

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

PRINTED: 06/16/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2010
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on 06/01/10 through 06/04/10 with deficiencies cited at the highest scope and severity of an E. The facility has the opportunity to correct the deficient practices before remedies would be recommended for imposition.	F 000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law.	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to identify incidents and thoroughly implement written policies and procedures that would prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property for two (2) of twenty-two (22) sampled residents. Resident #11 and Resident #20 had incidents that were not thoroughly investigated due to their assessed cognitive status; therefore, the determination could not be made to assure appropriate interventions and reporting mechanisms were utilized. The findings include: A review of the facility Resident Abuse Policy and Procedure states each resident has the right to be free from mistreatment, neglect and misappropriation of property. This includes the facility's identification of resident's whose	F 226	The Facility maintains that it protects the rights of residents that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. <i>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:</i> The Director of Nursing, Director of Social Services, and Staff Development Coordinator have met with the Administrator to review the facility policies and practices to ensure that these state the facility prohibits mistreatment, neglect and abuse of residents, misappropriation of resident property and continue to comply with the regulatory standards. Protocols for investigations and if allegations are substantiated, the actions and remedies for the allegation will be followed, including proper notification of the Office of Inspector General and other regulatory agencies as per regulatory requirements. Additionally, the outcome of the investigations will be maintained in the Social Services department. The Director of Nursing, Social Services Director, and the Staff Development Coordinator have met with the Administrator to review the residents affected by the alleged	7/2/2010

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

TITLE

(X6) DATE

Richard N. Flowers

Administrator

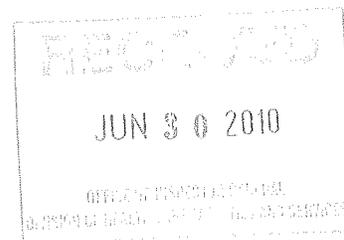
6/28/2010

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

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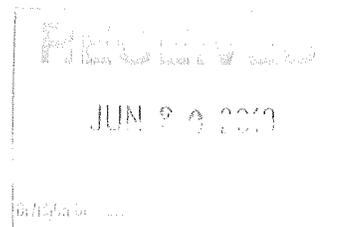
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F 226	Continued From page 1 personal histories render them at risk for abusing other residents, and development of intervention strategies that include screening, training, prevention, identification, investigation, protection and reporting to prevent occurrences, monitoring for changes that would trigger abusive behavior, and reassessment of the interventions on a regular basis. Record Review of Resident #11's medical record revealed the resident has diagnoses of Alzheimer, Dementia, and Senile Dementia with a cognition of three (3 severely impaired) on the Minimum Data Set (MDS). Record review revealed on 05/25/10 Resident #11 was documented to be screaming, hitting at staff, residents and visitors. Interview with Director of Nursing (DON) on 06/04/10 at 9:00am revealed Resident #11 went into Resident #22's room and smacked Resident #22 on the arm, but did not cause harm. The DON further stated that Resident #11 was combative at times and the incident was not reported to Office of Inspector General (OIG) because of Resident #11's cognitive issues. She also stated if a resident has a cognitive impairment, it is not abuse. The DON stated if the facility did not conduct a thorough investigation, the resident may continue to hit other residents and cause psychological issues for other residents. Social Services was responsible for reporting resident to resident altercations. Record Review of Resident #20's record revealed the resident had diagnoses of Vascular Dementia and a history of a Stroke. Resident #20 could not	F 226	deficient practice. The Facility will continue to ensure that residents have a safe and secure environment in which to live that is free from any type of abuse. Resident #11's care plan has been updated and staff will continue to monitor behaviors to maintain a safe environment for all residents. Resident #20 is no longer a resident of the facility. <i>The facility will identify other residents having the potential to be affected by the same alleged deficient practice by doing the following:</i> The Administrator, Social Services Director, and Director of Nursing or their designee will continue to make rounds routinely and observe residents and speak with staff to identify any resident concerns or situations that may lead to a resident to resident concern. The weekend nursing supervisor will also continue to routinely make rounds and observe residents and speak with staff to identify concerns or situations that may lead to a resident to resident concern. Any issues that are either observed or reported that would give rise to a resident to resident concern will be addressed immediately and reported to the appropriate parties according to the facility policy. <i>The Facility will put measures in place or make systemic changes to assure the alleged deficient practice does not recur by doing the following:</i> The Facility will continue to provide annual mandatory in-services for all staff on the	



