6 on 04/28/14, with diagnoses which included Congestive Heart Failure, Primary Cardiomyopathy, Cerebrovascular Accident, Atrial Fibrillation, Friedreich's Ataxia (a rare inherited disease which causes nervous system damage, movement problems and leads to impaired muscle coordination) and Muscular Dystrophy (a disease which causes progressive weakness and loss of muscle mass). Review of the 01/21/15 Quarterly Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #6 to be cognitively intact, and to be occasionally incontinent of bowel and bladder. Review of Resident #6's Comprehensive Care Plan dated 02/26/15, revealed no documented evidence the care plan was revised to include the resident's history of constipation with interventions in place to prevent further episodes of constipation, even though the resident had a diagnosis of Muscular Dystrophy.</p> <p>Review of Physician's Orders for February 2015 and March 2015 revealed the resident had orders dated: 09/19/14 for Bisac-Evac (Dulcojax) 10 milligram (mg) rectal suppository one (1) rectally daily as needed (PRN); 06/05/14 for MOM 30 milliliter (mL) by mouth daily PRN; and on 02/24/15 an order for Colace (a stool softener) 100 mg by mouth twice a day for constipation.</p>	F 309	<p>Director and Staffing Coordinator) will check all residents at risk for constipation for BM movements daily using the BM list. All nurses will be educated on proper bowel movement protocol, running bowel movement list daily and per shift, returning to again offer intervention in case of non-compliance and proper charting of non-compliance. A goal will be added to resident care plans that they will have a normal BM every 3 days with an intervention to follow the bowel protocol. Resident recorded bowel movements will be reviewed 5x/wk by nursing admin in the clinical meeting to ensure bowel protocol is followed and results. Nurses and CNA's will be educated to check bowel movements daily all new hires will be educated in orientation to check bowel movements every shift and follow BM protocol by ETD. Education was provided 4/23</p>		

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 309	Continued From page 22 Review of Resident #6's "Flow Sheet" where the resident's BMs were recorded revealed no documented evidence of the resident having a BM from 02/17/15 to 02/20/15, a four (4) day period, or from 03/08/15 to 03/12/15, a five (5) day timeframe. However, review of Resident #6's February 2015 and March 2015 Medication Administration Records (MAR) revealed no documented evidence the resident received the bowel medications for constipation as ordered. Even though the facility's "Bowel List" Protocol revealed if a resident had no BM for three (3) days the facility was to contact the Physician or Nurse Practitioner for orders for Milk of Magnesium (MOM) 30 cc or laxative of choice, Resident #6 already had MOM ordered; however, there was no documented evidence it was administered on 02/19/15 or 03/10/15. The Protocol noted if a resident continued to have no BM for four (4) days the facility was to contact the Physician or Nurse Practitioner for an order for Dulcolax suppository or laxative of choice. Resident #6 already had orders for the suppository; however, there was no documented evidence it was administered on 02/20/15 or 03/11/15. Additionally, the Protocol revealed if a resident had no BM for five (5) days the facility was to contact the Physician or Nurse Practitioner for referral for an x-ray of the resident's Kidneys, Ureter and Bladder (KUB) and notify the Physician or Nurse Practitioner of the results and further orders. However, review of Resident #6's record revealed no documented evidence the Physician was notified on 03/12/15, to obtain a referral for a KUB. Interview with Certified Nursing Assistant (CNA)	F 309	through 4/30. Form for recording bowel movements will be brought to morning meeting and reviewed by the clinical team 5x/wk ongoing to follow up on intervention. The QA committee will review monthly x3 to ensure the system for intervention and follow up on BM protocol is effective. DON or IDT member will provide documentation for any changes. Changes in protocol will be made as indicated by the QA committee.	4/30/15	

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 309	Continued From page 23 #14 on 03/27/15 at 2:46 PM, revealed Resident #6 preferred to wear an adult brief at night, and if the resident had not had a BM and needed a suppository, he/she preferred the medication at night. Interview with the Director of Nursing (DON) on 03/25/15 at 2:50 PM, revealed Resident #6's constipation concerns should have been carried over from the last Admission MDS Assessment. Per interview, Resident #6's history of constipation should have been care planned with interventions in place, as it had been care planned on the archived Comprehensive Care Plan dated 10/02/14. The DON revealed the nurses should have administered the bowel medications when Resident #6 did not have a BM for three (3) days or greater. no documented evidence of continued constipation concerns or interventions. Interview with the Assistant Director of Nursing (ADON) on 03/27/15 at 11:30 AM, in the absence of the DON, revealed the facility failed to follow the Bowel Protocol for Resident #6 from 02/17/15 to 02/20/15, and from 03/08/15 to 03/12/15. She stated it was her expectation for nurses to give the residents a laxative after three (3) days of no BMs. Per interview, the nurse should document the constipation and laxative administration in the medical record and notify the Physician. The ADON revealed however, Resident #6 had not received his/her bowel medication in a timely manner. She stated not following the facility's Bowel Protocol and not administering bowel medications for constipation could cause a potential for bowel impaction for the resident which could result in hospitalization. Further interview revealed Resident #6's history of	F 309			

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

PRINTED: 04/10/2015
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 03/27/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 309	Continued From page 24 constipation and current constipation problems should have been addressed on the resident's current Comprehensive Care Plans dated 02/25/15.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's "Fall Assessment" Process, it was determined the facility failed to ensure two (2) of fifteen (15) sampled residents received adequate supervision and assistance to prevent accidents (Residents #3 and #6). The facility failed to follow its written "Fall Assessment" Process when Resident #3 sustained a fall from his/her wheelchair when the wheelchair flipped backward onto the ground. There was no documented evidence of an initial assessment or of seventy-two (72) hour monitoring after the fall, even though the resident complained of hitting his/her head. In addition, there was no documented evidence an Incident Report was completed or an investigation conducted to analyze the incident and assess for the root cause of the fall to ensure appropriate interventions were initiated to prevent further falls.	F 323	1. Both Resident #6 and Resident #3 were checked on 4/21/2015 for any neurological, physical or mental issues which might result from fall by assigned nurse. None were noted. Care plan review shows that the fall of Resident #3 on 1/6/15 was addressed on the care plan and interventions were put in place on 1/7/15. Nurses note from 1/7/15 shows that the DON was made aware of the fall. Care plan review shows that the fall for Resident #6 on 9/3/14 was reviewed on 9/4/14, the incident on 2/25/15 was reviewed by the IDT on 2/26/15 and the fall on 3/17/15 was reviewed by the nurse and the nurse did notify the Nurse Practitioner on 03/17/15 at 11:45 per nurses noted documented in the computer system. It was	

