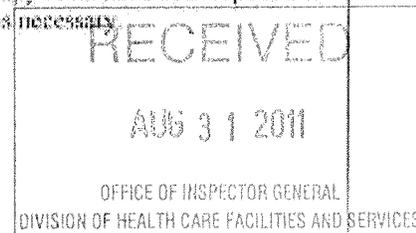


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2011
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 08/01/11 through 08/04/11 and a Life Safety Code survey was 08/02/11. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	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 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide maintenance services necessary to maintain an orderly and comfortable interior; one (1) of fifteen (15) rooms, room 134 had a reversible hot and cold water faucet, North shower room had one (1) of two (2) running toilet, the therapy room had no handles on cabinets which were used by residents and the hydrocollator did not have a GFS outlet. The findings include: No policy was provided by the facility Observations made of resident care areas in the facility, on 08/03/11 at 9:15 AM, revealed the therapy kitchen drawer handles, used by	F 253	F253 The Facility maintains that it provides housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice: The Administrator has met with the Housekeeping and Maintenance Supervisors to discuss the issues that were identified during the annual survey. The toilet in the shower room, the hot and cold water being reversed, the GFS outlet for the hydrocollator and the cabinet handles in the therapy room have been repaired or replaced as necessary.	9/02/2011	



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

TITLE

(X6) DATE

Richard Howan

Administrator

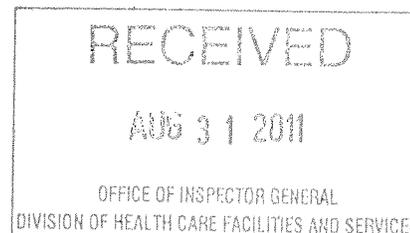
8/30/11

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 30 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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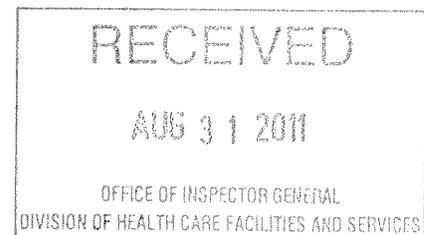
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F 253	<p>Continued From page 1 residents, were missing from the frame of the drawers.</p> <p>Interview with a Physical Therapist, on 08/03/11 at 9:15 AM, revealed the residents used the kitchen area for therapy, however, never paid attention to the handles of the drawer.</p> <p>Continued observation of the hydrocolator revealed the cord was not connected to a GFS outlet and the Hydrocolator was three (3) to four (4) feet from the outlet under a desk utilized by staff.</p> <p>Interview with the Maintenance Director, on 08/04/11 at 5:02 PM, revealed he was not aware the hydrocolator needed to be plugged in a GFS outlet or a surge connector outlet.</p> <p>Observation of the North Wing Shower Room, on 08/03/11 at 9:30 AM, revealed two (2) toilets, one (1) of the two (2) toilets was running constantly. At 9:17 AM, Room 124 located on the North Hall, had water faucet handles were reversed. The red faucet handle was releasing cold water and the blue faucet handle was releasing hot water.</p> <p>Interview with an unsampled resident, on 08/04/11 at 5:15 PM, revealed he/she was aware the water faucet handles were reversed, but did not make anyone aware. Interview with the Maintenance Director, on 08/04/11 at 5:16 PM, revealed the facility utilized new plumbers who put the faucets on the sink.</p> <p>Interview with the Maintenance Director, on 08/04/11 at 5:12 PM, revealed the process for staff to notify him of any maintenance concerns</p>	F 253	<p>How the Facility will identify other residents having the potential to be affected by the same alleged deficient practice:</p> <p>The Facility performed its Safety Checks through the Safety Committee of all areas the week of August 15th in order to make sure that there were no additional areas that needed to be repairs or had maintenance needs.</p> <p>Additionally, the Facility has an Ambassador Program that consists of the Department Manager group and eight staff members. This group is assigned to check on two to three rooms weekly for customer service type needs. This group has been assigned to monitor the rooms for any repair needs and report those to Maintenance as well.</p> <p>What measures will be put into place or what systemic changes the Facility will make to ensure that the alleged deficient practice does not recur?</p> <p>The Staff Inservice Coordinator has met with the Administrator to determine a method of making sure the staff and families are knowledgeable of how to request maintenance when needs are identified. The Staff Inservice Coordinator has added information to the orientation process and will inservice with the same information to existing staff information on the process of notifying maintenance of repair needs.</p>	