Resident Abuse Policies and Procedures as well as provide that information for all new employees through the orientation program. Additionally, the Facility will conduct mandatory in-service for all staff regarding the Facility Policy and Procedures for Resident Abuse prior to July 2, 2010 to further emphasize the policy. The Social Services Director will also be available to attend any Resident Council meeting to provide information on Resident Rights and Abuse and the Facility's policies regarding abuse. The Social Services Director will also be available to residents and their families or responsible parties to provide information and support about the facility policies regarding the above.

The facility will implement the corrective action and monitor them in the following manner:

The plan of corrections will be integrated into the Facility's QA program. The QA Program, chaired by the DON, shall review implementation of the facility policy and practices regarding resident abuse on a quarterly basis. Resident interviews will be conducted by the Social Services Director, Activities Director, or other designee that will specifically ask about abuse concerns prior to each QA meeting. The interview responses will be reviewed during the QA meetings and any adjustments to the facility policy and procedures will be implemented as needed to assure the facility continues to maintain an environment that is free from abuse.



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F 226	Continued From page 2 recall his/her date of birth and had short and long term memory deficits. On 02/12/10 Resident #20 picked up an empty soft drink can from the trash can and threw the empty can in the direction of Resident #21. Interview with Social Services on 06/04/10 at 11:47am confirmed Social Services (SS) Investigates resident to resident altercations. She stated she was told not to report incidents like Resident #11 and #20 if both residents have Dementia or if the resident who incites the incident has Dementia. She stated that she was not trained in this facility on when to report allegations of abuse. Social Services further stated that she did not report to Adult Protective Services (APS) the incidents regarding Resident #11 and Resident #20. Interview with the Administrator on 06/04/10 at 12:02pm revealed he did not know when to report incidents of altercations that occurred between residents. The Administrator further stated that he relied on the expertise of other staff members to appropriately report incidents of potential abuse.	F 226	Responsible parties: Social Services Director, Director of Nursing, Staff Development Coordinator and Administrator. F 272 The Facility will continue to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity per 483.20, 483.20(b). <i>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:</i> The Director of Nursing Services, and the MDS Coordinator(s) have met with the Administrator to review facility protocols regarding resident assessments including policies and practices to ensure all sections of the RAI as specified by the state are accurately completed as required. The resident identified by survey to be coded incorrectly was reviewed and a correction to said MDS was submitted to state. The plan of care for the resident in question was also reviewed and updated to reflect said correction.	7/2/2010
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information;	F 272	<i>The facility will identify other residents having the potential to be affected by the same alleged deficient practice by doing the following:</i> To assure accurate information regarding communication all new and questionable residents will be reviewed as part of weekly Standards of Care meeting with the MDS Coordinator providing available information for new admissions and to review and	

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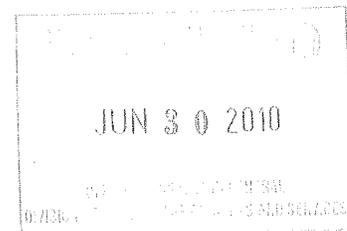
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F 272	<p>Continued From page 3</p> <p>Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to conduct a periodic comprehensive and accurate assessment on one (1) of twenty-two (22) sampled residents (#5). Resident #5 was assessed by staff as able to make them self understood and understands others; however, staff indicated this was not consistent due to dementia and combing multiple languages spoken.</p> <p>The findings include:</p> <p>Record review of the quarterly Minimum Data Set dated 05/03/10 for Resident #5, admitted on 10/26/09 with the diagnosis of Dementia, revealed a zero (understood) in making self</p>	F 272	<p>accurately identify any questions about communication.</p> <p><i>The Facility will put measures in place or make systemic changes to assure the alleged deficient practice does not recur by doing the following:</i> Every effort will be made to continue to provide accurate and thorough evaluation of residents to determine if receptive or expressive communication deficit may be present and provide for each residents individual needs for communication.</p> <p><i>The facility will implement the corrective action and monitor them in the following manner:</i> The Director of nursing or her designee and the MDS Coordinator will continue to review Section C of the RAI instruction manual to assure correct and accurate coding of the MDS for all residents. This corrective action will be incorporated into the QA Program for the facility that reviews the outcomes of its actions on a quarterly basis. This protocol will be monitored by including it as part of the items that are being reviewed with chart audits conducted by the Assistant Director of Nursing or her designee in preparation for the quarterly QA meetings.</p> <p>Responsible parties: MDS Coordinator, Director of Nursing, Administrator</p>	