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 25</p> <p>Also, there was no documented evidence the Physician was notified of the fall.</p> <p>Also, Resident #6 sustained three (3) falls between 09/03/14 and 03/14/15; however, there was no documented evidence of an initial assessment, ongoing 72-hour monitoring, care plan revision, investigation of the incident and/or root cause analysis completed for each fall.</p> <p>Additionally, the facility failed to ensure the Wanderguard door alarms were checked daily as per the facility's protocol. Observation on 3/26/15 revealed the East Exit door Wanderguard alarm was not working and did not alarm when tested.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 3/25/15 at 2:30 PM, revealed the facility did not have a policy related to falls. However, the facility utilized the "Fall Assessment" Process.</p> <p>Review of the "Fall Assessment" Process document, dated April 2011, revealed at the time of a fall after the resident was assessed, an Incident Report and investigation should be initiated to determine appropriate interventions. Per the Document the Interdisciplinary Team (IDT), family and Physician should be notified promptly, and medical record documentation for follow up and assessments should be completed promptly. Continued review revealed the medical record documentation should be reviewed by facility management, and follow up on the resident's condition would continue as needed for a minimum of seventy-two (72) hours. The "Fall Assessment" Process document revealed the fall injury plan of care was to be updated as</p>	F 323	<p>1. addressed on the care plan on 03/17/15 by EDT and intervention of PT to screen, pain assessment, re-education to ring for assistance while getting objects off the floor were put into place.</p> <p>2. All Fall risk residents have the potential to be affected.</p> <p>Education was provided on 4/21/15 by ETD, Education and training Director to all nursing staff, on documentation of falls immediately upon the event and for 72 hours later. An event board has been created for use by the IDT to show events and clue staff to document for 72 hours post event. DON will print, review and provide extra documentation in an IDT form related to falls. Nursing admin and IDT will review all falls for documentation, root cause and intervention for falls and follow up documentation pertaining to the fall. A binder has been created to review all falls in</p>	
-------	--	-------	--	--

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

PRINTED: 04/10/2015
FORM APPROVED
OMB NO. 0938-0397

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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 26</p> <p>appropriate. According to the Document, a Fall/Incident Investigation Tool must accompany any fall and the Quality Assurance (QA) Committee would review and ensure implementation of any recommendations offered by utilization of the Investigation Tool.</p> <p>Interview, on 03/27/15 at 6:00 PM, with the Social Worker (SW) revealed there was no policy related to falls, but the Incident Report, which was kept at each nurse's station was used by the nurses as a process for monitoring and documenting fall incidents.</p> <p>Review of the "Incident Report" form kept at the nurse's station, revealed an Accident/Incident Report was to be completed when a resident sustained a fall, and the fall was to be documented in the medical record with notification of the Physician and family. Per the "Incident Report" form when a resident sustained a fall, even if there were no apparent injuries, a fall investigation was to be completed. Continued review revealed if a resident had a fall and hit his/her head, the resident was to be placed on every shift charting and have vital signs obtained for three (3) days. Further review revealed if a resident hit his/her head or if it was unknown whether or not the resident hit his/her head in a fall, neurological checks were to be done and the neurological assessment flow sheet was to be completed.</p> <p>1. Review of Resident #3's clinical record revealed the facility re-admitted the resident on 12/03/14, with diagnoses which included Paraplegia, Convulsions, Depression, Osteoporosis, Chronic Pain and Neurogenic Bladder. Review of the Minimum Data Set (MDS)</p>	F 323	<p>3 QA. DON and IDT will review all Incident reports for accuracy/completion, follow up documentation, effectiveness of interventions and family and MD notifications. All nurse new hires will be instructed on falls documentation during nursing orientation and education will be completed for identified concerns by the DON an/or nursing admin.</p> <p>4 DON will report all results to weekly QA for evaluation and effectiveness of system and expectations. Results will be reviewed in the monthly QA by DON, ADON, ETD, UM or other nursing administration to discuss any systemic changes needing to be made or compliance of the program.</p>	5/5/15	

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

PRINTED: 04/10/2015
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 03/27/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 323 Continued From page 26
appropriate. According to the Document, a Fall/Incident Investigation Tool must accompany any fall and the Quality Assurance (QA) Committee would review and ensure implementation of any recommendations offered by utilization of the Investigation Tool.

Interview, on 03/27/15 at 6:00 PM, with the Social Worker (SW) revealed there was no policy related to falls, but the Incident Report, which was kept at each nurse's station was used by the nurses as a process for monitoring and documenting fall incidents.

Review of the "Incident Report" form kept at the nurse's station, revealed an Accident/Incident Report was to be completed when a resident sustained a fall, and the fall was to be documented in the medical record with notification of the Physician and family. Per the "Incident Report" form when a resident sustained a fall, even if there were no apparent injuries, a fall investigation was to be completed. Continued review revealed if a resident had a fall and hit his/her head, the resident was to be placed on every shift charting and have vital signs obtained for three (3) days. Further review revealed if a resident hit his/her head or if it was unknown whether or not the resident hit his/her head in a fall, neurological checks were to be done and the neurological assessment flow sheet was to be completed.

1. Review of Resident #3's clinical record revealed the facility re-admitted the resident on 12/03/14, with diagnoses which included Paraplegia, Convulsions, Depression, Osteoporosis, Chronic Pain and Neurogenic Bladder. Review of the Minimum Data Set (MDS)

F 323

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

PRINTED: 04/10/2015
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 03/27/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 27</p> <p>Assessment, dated 01/17/15, revealed Resident #3 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15). Further review of the MDS revealed the resident had impairment of the lower extremities on both sides.</p> <p>Review of the Nurse's Note, dated 01/07/15 at 2:12 PM, revealed the resident reported the day before he/she flipped backward in his/her wheelchair. However, there were no documented evidence in the Nurse's Notes of a fall occurring on 01/06/15. In addition, there was no documented evidence of any assessments including neurological checks, skin, pain, or range of motion, or of vital signs obtained. Continued review revealed no documented evidence the Physician or Physician Assistant (PA) were notified. Further review revealed there was no documented evidence of an Incident Report completed or a fall investigation completed on 01/06/15, as per the facility's "Fall Assessment" Process. Resident #3's Comprehensive Plan of Care was updated on 01/07/15, and to include having maintenance check the anti-tippers, do pain and fall assessment and educate the resident on proper wheelchair usage on a ramp.</p> <p>Interview, on 03/25/15 at 5:20 PM, with Resident #3 revealed the resident had fallen backwards in his/her wheelchair in January 2015, but could not recall the date. Resident #3 revealed he/she hit the back of his/her head. Continued interview revealed License Practical Nurse (LPN) #6 and a Certified Nurse Assistant (CNA), name not known, helped the resident up off the ground. The resident stated she told the nurse he/she had hit his/her head; however, no vital signs were taken, nor were neurological checks done after the fall.</p>	F 323		
-------	--	-------	--	--