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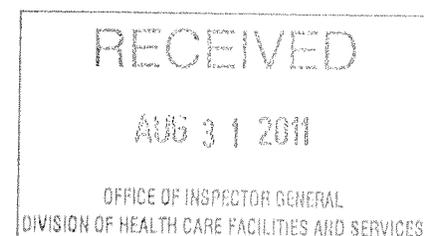
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F 253	Continued From page 2 was for the staff to fill out a work order and place the work order in a box. Maintenance then checked the box daily. Interview with Licensed Practical Nurse (LPN) #6, on 08/04/11 at 5:20 PM, revealed the nursing staff was to notify maintenance if it was an item that could be fixed, but she was unaware of having to fill out a work order. LPN #6 further stated there was a number that she could call to contact the Maintenance Director in person. Interview with the Administrator, on 08/04/11 at 5:20 PM, revealed staff were to fill out a work order and place the work order in the maintenance box. The Administrator stated he was unaware the hydroco/ator had to be connected to a GFS connector. He further stated he monitored the maintenance department by making rounds and monitoring plumbing issues throughout the building.	F 253	Information has been added to the Admissions Packet to include instructions on how families can notify the Facility when there are items that are in need of repair. Residents or Families are to contact the Nurse or Maintenance Department Director directly and inform them of the need. If the issue is not resolved in a timely fashion, they are to notify the Admissions Director or the Administrator. The Administrator has met with the Housekeeping and Maintenance Supervisor to review the process by which they are notified of issues to assure that the Facility continues to provide a sanitary, orderly and comfortable interior. The Housekeeping and Maintenance Supervisor are to advise the Administrator of the list of outstanding items that have not been addressed so that those issues can be prioritized and repaired in a timely fashion.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	How the Facility plans to monitor its performance to make sure that solutions are sustained: The Safety Committee and Quality Assurance Program will monitor repair issues to assure that this does not issue does not reoccur. Responsible Party(ies): Administrator, Maintenance Director, and Housekeeping Supervisor.	



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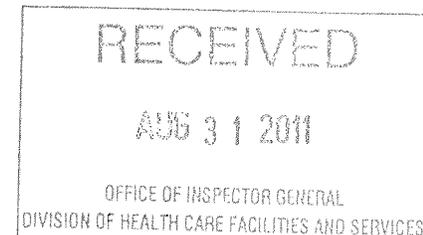
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F 279	<p>Continued From page 3</p> <p>psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for one (1) of sixteen (16) sampled residents, Resident #11, regarding his/her hemodialysis needs. Resident #11 received hemodialysis (a treatment that cleans the blood by removing wastes and excess water from the body) via a right arm shunt (vascular access for hemodialysis) three (3) times a week at a local hemodialysis provider. The facility failed to specify on the comprehensive care plan the need to monitor and assess Resident #11's vital signs and hemodialysis shunt for the resident to maintain the highest practicable well-being.</p> <p>The findings include:</p> <p>Review of the facility policy and procedure Quarterly Assessments, dated May 17, 2011, revealed: Objective: To maintain accurate risk assessments and plan of care for resident well being. Item #2 Once the assessments are completed, the care plan and C.N.A. (certified nurse assistant) care plan will be updated to communicate the high risk areas and interventions to prevent occurrence of skin breakdown, falls, etc...</p>	F 279	<p>F279</p> <p>The Facility maintains that it develops comprehensive care plans for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:</p> <p>Resident #11's comprehensive care plan was updated to reflect the the need to monitor and assess vital signs and hemodialysis shunt when returning from dialysis treatments.</p> <p>Resident #11 discharged home from the Facility on August 4, 2011.</p> <p>How the facility will identify other residents having the potential to be affected by the same alleged deficient practice:</p> <p>The Director of Nursing has met with the Staff Development Nurse and Lead LPN and Assistant Director of Nursing to review the Facility's procedures for monitoring dialysis residents.</p> <p>Facility identified other Resident(s) with dialysis treatments and made sure the comprehensive care plan reflected the need to monitor and assess vital signs and hemodialysis shunt when returning from dialysis treatments.</p>	9/02/2011	