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F 272	Continued From page 4 understood and a zero (understands) in ability to understand others. The admission Resident Assessment Protocol (RAP) dated 11/08/09 triggered for communication. The RAP stated the resident speaks Bosnian and a communication book was provided to assist the staff in providing care for the resident and to assist the resident to communicate his/her needs to the staff. Observation during the skin assessment on 06/02/10 at 2:50pm revealed the resident did not follow instructions to turn nor did the resident attempt to verbally interact with staff members. Interview with Licensed Practical Nurse (LPN) #1 on 06/02/10 at 2:50pm revealed Resident #5 was from Bosnia and had a history of speaking five languages. According to the LPN, the resident understands a few English phrases and due to his/her dementia the resident often combines all five languages when speaking. She stated the staff have learned a few Bosnian phrases and use the communication book containing pictures and Bosnian words to assist in communicating with the resident. Interview with the Minimum Data Set (MDS) Coordinator on 06/04/10 at 12:55pm revealed Resident #5 did have difficulty making him/herself understood and had difficulty understanding others due to the language barrier. She admitted it was an error to code the MDS a zero in making self understood and the ability to understand others.	F 272	F323 The Facility will continue to maintain an environment for residents that is as free of accident hazards as is possible, and each resident will continue to receive adequate supervision and assistance devices to prevent accidents. <i>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:</i> The Director of Nursing, Director of Social Services, and Staff Development Coordinator have met with the Administrator to review the facility policies and practices to ensure that these state the facility prohibits mistreatment, neglect and abuse of residents, misappropriation of resident property and continue to comply with the regulatory standards. Protocols for investigations and if allegations are substantiated, the actions and remedies for the allegation will be followed, including proper notification of the Office of Inspector General and other regulatory agencies as per regulatory requirements. Additionally, the outcome of the investigations will be maintained in the Social Services department. The Director of Nursing, Social Services Director, and the Staff Development Coordinator have met with the Administrator to review the residents affected by the alleged deficient practice. The Facility will continue to ensure that residents have a safe and secure environment in which to live that is free from any type of abuse. Resident #11's care plan has been updated and staff will continue to	7/2/2010	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323			



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F 323	<p>Continued From page 5</p> <p>as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT Is not met as evidenced by: Based on interview and record review it was determined the facility failed to thoroughly investigate incidents involving two (2) of twenty two (22) sampled residents. Resident #11 and Resident #20 had incidents that were not thoroughly investigated due to their assessed cognitive status; therefore, the determination could not be made to assure appropriate supervision was provided as necessary.</p> <p>The findings include:</p> <p>A review of the facility Resident Abuse Policy and Procedure states each resident has the right to be free from mistreatment, neglect and misappropriation of property. This includes the facility's identification of resident's whose personal histories render them at risk for abusing other residents, and development of intervention strategies that include screening, training, prevention, identification, investigation, protection and reporting to prevent occurrences, monitoring for changes that would trigger abusive behavior, and reassessment of the interventions on a regular basis.</p> <p>Record Review of Resident #11's medical record revealed Resident #11 has diagnoses to include Alzheimer's, Dementia, and Senile Dementia with a cognition of three (3 severely impaired) on the</p>	F 323	<p>monitor behaviors to maintain a safe environment for all residents. Resident #20 is no longer a resident of the facility.</p> <p><i>The facility will identify other residents having the potential to be affected by the same alleged deficient practice by doing the following:</i> The Administrator, Social Services Director, and Director of Nursing or their designee will continue to make rounds routinely and observe residents and speak with staff to identify any resident concerns or situations that may lead to a resident to resident concern. The weekend nursing supervisor will also continue to routinely make rounds and observe residents and speak with staff to identify concerns or situations that may lead to a resident to resident concern. Any issues that are either observed or reported that would give rise to a resident to resident concern will be addressed immediately and reported to the appropriate parties according to the facility policy.</p> <p><i>The Facility will put measures in place or make systemic changes to assure the alleged deficient practice does not recur by doing the following:</i> The Facility will continue to provide annual mandatory in-services for all staff on the Resident Abuse Policies and Procedures as well as provide that information for all new employees through the orientation program. Additionally, the Facility will conduct mandatory in-service for all staff regarding the Facility Policy and Procedures for Resident Abuse prior to July 2, 2010 to further emphasize the policy. The Social Services</p>	