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	Continued From page 28 Interview, on 03/26/15 at 3:00 PM, with LPN #6 revealed a CNA, name unknown, summoned her to the facility's smoking area to help get Resident #3 up off the ground. LPN #6 stated she observed Resident #3 in his/her wheelchair which was lying backwards on the ground. Per interview, Resident #3 told her he/she hit his/her head at the time of the fall; however, the CNA gestured to the nurse to indicate the resident had hit his/her head, so she did not do neurological checks. Continued interview revealed LPN #6 "looked the resident over", and the resident did not appear hurt because he/she was moving his/her arms. LPN #6 stated she did not do an Incident Report or document the fall and her assessment in the medical record, nor did she notify the Physician or family. Further interview revealed because the fall was witnessed by the CNA, she did not feel the need to document the incident. Interview, on 03/27/15 at 8:50 PM, with Registered Nurse (RN) #1 revealed she entered Resident #3's room to administer medication on 01/07/15 at 2:12 PM, when the resident told her he/she had flipped out of the wheelchair the day before on 01/06/15. However, RN #1 revealed there was no documented evidence of a fall on 01/06/15, and it should have been according to facility's policy. RN #1 stated she did not complete an Incident Report, since she did not actually observe or witness the incident. However, she stated she did write a Nurse's Note, relating the information the resident had given her regarding his/her wheelchair flipping backward onto the ground, while he/she was in it. Interview, on 03/26/15 at 4:20 PM, with the	F 323			

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

PRINTED: 04/10/2015
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 03/27/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 29</p> <p>Assistant Director of Nursing (ADON), in the absence of the DON, revealed Resident #3 should have had an assessment, including vital signs, range of motion, and a skin check as well as, been checked for pain after the fall. She stated if a resident stated he/she hit their head whether it was witnessed or unwitnessed, neurological checks should have been done and documented in the medical record. Also, she stated an Incident Report should have been completed by the nurse. In addition, the ADON indicated the "Fall Assessment" Process should have been followed; however was not followed for Resident #3's fall. Per the ADON, there was no indication of an investigation to determine the root cause and ensure appropriate interventions were added to the care plan after the fall in order to prevent further falls. In addition, the ADON revealed there was no documentation of the fall and the initial assessment after the fall, as well as, continued assessments for seventy-two hours, as per the facility's process. Further interview revealed there was no documentation indicating the Physician was notified of the fall either, but there should have been.</p> <p>2. Review of Resident #6's medical record revealed the facility readmitted the resident on 04/28/14, with diagnoses which included Atrial Fibrillation, Friedreich's Ataxia (a rare inherited disease which causes nervous system damage, movement problems and leads to impaired muscle coordination), Muscular Dystrophy (a disease which causes progressive weakness and loss of muscle mass), Congestive Heart Failure, and Cerebrovascular Accident. Review of the Quarterly MDS Assessment dated 01/21/15, revealed the facility assessed the resident to have a BIMS of fifteen (15) indicating no cognitive</p>	F 323		
-------	---	-------	--	--

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

PRINTED: 04/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155336	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 30</p> <p>impairment. Further review of the MDS Assessment revealed the facility assessed Resident #6 as requiring extensive physical assistance of two (2) persons for transfers and for bed mobility. Review of Resident #6's Comprehensive Care Plans dated 07/18/14 and 02/25/15, revealed the resident was care planned to receive assistance of two (2) persons for transfers and bed mobility.</p> <p>Review of Resident #6's Fall Incident Reports revealed the resident experienced falls on 09/03/14, 02/25/15 and 03/14/15.</p> <p>Per the Fall Incident Report, for the fall incident on 09/03/14, the "nurse reported resident was in the floor". Continued review of the 09/03/15, Report revealed Resident #6 was assessed, denied hitting his/her head, denied any pain from fall and had a small scratch noted to the right upper arm. Continued record review revealed no documented evidence of an initial assessment, of a Fall Investigation Worksheet having been completed after the fall, or of ongoing assessments for 72 hours were completed regarding the fall incident on 09/03/14, as per the facility's "Fall Assessment" Process. In addition, the Fall Incident Report and Nurse's Notes revealed no documented evidence of the root cause of Resident #6's fall incident. Review of the Comprehensive Care Plan revealed no documented evidence it was revised/updated for Resident #6's fall on 09/03/14.</p> <p>Interview with Registered Nurse (RN) #1 on 03/25/15 at 2:20 PM, revealed she was assisting Resident #6 on 09/03/14, after he/she spilled urine from the urinal on the bed linens. Per interview, she attempted to change the bed linen</p>	F 323			

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 31</p> <p>alone, with Resident #6 grabbing for the enabler bar. She stated Resident #6 pulled too hard on the enabler bar and fell out of the bed onto the floor. was present during the fall incident of 09/03/14. She stated the date of 09/04/14 entered on the Comprehensive Care Plan was for the incident of 09/03/14. Per RN #1, the Nurse Aide Care Plans at the time of Resident #6's fall on 09/03/14, indicated the resident was an assist of one (1). RN #1 reviewed Resident #6's Comprehensive Care Plan, and stated she agreed there should have been two (2) staff assisting the resident on 09/03/14. Further interview revealed by assisting Resident #6 by herself on 09/03/14, the care plan was not followed with regard to the resident's care planned needs.</p> <p>Review of Resident #6's Fall Incident Report dated 02/25/15, revealed the resident "fell" when he/she reached for his/her iPad (electronic tablet). Review revealed the resident became wedged between the bed and the dresser when he/she fell. Per the Report, Resident #6 called for help and the nurse and a Certified Nursing Assistant (CNA) helped the resident back to a seated position on the bed, and the resident stated he/she was not hurt. Further review of the resident's medical record revealed no documented evidence of the facility's ongoing assessment of the resident for 72 hours after the incident, as per the facility's "Fall Assessment" Process.</p> <p>Review of Resident #6's Fall Incident Report dated 03/17/15, revealed the resident "was attempting to pick up" his/her urinal off the floor, and the upper part of the resident's body was laying on the floor, with his/her legs still on the</p>	F 323		

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	Continued From page 32 bed. Per the Report, Resident #6's head was raised up off the floor. Additional record review revealed the fall incident was documented in Nurse's Notes with an initial assessment and vital signs noted. However, record review revealed no documented evidence of the 72 hour ongoing assessment of the resident after the incident, as per the facility's "Fall Assessment" Process. Interview with the Director of Nursing (DON) on 03/25/15 at 10:52 AM, revealed based on the archived Comprehensive Care Plans, there was no documentation of the fall incident which occurred on 09/03/14, nor documentation in the Nurse's Notes that would assist in the determination of the root cause of the incident. She stated the nurses were to fill out an Incident Report after a fall or incident. Per interview, the nurses were responsible for notifying the family and the Physician on the same date of the incident. The DON revealed it was her expectation the nurses document in the Nurse's Notes regarding any follow-up activity conducted with a resident who had fallen, for up to 72 hours. She stated the facility's "Fall Assessment" Process called for a morning stand-up meeting, to be conducted on the next morning after the fall or incident, to review for interventions and update/revise the care plan. Continued interview revealed the nurses were required to put interventions in place on the date of the fall and if not entered, the Interdisciplinary Team (IDT) reviewed and placed the interventions on the Comprehensive Care Plans. She stated the falls process was not followed completely for Resident #6's fall incidents on 09/03/14, 02/25/15 and 03/17/15. Further interview revealed there was no documentation of 72 hour monitoring for the fall incidents which occurred on 09/03/14.	F 323			

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 323 | Continued From page 33

02/25/15 or 03/17/15; however, there should have been. Additional interview with the DON on 03/25/15 at 2:30 PM, revealed the facility did not keep copies of Nurse Aide Care Plans, and therefore was unable to provide documented evidence the resident was an assist of one (1) at the time of the fall incident on 09/03/14.