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F 279	Continued From page 4 Review of the medical record for Resident #11 on 08/04/11 at 8:30 AM revealed Resident #11 was admitted to the facility 07/15/11 with a diagnosis of ESRD (end stage renal disease) and Resident #11 received hemodialysis via a right arm shunt three (3) days a week. The record revealed the facility assessed Resident #11 as interviewable with a score of fifteen (15) on the Minimum Data Set. Resident #11 was also assessed by the facility as needing to have vital signs and the hemodialysis shunt assessed and monitored after dialysis due to having a history of drop in blood pressure. The facility failed to carry this information from the initial care plan over to the comprehensive care plan dated 7/22/11. Review of the nursing notes revealed Resident #11 was in the facility for twenty (20) days and the right arm shunt was assessed two (2) times during that admission. Review of vital signs records revealed no blood pressure entries for hemodialysis dates; 07/16/11, 07/19/11, 07/21/11, 07/26/11, 07/28/11, 07/30/11 and 08/02/11. Interview with Resident #11, on 08/03/11, at 5:20 PM, in his/her room revealed no staff had assessed his/her vital signs or right arm shunt when he had returned from hemodialysis treatments. Resident #11 stated the staff does not check his/her blood pressure, other vital signs, or the shunt site/dressing. Interview with License Practical Nurse (LPN) #9, on 08/04/11 at 4:05 PM in the conference room revealed he had not assessed Resident #11's vital signs or right arm shunt after hemodialysis when Resident #11 was assigned to him.	F 279	What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur: The DON developed a policy entitled Assessments prior to leaving facility and upon return, which outlines the protocols for assessing the Resident prior to leaving Facility for scheduled appointments or procedures and upon return to Facility. Staff Development Nurse has educated RNs and LPNs on the new Facility policy entitled Assessments prior to leaving facility and upon return to assure proper documentation of vitals and conditions before and after scheduled appointments. How the Facility plans to monitor its performance to make sure that the solutions are maintained: The DON will develop a monitoring tool for the new policy to assure adherence and will include this in the Quality Assurance program for two quarters and then as necessary. Responsible Party: Director of Nursing		