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JUN 30 2010
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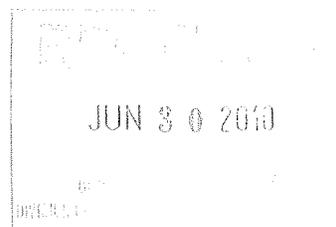
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F 323	<p>Continued From page 6 Minimum Data Set (MDS).</p> <p>Record review revealed on 05/25/10 Resident #11 was documented to be screaming, hitting at staff, residents and visitors.</p> <p>Interview with the Director of Nursing (DON) on 06/04/10 at 9:00am revealed Resident #11 went into Resident #22's room and smacked Resident #22 on the arm, but did not cause harm. The DON further stated that Resident #11 was combative at times and the incident was not reported to Office of Inspector General (OIG) because of Resident #11's cognitive issues. She also stated if a resident has a cognitive impairment, it is not abuse. The DON stated if the facility did not conduct a thorough investigation, the resident may continue to hit other residents and cause psychological issues, for other residents. Social Services was responsible for reporting resident to resident altercations.</p> <p>Record Review of Resident #20's medical record revealed Resident #20 had diagnoses of Vascular Dementia and a history of a Stroke. Resident #20 could not recall his/her date of birth and had short and long term memory deficits. On 02/12/10 Resident #20 picked up an empty soft drink can from the trash can and threw the empty can in the direction of Resident #21.</p> <p>Interview with Social Services on 06/04/10 at 11:47am confirmed Social Services (SS) investigates resident to resident altercations. She stated she was told not to report incidents like Resident #11 and #20 if both residents have Dementia or if the resident who incites the incident has Dementia. She stated that she was</p>	F 323	<p>Director will also be available to attend any Resident Council meeting to provide information on Resident Rights and Abuse and the Facility's policies regarding abuse. The Social Services Director will also be available to residents and their families or responsible parties to provide information and support about the facility policies regarding the above.</p> <p><i>The facility will implement the corrective action and monitor them in the following manner:</i></p> <p>The plan of corrections will be integrated into the Facility's QA program. The QA Program, chaired by the DON, shall review implementation of the facility policy and practices regarding resident abuse on a quarterly basis. Resident interviews will be conducted by the Social Services Director, Activities Director, or other designee that will specifically ask about abuse concerns prior to each QA meeting. The interview responses will be reviewed during the QA meetings and any adjustments to the facility policy and procedures will be implemented as needed to assure the facility continues to maintain an environment that is free from abuse.</p> <p>Responsible parties: Social Services Director, Director of Nursing, Staff Development Coordinator and Administrator.</p>	

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F 323	Continued From page 7 not trained in this facility on when to report allegations of abuse. Social Services further stated that she did not report to Adult Protective Services (APS) the incidents regarding Resident #11 and Resident #20. Interview with the Administrator on 06/04/10 at 12:02pm revealed that he did not know when to report incidents of altercations that occurred between residents. The Administrator further stated that he relied on the expertise of other staff members to appropriately report incidents of potential abuse.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	F 441 The Facility will continue to maintain an Infection Control Program that is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. <i>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:</i> The policy regarding the cleaning and disinfecting of shared medical equipment was revised on 3/11/2010 to reflect the newly revised standards of care ensuring the best way to prevent the spread of infection when the equipment is shared between residents. All nursing personnel received training on the policy including nurse #1 cited in the findings by the survey team on 6/2/2010. All nursing staff, including Nurse #1, attending the mandatory in-services on 6/8/2010 & 6/9/2010 were re-in-serviced on said policy. Those nursing staff members who did not attend meetings will have received the re-in-service by 7/2/2010. <i>The facility will identify other residents having the potential to be affected by the same alleged deficient practice by doing the following:</i> Weekly the infection control nurse or designated administrative nurse will do an audit of nursing personnel to ensure adherence to the policy.	7/2/2010