Interview with the Assistant Director of Nursing (ADON) on 03/27/15 at 11:30 AM, in the absence of the DON, revealed it was her expectation staff assess a resident experiencing a fall and indicate the root cause of the incident, send the injured resident out if needed, complete vital signs, and complete neurological checks if there was no witness to the fall. According to the ADON, the nurse should notify the Physician and family, complete the Incident Report, assess and chart on the resident every day for three (3) days including vital signs and monitoring of the resident. Per interview, staff should enter interventions on the Incident Report and Comprehensive Care Plan and in the Nurse's Notes. She stated failing to do all this would result in the potential for a repeat fall or incident for a resident.

3. Review of the Elopement Books at each nurses station, revealed there was twelve (12) residents who were at risk for elopement who wore Wanderguard bracelets.

Interview with the Administrator on 03/26/15 at 5:30 PM, revealed there was no written policy related to checking Wanderguard door alarms; however, his expectation was that all the Wanderguard doors be checked daily by the Maintenance Director on weekdays, and by the Weekend Supervisor on weekends. He stated

F 323

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 34</p> <p>the Wanderguard alarms system on the doors was checked with a Wanderguard bracelet by getting close to the door with the bracelet and ensuring the door locked down and alarmed.</p> <p>Observation of the Administrator checking the Wanderguard alarm doors on 03/26/15 from 5:35 PM until 6:00 PM, revealed the front door lobby door sounded and locked down when tested with the Wanderguard bracelet, the west exit door sounded and locked down when tested, the east side door sounded and locked down when tested; however, the east back exit door did not sound and lock down when tested. The east back exit door opened after fifteen (15) seconds of pushing on the door.</p> <p>Continued interview with the Administrator on 03/26/15 at 6:00 PM, revealed four (4) doors had the Wanderguard system alarms, the lobby door, the east side door, and the east and west back doors. The Administrator revealed he was to check the Wanderguard alarm doors when the Maintenance Director was not here during the week. The Administrator stated the Maintenance Director had not been at the facility on 03/25/15 and 03/26/15, and had left for vacation and he (the Administrator) had not checked the Wanderguard alarm system on the doors for the past two (2) days. He stated this could be a concern if a resident with a Wanderguard attempted to exit the east back door exit. Further interview revealed he was not sure if Maintenance had logged checking the Wanderguard alarm system in a book or the computer, and he was unable to readily find the information. According to the Administrator, he would place someone at the east back door exit until the door alarm system could be fixed, and he</p>	F 323			

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

PRINTED: 04/10/2015
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 03/27/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	----------------------

<p>F 323</p> <p>F 441 SS=E</p>	<p>Continued From page 35 would call right away to have the door alarm system repaired.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of</p>	<p>F 441</p>	<p>CNA who could not identify proper procedures or technique for hand washing and infection control was immediately removed from patient care during the survey when reported to the DON and received re-education immediately by EDT, EDT on hand washing, infection control and glove usage. She demonstrated to the EDT, after education, correct procedure. Observation of residents 1,2,4,7 and 9 show poor infection control practices. These residents were followed for 1 week and revealed no signs or symptoms of skin integrity infections. Residents E, F and G have shown no signs or symptoms of infections. Resident H no longer has apples on the sink and the sink was disinfected properly by housekeeping.</p> <p>All residents have the potential to be affected. A staff skill test being instructed by Education and</p>	
------------------------------------	--	--------------	--	--

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	Continued From page 36 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a sanitary environment and to help prevent the development and transmission of disease and infection for six (6) sampled residents (Residents #1, #2, #4, #5, #7 and #9) out of a total of fifteen (15) sampled residents, and four (4) unsampled residents (Unsampled Residents E, F, G and H). Observation of a skin assessment and/or dressing change for Residents #1, #4, and #5 revealed poor infection control technique by staff related to handwashing and glove usage. In addition, during the dressing change for Resident #5, the nurse placed the plastic bag holding the soiled dressings and soiled gauze on the sink counter on the side of the sink which belonged to Unsampled Resident H right next to an open bag of apples. Observation of meal trays being served in the hallway revealed a staff member was not washing or sanitizing her hands between setting up meal trays, although she was assisting residents to sit up in bed and touching objects in resident rooms when serving the trays. This affected Unsampled Resident E, Unsampled Resident F and Unsampled Resident G.	F 441	training Director April 23 rd through April 30 th . Skills competency test will be done on an ongoing basis, skills education will given as needed. DON, ADON, Unit Manager, or, Education and training Director will watch 2 staff members per day demonstrate proper procedures/technique for hand washing and infection control 5 days per week for 4 weeks, 1 staff member per day 5 days per week for 4 weeks and 1 per week for 4 weeks. All new hires will be instructed on proper hand washing procedures and techniques and glove usage upon hire and as needed for compliance, in addition to above stated system. LPN #1 and 8 identity was not revealed by the survey team. All licensed staff have been educated on proper skin assessments and reeducated on hand hygiene, hand washing, sanitizing between meal trays and proper		

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 37</p> <p>Observation of Resident #7 revealed a staff member did not wear gloves while assisting the resident to blow his/her nose and the staff member also failed to wash her hands afterwards, touching a doorknob to an office.</p> <p>Resident #9 did not receive the pneumococcal vaccine as ordered, and there was no documented evidence the resident had declined the vaccine.</p> <p>Review of Resident #2's Physician's Orders dated 03/12/15, revealed orders to re-collect a urinalysis and culture and sensitivity. However, review of the laboratory data revealed the urine specimen was not collected until 03/16/14, four (4) days later.</p> <p>The findings include:</p> <p>Review of the facility's, "Handwashing/Hand Hygiene" Policy, revised August 2012, revealed the facility considered hand hygiene the primary means to prevent the spread of infection. Review revealed employees must wash their hands under the following conditions: before and after direct resident contact; before and after assisting a resident with meals; before and after entering isolation precaution settings; before and after changing a dressing; after blowing or wiping nose; after contact with a resident's mucous membranes and body fluids or excretions; and after handling soiled or used dressings. Continued review of the Policy, revealed if hands were not visibly soiled, staff could use an alcohol based hand rub for the following situations: before and after direct contact with residents; and before moving from a contaminated body site to a</p>	F 441	<p>disposal of soiled dressings 4/23 through 4/30/15. Activities staff was verbally educated by ADON on 4/3/15 regarding infection control practices to include wearing gloves when coming in contact with residents body fluids and immediate hand washing.</p> <p>DON will report all results to weekly QA for evaluation and effectiveness of system and expectations. Resident #9 received their vaccination on 3/23/2015. ETD provided written education to ADON on vaccine compliance and quarterly monitoring of vaccines on 4/30/2015. ETD provided education to all licensed staff regarding urinalysis collection, timing and obtaining in and out catheter orders if needed in order to obtain timely specimens on 4/23/2015. ADON or IDT member will monitor compliance with labs 5 days per week and report compliance in morning</p>		