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F 279	<p>Continued From page 5</p> <p>Interview with LPN #11 on 08/04/11 at 4:25 PM in conference room revealed she had been employed with the facility for five (5) weeks and worked on the second shift. She revealed she had cared for Resident #11 after he/she had returned from hemodialysis and she had monitored the resident for a drop in blood pressure. She also stated it was not mandatory to record findings unless they were abnormal. In addition, LPN #11 stated this was standard nursing practice to assess and monitor a resident's vital signs and shunt site/dressing when the resident returned from a hemodialysis treatment.</p> <p>Interview with the ADON on 08/04/11 at 4:38 PM in conference room revealed residents should be assessed after they return to the facility from hemodialysis treatment. She further revealed hemodialysis residents should have their vital signs monitored and hemodialysis shunt assessed for bleeding /thrill (vibration that can be felt over shunt) upon returning to the facility.</p> <p>Interview with Minimum Data Set (MDS) LPN #10 Coordinator on 08/04/11 at 5:00 PM in the conference room revealed her role was to develop care plans for residents. She stated she referred to the Lippincott Manual as a guide to care plan development, but she did not develop Resident #11's care plan. She revealed that a resident who needed hemodialysis would have a need for a plan of care. She stated there was no facility policy regarding how to care for a hemodialysis resident but staff should know how to care for hemodialysis residents from nursing school.</p>	F 279		
F 282 SS=0	453.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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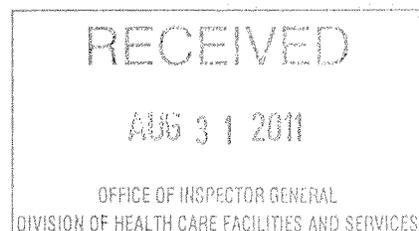
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F 282	<p>Continued From page 6</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and the Policy and Procedure for using a Hoyer and Sara Lift for transfer, it was determined the facility failed to follow the care plan for one (1) of sixteen (16) residents sampled, Resident # 4. Resident #4 was transferred with a Hoyer lift by one (1) staff member instead of two (2) staff members as care planned.</p> <p>The findings include:</p> <p>Review of the facility policy, Using Hoyer or Sara Lift for Transfer, dated 06/22/11 revealed the Objective: To provide safe transfer for residents. The policy also revealed at any time a lift is used to transfer a resident, two (2) staff members will be present during the transfer.</p> <p>Record Review for Resident #4, revealed the facility admitted the resident on 09/21/09 with diagnoses of Left Sided Hemiparesis and Cerebral Vascular Accident. The facility assessed his/her cognition with a score of fifteen (15) on 05/23/11, which indicated Resident #4 was interviewable. Record review of the CNA (Certified nursing Assistant) care plan, revealed the resident was to be transferred with a Hoyer Lift and only with two (2) people.</p>	F 282	<p>F282</p> <p>The Facility maintains that it provides services by qualified persons in accordance with each resident's written plan of care.</p> <p>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:</p> <p>CNA #4 is no longer with the Facility.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>The Staff Development Nurse has provided inservices to all nursing staff to reinforce the facility's policy, Using a Hoyer and Sara Lift for transfer, to further emphasize the correct procedures are followed when using the lifts for clients.</p> <p>The Assistant Director of Nursing and Lead LPN reviewed the care plans and have spoken with all of the certified nursing assistants on the the units and rechecked the care plans to verify the c.n.a. care plans have the correct transfer instructions.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur:</p> <p>The Director of Nursing and Staff Development Coordinator have met with the</p>	9/02/2011

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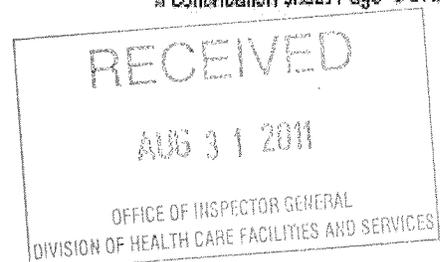
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F 282	<p>Continued From page 7</p> <p>Observation of Resident #4's room, on 08/02/11 at 11:24 AM, revealed one (1) CNA, CNA #4, entering Resident #4's room while pushing a Hoyer lift into the resident's room. While the surveyor waited outside the residents door, it was observed at 11:41 AM one (1) CNA, CNA #4 exiting Resident #4's room with dirty linen in a bag and transporting the linen to the dirty linen room.</p> <p>Interview with Resident #4, on 08/02/11 at 11:24 AM, revealed the staff was short and the CNA could not find help.</p> <p>Interview with CNA #4, on 08/04/11 at 2:10 PM, revealed the Hoyer Lift should be used with two (2) staff members present. One staff member to guide the lift and the other staff member to be present for support. The resident and the staff member can become injured if there are not two (2) staff members present. CNA #4 further stated, she asked License Practical Nurse (LPN) #4 to help but no one came to assist her with Resident #4.</p> <p>Interview with LPN #4, on 08/04/11 at 2:20 PM, revealed she could not remember if CNA #4 asked her to help with Resident #4. LPN #4 further stated the resident could fall with just one (1) staff member assisting with the lift.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 08/04/11 at 3:20 PM, revealed staff were to use two (2) staff members when using the Hoyer Lift. She further stated we use two (2) assist for safety reasons.</p> <p>Interview with the Director of Nursing (DON), on</p>	F 282	<p>RNs and LPNs and the lead LPN and Assistant DON to reemphasize the expectations of the Facility that the nursing staff are expected to assist the c.n.a. staff as needed when they are requested.</p> <p>The Facility was unable to determine that C.N.A #4 ever requested assistance and had followed expectations of Facility for proper transfer using lifts.</p> <p>How the Facility plans to monitor its performance to make sure that the solutions are maintained:</p> <p>Proper transfer using lifts will be included in the Facility Quality Assurance Program for the next two quarters to assure this issue is being consistently followed properly.</p> <p>Responsible Party: Director of Nursing</p>	