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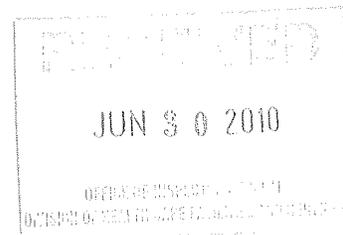
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F 441	<p>Continued From page 8</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing 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 infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to prevent the spread of infection for two (2) of twenty-two (22) sampled residents. The glucometer was not sanitized between Resident #5 and Resident #19 before or after performing the finger stick to obtain the glucose level.</p> <p>The findings include:</p> <p>Observation on 06/02/10 at 11:30pm revealed Licensed Practical Nurse (LPN) #1 took the glucometer supply tray in the room of Resident #5 who was admitted with a diagnosis of Insulin Dependent Diabetes Mellitus. She washed her hands, put on gloves and proceeded to clean the resident's finger with an alcohol swab. The finger stick was completed with a disposable needle. After reading the result, LPN #1 removed her gloves and returned the glucometer to the supply tray. After discarding the needle, she then proceeded to take the supply tray into the room of Resident #19 who was admitted with a diagnosis of insulin Dependent Diabetes Mellitus. LPN #1</p>	F 441	<p><i>The Facility will put measures in place or make systemic changes to assure the alleged deficient practice does not recur by doing the following:</i></p> <p>All newly hired nursing personnel receive training on the above mentioned policy as well as annual in-service will be conducted on this policy. Weekly the infection control nurse or designated administrative nurse will do a random audit of nursing personnel to ensure adherence to the policy. Those personnel who are found to be out of compliance with the policy will receive coaching. Those staff members who continue to be out of compliance will be subject to progressive disciplinary action</p> <p><i>The facility will implement the corrective action and monitor them in the following manner:</i></p> <p>The plan of corrections will be integrated into the Facility's QA program. The Infection Control Nurse report to the QA Committee will include a summary of the weekly audit results. The Facility will monitor and adjust as necessary based upon the outcome of these reports.</p> <p>Responsible Parties: Infection Control Nurse, Staff Development Coordinator, Director of Nursing, and Administrator.</p>	

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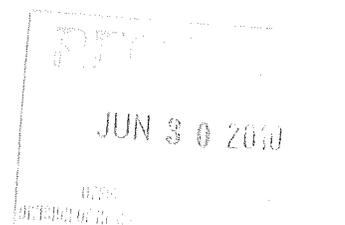
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F 441	Continued From page 9 washed her hands and put on gloves, proceeded to clean the resident's finger with alcohol and performed the finger stick with a disposable needle. After obtaining the result, she placed the glucometer in the supply tray. No sanitizing of the glucometer was observed between residents. Interview with LPN #1 on 06/02/10 at 11:30am revealed she did not clean the glucometer between residents. She stated she forgot to clean the glucometer. LPN #1 stated she would clean the glucometer with an alcohol swab. When asked about using a bleach wipe to clean the glucometer, she stated there were no bleach wipes in the facility. Interview with the Director of Nursing (DON) on 06/02/10 at 2:00pm revealed she had in-serviced the staff on cleaning reusable medical equipment with bleach wipes. She stated it was an expectation that the staff clean the glucometer between residents with the bleach wipes. The facility policy dated 03/11/10 stated each piece of shared medical equipment must be cleaned before and after each use. The medical device must be cleaned of visible blood or body fluids with a cloth dampened with soap and water and disinfected using a wipe containing a bleach solution.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	The Facility will continue to maintain its clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. <i>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:</i> The Social Services Director, Director of Nursing, and Assistant Director of Nursing will ensure that residents affected by the alleged deficient practice have been assessed, care planned, monitored, provided treatment as ordered by the medical staff in order to maintain a safe and healthy environment for all residents. <i>The facility will identify other residents having the potential to be affected by the same alleged deficient practice by doing the following:</i> The Social Services Director and Director of Nursing and Assistant Director of Nursing have performed an audit of the resident records to assure compliance with this requirement. <i>The Facility will put measures in place or make systemic changes to assure the alleged deficient practice does not recur by doing the following:</i> In-services have been provided to the nursing staff under the direction of the Director of Nursing on the use of behavior forms. Those staff responsible for completing mood and	7/2/2010