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	Continued From page 38 clean body site during care, and after removing gloves. 1. Review of Resident #5's medical record revealed the facility re-admitted the resident on 10/23/14, with diagnoses which included Depression, Diabetes Mellitus, and Chronic Kidney Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 01/19/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a two (2) indicating severe cognitive impairment. Further review revealed the facility assessed the resident as having no ulcers, wounds, or skin problems. Observation, on 03/25/15 at 9:30 AM, of a skin assessment and dressing change for Resident #5, revealed Licensed Practical Nurse (LPN) #1 assessed the resident's perineal area, then replaced the resident's brief. Continued observation revealed the nurse then, with the same soiled gloves, assessed the resident's neck. LPN #1 was observed to then remove her gloves and without washing or sanitizing her hands, placed Resident #5's hearing aid in the resident's right ear. Prior to the skin assessment and dressing change LPN #1 was observed to have placed a plastic bag on the sink counter which was shared by Resident #5 and Unsampled Resident H. Further observation revealed LPN #1 utilized the plastic bag during the dressing change to place the soiled dressings and used gauze in. Observation revealed the bag was on the side of the counter which belonged to Unsampled Resident H, and there was an open bag of apples lying next to bag with the soiled dressings.	F 441	meeting. Admin nursing will monitor and audit hand washing, patient care, labs, meal delivery, 2 skin assessments and 2 dressings 5 days per week for 8 weeks. Shifts will be rotated. There are no weekend only staff. If admin nursing identifies issues during the audits, immediate written on the job training will be done by the admin nurse for the deficient practice. Results will be reviewed in the weekly QA to discuss any systemic changes needing to be made or compliance of the program.	5/11/15	

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 39</p> <p>Interview with LPN #1 on 03/25/15 at 9:50 AM, revealed it had been awhile since anyone had observed her to do a skin assessment or dressing change. She stated she was nervous and most of the time she would put the plastic bag for soiled dressings on the resident's bed; however, did not see a concern with placing the plastic bag on the sink counter. LPN #1 stated she should have washed her hands after putting the resident's brief back on, and before assessing the resident's neck. She also stated she should have washed her hands prior to placing the resident's hearing aid in the resident's ear.</p> <p>Interview with the Infection Control Nurse (ICN)/Assistant Director of Nursing (ADON), on 03/25/15 at 11:20 AM, revealed the plastic bag should have not been placed on the sink counter due to infection control issues, and should have been placed on the bed during the dressing change. She stated the nurse should have washed her hands after placing the resident's brief on and before assessing the resident's neck. The ICN/ADON revealed the nurse should also have washed her hands before placing the hearing aid in Resident #5's ear.</p> <p>2. Review of Resident #4's medical record revealed the facility re- admitted the resident on 12/31/14, with diagnoses which included Diabetes Mellitus and Diabetic Ulcers. Review of the Quarterly MDS Assessment dated 01/18/15, revealed the facility assessed the resident as having a BIMS of a thirteen (13) out of fifteen (15) indicating he/she was cognitively intact. Further review of the MDS revealed the facility assessed the resident as having a diabetic foot ulcer and as receiving dressings to the feet.</p>	F 441			

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

PRINTED: 04/10/2015
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 03/27/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 40</p> <p>Review of the laboratory (lab) report data revealed a wound culture was collected of the resident's right little toe on 03/13/15, and verified on 03/17/15, as Methicillin Resistant Staphylococcus Aureus (MRSA), a strain of bacteria resistant antibiotics and Morganella Morganii (a gram negative rod bacteria).</p> <p>Review of the Physician's Orders dated 03/17/15, revealed orders for Zosyn (an antibiotic medication) 13.5 grams (gms) intravenous (IV) every six (6) hours for six (6) weeks, PICC line placement and contact isolation.</p> <p>Observation on 03/25/15 at 10:00 AM, of a skin assessment and dressing change for Resident #4 revealed LPN #8 donned Personal Protective Equipment (PPE) prior to entering the room stating the resident had MRSA in the ulcer of the right fifth toe. Observation revealed the nurse removed the dressing from the resident's right heel and right fifth toe, then removed her soiled gloves and washed her hands and donned new gloves. Continued observation revealed LPN #8 cleansed the resident's right heel ulcer with Normal Saline and gauze, then with the same soiled gloves cleansed the ulcer to the right fifth toe with Normal Saline and gauze. LPN #8 was then observed, with the same soiled gloves on, to measure the right fifth toe ulcer and commenting the diabetic ulcer had MRSA. Observation revealed LPN #8 still using the same soiled gloves measured the diabetic ulcer on the resident's right heel. Further observation revealed LPN #8 then sprinkled Celerate Powder (a collagen based powder which conforms to a wound of any size or shape, and does not need to be removed from the wound bed) to both wounds and then placed a non adhesive dressing. Kerlex</p>	F 441		

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

PRINTED: 04/10/2015
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 03/27/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 41 and Coban over the wounds. LPN #8 then observed to removed her PPE and wash her hands prior to exiting the room.</p> <p>Interview, on 03/25/15 at 10:35 AM, with LPN #8 revealed she had not been observed to perform dressing changes or skin assessments at the facility, and was nervous. She stated, after thinking about it, she should have washed her hands and changed gloves after cleansing the heel ulcer, and before cleansing the right fifth toe ulcer. Per interview, she should have washed her hands and donned new gloves between measuring the two (2) ulcers and dressing the two (2) ulcers. LPN #8 stated she should have completed the dressing change on one wound, and then completed the dressing on the next wound to prevent cross contamination from one (1) wound to the other. She stated she could have contaminated the heel ulcer with MRSA from the right fifth toe ulcer.</p> <p>Continued interview with the ICN/ADON on 03/25/15 at 11:20 AM, revealed the nurse should have washed her hands and changed her gloves between cleaning the two (2) ulcers, and also between measurements and dressing changes of the two (2) ulcers to prevent contamination of the wound sites.</p> <p>3. Review of Resident #1's medical record revealed the facility re-admitted the resident on 01/28/15, with diagnoses which included Alzheimer's Disease, Dementia with Behaviors, Hypertension, Muscle Weakness, Anxiety and Depression. Review of the Annual MDS Assessment dated 01/123/15, revealed the facility assessed the resident as having a BIMS of a three (03) out of fifteen (15), which indicated</p>	F 441		
-------	--	-------	--	--

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 42 severe cognitive impairment.</p> <p>Observation on 03/26/15 at 9:55 AM, of Resident #1's head to toe skin assessment performed by LPN #8, revealed the nurse assessed the resident's head, ears, face and upper torso area, and then assessed the perineal and rectal area. Continued observation revealed LPN #8 did not wash her hands or don new gloves before assessing the resident's thighs, lower legs and feet. Further observation revealed after completing the assessment LPN #8 removed her gloves and washed her hands.</p> <p>Interview, on 03/26/15 at 10:05 AM, with LPN #8 revealed she should have washed her hands and donned new gloves after she assessed the resident's perineal and rectal area. LPN #8 stated she had been educated on hand washing and infection control and she knew to wash her hands and change gloves after assessing the perineal and rectal area. However, she stated she was nervous being observed by the Surveyor.</p> <p>Interview, on 03/26/15 at 10:45 AM, with the ICN/ADON revealed the nurse should have washed her hands and donned new gloves after assessing the perineal and rectal area, which were considered "dirty" areas.</p> <p>4. Observation on 03/24/15 at 12:00 PM, revealed Certified Nursing Assistant (CNA) #15, entered room 29-1 donned gloves, used the bed control to raise the head of the bed for Unsampled Resident E, and assisted the resident to a sitting position. Continued observation revealed CNA #15 then ran a gloved hand through the resident's hair, removed her gloves and exited the room without washing her hands.</p>	F 441		

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

PRINTED: 04/10/2015
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 03/27/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 43</p> <p>CNA #15 was then observed to go to the meal cart, pick up a meal tray and enter Room #33 which had a sign on the door stating "see nurse before entering", and with PPE hanging on a rack on the door. Observation revealed CNA #15 set up the meal tray for Unsampled Resident F who was in room 33-bed 1, moved the wash basin which was at the foot of the bed, then exited the room without washing her hands. CNA #15 was then observed to don a mask and gown, but not gloves and went to the meal cart, picked up a tray, then re-entered Room 33 and went to bed 2 to deliver a tray to Unsampled Resident G. Further observation revealed CNA #1 then removed her PPE, and exited the room without washing her hands and was observed to sanitize her hands in the hallway.</p> <p>Interview, on 03/24/15 at 1:00 PM, with CNA #15 revealed she should have sanitized her hands or washed her hands between delivering each meal tray because she could touch the resident or resident's belongings, and she should always wash her hands after removing gloves. Per interview, she should wear gloves if a resident was in isolation, and she should have washed her hands prior to exiting the isolation room. CNA #15 confirmed that Unsampled Resident F was in isolation. Further interview revealed she did not remember ever being observed by facility staff when passing hall trays, but stated she had been educated on when to wash her hands and use gloves.</p> <p>Continued interview with the ICN/ADON on 03/25/15 at 11:20 AM, revealed staff should wash or sanitize hands between meal trays, and also prior to exiting the rooms. She stated the CNA should have worn gloves as part of the PPE for</p>	F 441		
-------	--	-------	--	--

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 44</p> <p>Unsampled F and should have washed hands before exiting the isolation room. Per interview, she did not perform infection control observations/audits of staff while they were providing care to the residents. She stated however, she was unsure if the staff development nurse was auditing staff for infection control.</p> <p>Interview with the Staff Development Nurse (SDN) on 03/25/15 at 11:30 AM, revealed she had been employed at the facility for about a year. She stated on hire, staff got verbal training related to skin assessments and isolation precautions including PPE as well as handwashing. Per interview, recently she had verbally educated staff related to passing meal trays. According to the SDN, she had not done observations or audits related to dressing changes, skin assessments, or passing meal trays however. Further interview revealed she did do observations randomly of staff doing handwashing to ensure staff knew how to wash their hands at the sink, but did not watch staff providing care to ensure they knew when to wash their hands during care.</p> <p>5. Observation on 03/25/15 at 1:25 PM, revealed Activity Staff Member #1 assisted Resident #7 with blowing his/her nose and wiped the resident's nose using a tissue; however, the staff member was observed not to be wearing gloves. Further observation revealed Activity Staff Member #1 did not wash her hands after assisting the resident, but went to the Human Resources room and opened the door touching the door knob.</p> <p>Interview, on 03/25/15 at 1:30 PM, with Activity Staff Member #1 revealed she had assisted</p>	F 441			

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

PRINTED: 04/10/2015
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 03/27/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 441 Continued From page 45

Resident #7 with blowing his/her nose without wearing gloves; however, she should have worn gloves. She stated she had entered the Human Resource room without washing her hands and should have washed her hands after assisting Resident #7.

Interview with the ICN/ADON on 03/27/15 at 5:10 PM, revealed staff should wear gloves when assisting residents to blow their nose and should wash their hands directly afterwards.

6. Interview, on 03/27/15 at 10:15 AM, with the ICN/ADON, in the absence of the Director of Nursing (DON) revealed the facility had no policy related to residents' immunizations. Per interview, however, the pneumovax vaccine was to be offered and a consent form signed, and the facility was to administer the vaccine if the resident or responsible party was agreeable.

Review of Resident #9's medical record revealed the facility admitted the resident on 11/24/14, with diagnoses which included Alzheimer's Disease and Hypertension. Review of the Admission MDS Assessment dated 12/05/14, revealed the facility assessed the resident as having a BIMS score of a thirteen (13) out of fifteen (15), indicating the resident was cognitively intact. Further review of the MDS revealed no documented evidence the facility addressed if the resident's pneumococcal vaccine was up to date.