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F 514	<p>Continued From page 10</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to document behaviors for (2) of twenty-two 22 sampled residents. Resident #6 and Resident # 11 had behaviors that were not reflected on the MDS due to the lack of nursing documentation.</p> <p>The findings include:</p> <p>Record review of the care plan for Resident #6, admitted on 03/22/07 with the diagnoses of Mental Retardation, Hypothyroidism, Hypertension, Behaviors, Depression and Psychological Medications, revealed the care plan was last reviewed on 4/12/10. The care plan indicated the resident had behaviors of medication refusals, cursing at staff, hitting, and kicking.</p> <p>Interviews with LPN #2 and LPN #3 on 06/04/10 at 2:10pm revealed Resident #6 frequently refuses medications and hygiene care. Both stated they leave the resident alone for a period of time and then re-approach the resident and then the resident would become compliant. Both LPN #2 and LPN #3 failed to document the resident's behavior in the nurses' notes and the behavior log on the North Nursing Unit. In</p>	F 514	<p>behavior forms have been in-serviced by the Director of Nursing as well. The Clinical staff that has not received this education will be trained by July 2, 2010. All new hires will continue to be provided with education on these policies and procedures and this education will also be provided on an annualized basis by the Staff Development Coordinator or her designee.</p> <p><i>The facility will implement the corrective action and monitor them in the following manner:</i></p> <p>The plan of correction will be integrated into the Facility's QA program. Monthly audits will be conducted by the Social Services Director to ensure the completeness and accuracy of the mood and behavior monitoring forms. The Social Services Director will provide the results of these audits to the Director of Nursing and they will work together to assure compliance is achieved. Summary results of these findings will be provided at the quarterly QA meetings and this will continue to be monitored as necessary to assure that this requirement continues to be maintained.</p> <p>Responsible parties: Social Services Director, Director of Nursing, and Administrator.</p>	