Review of the Physician's Orders dated 03/12/15, revealed orders to administer the Pneumovax Vaccine. However, continued review of the medical record revealed there was no documented evidence the pneumococcal vaccine was administered, or that the resident or

F 441

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 46</p> <p>responsible party had declined the vaccine.</p> <p>Interview, on 03/25/15 at 6:40 PM, with the ICN/ADON revealed the facility had not administered the pneumococcal vaccine to the resident. The ICN/ADON stated however, the vaccine should have been administered by the admission nurse on the day of admission, because the resident's responsible party had consented to have the vaccine given as per documentation. Further interview revealed she had started an audit recently after she recognized other residents were not receiving vaccines on admission when they consented to have the vaccines administered.</p> <p>7. Interview, on 03/27/15 at 4:45 PM, with the ICN/ADON, in the absence of the DON, revealed there was no policy related to collecting urine specimens as ordered; however, it was her expectation the specimens be collected by the next day.</p> <p>Review of Resident #2's medical record revealed the facility admitted the resident on 03/09/15, with diagnoses which included Paraplegia, Depression, and a suprapubic catheter for a diagnosis of Neurogenic Bladder. Review of the Admission MDS Assessment dated 03/15/15, revealed the facility assessed the resident as having a BIMS of a fifteen (15) indicating no cognitive impairment and as having an indwelling catheter.</p> <p>Review of the Physician's Orders dated 03/12/15, revealed orders to re-collect a urinalysis and culture and sensitivity. Review of the lab report data revealed the urine specimen was not collected until 03/16/14, four (4) days later.</p>	F 441			

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

PRINTED: 04/10/2015
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 03/27/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40060
---	--

(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 441	<p>Continued From page 47</p> <p>Review revealed the urinalysis was reported on 03/18/15 and the organism was Proteus Mirabilis, Gram Negative Rods and no sensitivity would be done. Review of the Physician's Orders dated 03/18/15, revealed orders for Keflex (an antibiotic medication) 500 milligrams (mgs) twice a day every twelve (12) hours for ten (10) days for a Urinary Tract Infection (UTI).</p> <p>Interview, on 03/27/15 at 4:45 PM, with the ICN/ADON, in the absence of the DON, revealed she reviewed Resident #2's chart and the urine specimen should have been collected by 03/13/15, because it was ordered on 03/12/15. She stated it would not be a problem to obtain a urine on Resident #2 because the resident had a suprapubic catheter. She further stated the urine specimen should have been collected promptly.</p>	F 441		
F 520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>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.</p> <p>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.</p> <p>A State or the Secretary may not require disclosure of the records of such committee</p>	F 520	<p>1. Members of the Quality Assurance Committee met on 4/21/15 and discussed the Care Plan revision process and Infection Control Program to ensure all care plans will be revised when appropriate and that Infection Control practices are followed throughout the facility. Processes and guidelines for documentation were reviewed by the committee with education being developed and audits discussed and created to be monitored and brought back to the quality Assurance Committee for any further directions or recommendations required. The</p>	

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 520 Continued From page 48
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 record review, it was determined the facility failed to maintain a Quality Assessment and Assurance Program which developed and implemented appropriate plans of action to correct quality deficiencies. This was evidenced by repeated deficiencies related to the facility's failure to ensure Comprehensive Care Plans were reviewed and revised, failure to ensure Comprehensive Care Plans were followed, and failure to ensure there was an effective Infection Control Program.

The findings include:
Review of the facility's, "Quality Assurance (QA) Systems Process Overview", revised March 2013, revealed QA systems were for investigation of the skin management system, Infection Control, Restraints, Abuse Prevention, Behavior Monitoring, Weights, Change of Condition and Pain.

1. Review of the facility's Plan of Correction, with a compliance date of 05/11/14, for deficiencies cited on 03/27/14 and 04/16/14, revealed all new Physician's Orders would be reviewed daily in the

F 520

1. Quality Assurance Committee reviewed the Care Plan Process and Infection Control Program along with the educational sessions for updating the care plan and following the infection control program for any recommendations on 4/21/15. The QA Committee reviewed the employee roster and compared with the education required set forth in this plan of correction that all employees received the appropriate education and signed the educational requirement. The committee also determined that all new employees will be inserviced on the Infection Control program and any new licensed nurse hired would receive education on updating care plans prior to their start of work.
2. All residents have the potential to be affected if their plan of care is not updated when required or the infection control process is broken.
3. During each weekly IDT meeting and/or monthly committee meeting for 1 year, each deficiency will be read and the plan of correction reviewed with a follow

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 520	<p>Continued From page 49</p> <p>clinical meeting by the Interdisciplinary Team (IDT) to ensure they were placed in the residents' plan of care when applicable. A monthly audit of all resident care plans would be conducted by the Director of Nursing (DON) for two (2) months with the results taken to the QA meeting for further recommendations. This was a repeat deficiency for the facility which was cited on 03/27/14 related to the care plan not being revised related to changing a resident's Foley catheter every two (2) weeks and on 04/16/14 related to the care plan not being revised timely after a resident experienced a fall.</p> <p>However, record review during the current survey revealed the care plan was not revised related to Resident #6's request to be assisted to bed and out of bed at specific times of the day. Even though interviews with staff revealed they were aware of the specific times Resident #6 wanted to lie down and be assisted back out of bed, and were aware of the resident becoming anxious when not assisted to and from bed at these times. In addition, Resident #6's Comprehensive Care Plan was not revised to address the trunk restraint utilized by the resident or for the resident's history of constipation and ongoing constipation problem.</p> <p>Interview, on 03/27/15 at 11:30 AM, 3:15 PM and 8:40 PM, with the Assistant Director of Nursing (ADON), in the absence of the Director of Nursing (DON), and in the presence of the Administrator at 8:40 PM, revealed the care plans were still being reviewed and revised in the morning meetings Monday through Friday according to Physician's Orders. The ADON stated however, there was no monthly auditing of care plans currently occurring. Per interview, the facility had</p>	F 520	<p>3 up audit and/or competency to ensure compliance is maintained. If the system shows a failure the QA committee will meet and discuss the root cause for system failure and implement an appropriate plan for compliance; results of the investigation will be immediately reviewed by the QA committee.</p> <p>4 Results will be reviewed by the QA committee for identified non-compliance with assigned administrative members with results reviewed for compliance as determined by the QA Committee.</p>	5-5-15	

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

PRINTED: 04/10/2015
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 03/27/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 520	<p>Continued From page 50</p> <p>realized there was a problem of care plans not being revised about six (6) to eight (8) weeks ago, and at that time divided the care plans up among department heads and administrative staff and reviewed them and revised them for accuracy. Further interview revealed Resident #6's care plan should have been updated/revised according to his/her preferences related to when to get out of bed and when to be assisted to bed which was not related to a Physician's Order, and for the restraint and constipation problem.</p> <p>2. Review of the facility's Plan of Correction, with a compliance date of 05/11/14, revealed the DON or designee would monitor Monday through Friday, and the weekend Nurse Manager would review all new orders to ensure new orders were updated on the care plan. The nurse who executed the order was to ensure the order was carried out and report to the DON that the order was implemented. The DON was to check ten (10) percent of all orders each day and report to the QA committee each week for three (3) weeks and monthly thereafter that the orders were implemented. This was a repeat deficiency for the facility which was cited 04/16/14 related to the care plan not being followed related to fall interventions.</p> <p>Record review and interviews during the current survey revealed Resident #6's care plan a need for two (2) staff assist for bed mobility and incontinence care. However, the care plan was not followed on 09/03/14, when a nurse attempted to assist Resident #6 with bed mobility alone, which resulted in the resident sustaining a fall.</p> <p>Continued interview, on 03/27/15 at 8:40 PM, with</p>	F 520			