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F 514	<p>Continued From page 11</p> <p>addition, both LPN's agreed that Resident #6 refused medications or care several times a week. LPN #2 and LPN #3 did not document the behaviors because the resident was usually compliant at a later time.</p> <p>An interview with Social Services on 06/04/10 at 2:20pm revealed, she does not document behaviors other than "0" unless she witnessed the behavior or the nurses have documented inappropriate behaviors in the nursing notes or in the behavior log book. The behavior would also be documented as "0" if it fell outside the seven (7) day window. When asked, why behaviors were on the care plan, she responded the resident had a history of behaviors.</p> <p>Record review of Resident #11 revealed diagnoses of Alzheimer's, Dementia, Senile Dementia, Depression and Psychological Medications with Psych Services following the behaviors. Review of the nursing notes revealed no documented behaviors between December 29, 2009 and May 24, 2010. The behavior sheets for February, March, and April 2010 revealed Resident #11 was to be observed daily for behaviors of biting, spitting and unrelenting agitated motion. All three behavior sheets revealed no behaviors were documented. The annual Minimum Data Set (MDS) dated 11/23/09 revealed a zero (0) for behaviors. The Quarterly MDS dated 02/18/09 and 05/19/10 also revealed a zero (0) for behaviors.</p> <p>Interviews with Certified Nursing Assistants (CNA) #1 and #2 on 06/03/10 at 10:21am revealed Resident #11 has had some behaviors for the past seven (7) months, since CNA #1 has been employed. CNA #1 and #2 stated the</p>	F 514		
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F 514	<p>Continued From page 12</p> <p>resident exhibits more aggression like biting and hitting during bathing and changing of his/her brief.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 on 06/04/10 at 1:20pm revealed Resident #11 has behaviors nearly every day like scratching and hitting. This behavior is not documented anymore because Resident #11 has this behavior all the time especially with care. Resident #11 acts out more when taking a bath or during brief changes.</p> <p>Interview with Social Services on 06/04/10 at 1:08pm revealed that when doing the behavior section of the Minimum Data Set (MDS), Social Services makes a determination on resident behavior based on nurses notes, behavior sheets and observations made by Social Services within a 7 day look back. If nothing is documented or observed a zero (0) is placed in the behavior section.</p> <p>Interview with Director of Nursing (DON) on 06/04/10 at 2:40pm revealed she was not aware that nursing staff was not documenting behaviors appropriately.</p>	F 514		
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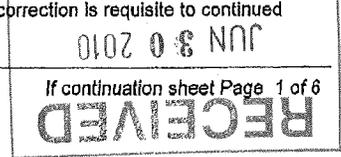
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K 000	INITIAL COMMENTS	K 000		
K 046 SS=D	<p>A Life Safety Code survey was initiated and concluded on 06/16/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "E".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 06/16/10, the facility failed to provide outside lighting for an emergency exit, and to maintain emergency lighting according to NFPA standards.</p> <p>During the Life Safety Code survey on 06/16/2010 at 10:28 AM, with the Maintenance Director, observation at that time revealed that the North Wing West exit had no emergency lighting for the outside walkway.</p> <p>Interview on 06/16/2010 at 10:28 AM, with the Maintenance Director, revealed that he had never noticed that the emergency exit did not have the required lighting for the outside walkway.</p> <p>Record review on 06/16/2010 at 12:35 PM, with the Maintenance Director, revealed that the facility could not show documentation of the Yearly 90 minute testing of battery powered emergency lighting.</p>	<p>K 046</p> <p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law.</p> <p>K046</p> <p>The Facility will continue to maintain Emergency Lighting with at least 1.5 hours duration according to NFPA standards.</p> <p>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice: Facility's Maintenance Director has corrected the alleged deficiency by installing emergency lighting for the exit area identified.</p> <p>The facility will identify other residents having the potential to be affected by the same alleged deficient practice by doing the following: Facility's maintenance Director has examined the remainder of the Facility's emergency exits and determined that there emergency lighting is in place for those areas.</p> <p>The Facility will put measures in place or make systemic changes to assure the alleged deficient practice does not recur by doing the following: The Facility's Maintenance Director or designee will include observation and</p>	7/15/2010	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Richard N. Flower* TITLE: *Administrator* (X6) DATE: *6/29/2010*

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

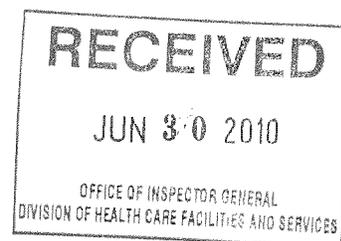


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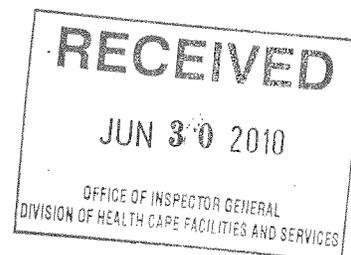
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K 046	<p>Continued From page 1</p> <p>Interview on 06/16/2010 at 12: 35 PM, with the Maintenance Director, revealed that the facility checked all battery powered emergency lighting 30 seconds monthly, but was not aware of the requirement for the annual 90 minute testing of battery powered emergency lighting.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 42 (2) Underground and windowless structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed egress locks (5) The stair shaft and vestibule of smokeproof enclosures, which shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment and used for the stair shaft and vestibule emergency lighting power supply</p> <p>For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment.</p>	K 046	<p>testing of this on its monthly routine maintenance checks to assure continued compliance with this standard.</p> <p><i>The facility will implement the corrective action and monitor them in the following manner:</i> The plan of corrections will be integrated into the Facility's QA program. Maintenance Director will report on the preventative maintenance program for the Maintenance Department on a Quarterly Basis. This report will include the status of the emergency lighting for building.</p>	