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

PRINTED: 04/10/2015
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 03/27/2015	
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 520	<p>Continued From page 51</p> <p>the ADON revealed there was no audit at the current time to ensure the care plans were being followed and care plan interventions were being implemented.</p> <p>3. Review of the Plan of Correction (POC), with a compliance date of 05/11/14, for deficiencies cited on 03/27/14, revealed all staff would be re-educated on the infection control practices, including handwashing technique, and isolation guideline by the Education Director (ED), and all newly hired employees would receive this education prior to employment. The DON, ADON and ED would conduct return demonstration exercises on Nurses and Certified Nursing Assistants (CNA's). The POC noted the DON, ADON and ED were to do ten (10) return demonstrations per week for four (4) weeks, then one (1) nurse staff member per week for four (4) weeks. Review of the POC, with a compliance date of 04/11/14, for deficiencies cited on 04/03/14, revealed an all staff inservice would be held 04/30/14, to discuss hand washing and contact precautions. The DON, ADON and ED would conduct return demonstration exercises ten (10) per week for four (4) weeks, then one (1) nurse staff member per week for four (4) weeks.</p> <p>However, observation during the current survey revealed poor infection control technique by facility staff with handwashing and glove usage related to skin assessments and/or dressing changes for Residents #1, #4 and #5. Also, during Resident #5's dressing change, the nurse placed the bag for soiled dressing removed on Unsampled Resident H's side of the sink right next to a bag of apples. In addition, observation of meal service in the hallway revealed a staff member was not washing or sanitizing her hands</p>	F 520		

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

PRINTED: 04/10/2016
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 03/27/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 520 Continued From page 52
between setting up meal trays, although she was touching residents and touching objects in resident rooms which affected Unsampled Residents E, F and G. Observation revealed a staff member did not wear gloves while assisting Resident #7 to blow his/her nose and the staff member also failed to wash her hands afterwards, touching a doorknob to an office.

Interview with the ED on 03/27/15 at 8:50 PM, in the presence of the Administrator, in the absence of the DON, revealed she was still doing handwashing audits to ensure staff knew how to wash their hands properly at the sink. The ED revealed however, she was not watching staff when providing care, such as, during skin assessments, dressing changes or passing meal trays in the hall to ensure they knew when to wash their hands or change gloves. Further interview revealed she was not completing any infection control audits of staff during provision of care.

F 520

PRINTED: 04/10/2015
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: 185336	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2015
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	----------------------

K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1968

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One (1) story, Type (111)

SMOKE COMPARTMENTS: Three (3) smoke compartments

FIRE ALARM: Complete fire alarm system with smoke detectors.

SPRINKLER SYSTEM: Complete automatic dry sprinkler system.

GENERATOR: New Installation 01-01-14 Generac Type II Diesel

A standard Life Safety Code survey was conducted on 03/26/15 and the facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for seventy (70) beds with a census of sixty-four (64) on the day of the survey.

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

Disclaimer; Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.

RECEIVED
MAY 26 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 05/22/2015
--	------------------------	-------------------------

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 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.

PRINTED: 04/10/2015
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: 185336	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 03/26/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 000 K 062 SS=F	Continued From page 1 deficiency identified at "F" level. NFFA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFFA 13, NFFA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the automatic sprinkler system had an internal pipe inspection performed, according to National Fire Protection Association (NFFA). The deficiency had the potential to affect three (3) of three (3) smoke compartments, seventy (70) residents, staff and visitors. The findings include: Review of the automatic sprinkler inspection records on 03/26/15 at 1:22 PM, with the Administrator, revealed the facility failed to have an internal pipe inspection performed within the last five (5) years. Interview with the Maintenance Director at the time of the review revealed the facility did not have documented proof an internal pipe inspection had been performed within the last five (5) years. The findings were acknowledged by the Administrator during the exit conference. Reference: NFFA 25 (1998 Edition) 10-2.2* Obstruction Prevention. Systems shall be	K 000 K 062	Armor Fire Protection has been contacted, has bid to flush the system and the bid has been accepted. The flush will be performed on May 11, 2015. All residents have the potential to be affected Whenever there is an inspection from an outside source, the results will be taken to weekly QA for examination and any recommendations will be scheduled at that time. The pipe inspection was performed February 13, 2014. Maintenance Director will take inspection, recommendations and documentation of work scheduled or completed to Monthly QA and report..	05/12/15	

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

PRINTED: 04/10/2015
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 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2015
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	----------------------

K 062	Continued From page 2 examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.	K 062		
K 064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure fire extinguishers were inspected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, three (3) residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 03/26/15 at 11:53 AM, with the Administrator, revealed the fire extinguisher near the East Wing exit did not have a verification of service collar indicating a hydrostatic test had been performed. The fire extinguisher had a manufacture date of 2007. Interview with the</p>	K 064	<ol style="list-style-type: none"> 1. The Fire Extinguisher has been replaced. 2. All residents on East Wing have the potential to be affected. 3. At the same time the Maintenance Director does rounds to check pressure each month, Maintenance Director will also check the verification of service collar for placement and assure it is current. A check list will used to check off each verification of service collar. 4. Maintenance Director will bring check list as documentation to monthly QA meeting to report. 	5/5/15

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

PRINTED: 04/10/2015
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 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2015
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 064	<p>Continued From page 3</p> <p>Administrator revealed he was did not know why the fire extinguisher did not have a verification of service collar.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 10 (1998 Edition).</p> <p>4-4.3* Six-Year Maintenance. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon closed recovery system. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall begin from that date.</p> <p>Exception: Nonrechargeable fire extinguishers shall not be hydrostatically tested but shall be removed from service at a maximum interval of 12 years from the date of manufacture. Nonrechargeable halon agent fire extinguishers shall be disposed of in accordance with 4-3.3.3.</p> <p>4-4.4.1* Fire extinguishers that pass the applicable 6-year requirement of 4-4.3 shall have the maintenance information recorded on a suitable metallic label or equally durable material having a minimum size of 2 in. x 3 1/2 in. (5.1 cm x 8.9 cm).</p> <p>The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self-destructive type when removal from a fire extinguisher is attempted. The label shall include the following information:</p> <p>(a) Month and year the maintenance was</p>	K 064			

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

PRINTED: 04/10/2015
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 01 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2015
--	--	---	--

NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 064	<p>Continued From page 4</p> <p>performed, indicated by a perforation such as is done by a hand punch</p> <p>(b) Name or initials of person performing the maintenance and name of agency performing the maintenance</p> <p>4-4.4.2* Verification of Service (Maintenance or Recharging). Each extinguisher that has undergone maintenance that includes internal examination or that has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch.</p> <p>Exception No. 1: Fire extinguishers undergoing maintenance before January 1, 1999.</p> <p>Exception No. 2: Cartridge/cylinder-operated fire extinguishers do not require a "Verification of Service" collar.</p>	K 064		