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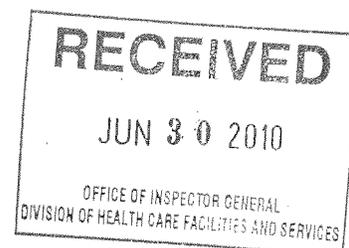
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K 046	Continued From page 2 A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day interval NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review and staff interview conducted on 06-16-2010, the facility failed to maintain the emergency generator according to NFPA standards.	K 046	K144 The Facility will continue to maintain generator testing according to NFPA standards. <i>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:</i> Facility's Maintenance Director has corrected the alleged deficiency by updating the preventative maintenance testing of the generator under load from monthly to weekly. <i>The facility will identify other residents having the potential to be affected by the same alleged deficient practice by doing the following:</i> K 144 Facility's Maintenance Director has reviewed the preventative maintenance program for the generator testing and determined that there are no other areas of concern at this time. <i>The Facility will put measures in place or make systemic changes to assure the alleged deficient practice does not recur by doing the following:</i> The Facility's Maintenance Director or designee will continue to assure that the generator testing is performed on a weekly basis under load per the NFPA standards and record the results of those tests .	7/15/2010
K 144 SS=E				



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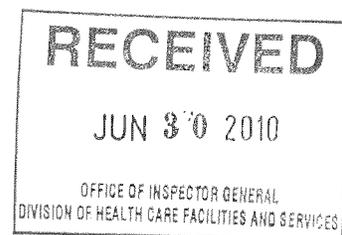
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K 144	Continued From page 3 Record review on 06/16/2010 at 12:35 PM, with the Maintenance Director, revealed that the facility could not produce documentation of the weekly required inspection of the emergency generator. An interview with the Maintenance Director on 06/16/10 at 12:35 PM revealed that he performed monthly inspection of the generator, but he did not perform weekly inspection of the generator. Reference: NFPA 110 (1999 Edition). 6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer 's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at	K 144	<i>The facility will implement the corrective action and monitor them in the following manner:</i> The plan of corrections will be integrated into the Facility's QA program. Maintenance Director will report on the preventative maintenance program for the Maintenance Department on a Quarterly Basis. This report will include the status of the generator testing for building.	



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K 144	Continued From page 4 not less than 30 percent of the EPS nameplate rating b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations. 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position. 6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.	K 144	 K 147 The Facility will continue to maintain electrical wiring and equipment according to NFPA standards. <i>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:</i> Facility's Maintenance Director has corrected the alleged deficiency by installing covered boxes for the electrical outlets in the areas identified by the alleged deficiency. <i>The facility will identify other residents having the potential to be affected by the same alleged deficient practice by doing the following:</i> Facility's maintenance Director has examined the remainder of the Facility's electrical junction boxes and identified whether there were more areas that needed to have covers in place.	7/15/2010
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 06/16/2010, the facility failed to maintain electrical wiring according to NFPA standards.	K 147	<i>The Facility will put measures in place or make systemic changes to assure the alleged deficient practice does not recur by doing the following:</i> The Facility's Maintenance Director or designee will include observation of the electrical junction boxes. On a monthly basis the preventative maintenance log will include the outcome of those observations.	



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 06/16/2010
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241		
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K 147	Continued From page 5 During the Life Safety Code survey on 06/16/2010 at 10:00 AM, with the Maintenance Director, observation at that time revealed six uncovered electrical junction boxes in the attic area. An interview with the Maintenance Director on 06/16/2010 at 10:00 AM revealed he was unaware of the uncovered electrical junction boxes. Refer to NFPA 70 (1999 Edition). 370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22,	K 147	<i>The facility will implement the corrective action and monitor them in the following manner:</i> The plan of corrections will be integrated into the Facility's QA program. Maintenance Director will report on the preventative maintenance program for the Maintenance Department on a Quarterly Basis. This report will include the status of the proper covers for the electrical junction boxes for the building.		