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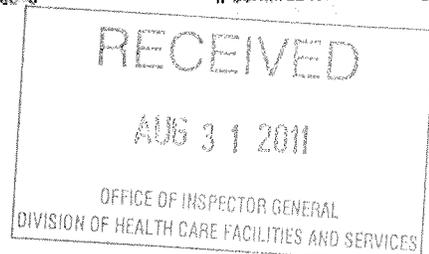
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F 282	Continued From page 8 08/04/11 at 3:40 PM, revealed their policy for the Hoyer Lift was for two (2) people to be present while doing transfers. Two (2) CNA's are asked to be present so that one (1) CNA can get assistance in an emergency situation and the other CNA can stay with the resident.	F 282	F309 The facility maintains that it provides each resident 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.	9/02/2011
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 observation, interview, and records review it was determined the facility failed to provide one (1) of sixteen (16) sampled residents with the necessary care that was related to monitoring and assessing his/her right arm shunt (vascular access for hemodialysis) after hemodialysis treatment (a treatment that cleans the blood by removing wastes and excess water from the body) for three (3) days a week. The facility did not assess shunt upon return. The findings include: The facility did not provide a policy related to hemodialysis residents. Review of medical record for Resident #11 revealed orders dated from 07/01/11 through	F 309	How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice: Resident #11 was discharged home from the Facility on August 4 th , therefore the implementation of any corrective action was not required for this alleged deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice: The DON reviewed the clinical record(s) of other resident(s) that receive routing dialysis treatments outside the facility to determine whether corrective action was needed What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur: The DON developed a policy entitled Assessments prior to leaving facility and upon return, which outlines the protocols for assessing the Resident prior to leaving Facility for scheduled appointments or procedures and upon return to facility.	



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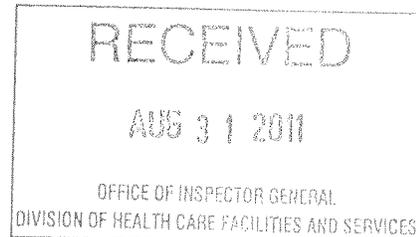
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2011
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F 309	<p>Continued From page 9</p> <p>07/31/11 chart did not reveal the necessary care for monitoring and assessing his/her right arm shunt after hemodialysis treatment for Resident #11. The nursing notes dated 07/15/11 through 08/03/11 that two (2) out of twenty (20) days Resident #11 had an assessment of right arm shunt. Review of vital signs record revealed no blood pressure entries for hemodialysis dates; 07/16/11, 07/19/11, 07/21/11, 07/26/11, 07/28/11, 07/30/11 and 08/02/11.</p> <p>Review of the medical record for Resident #11 revealed the facility admitted the resident on 07/15/11 with a diagnosis of End Stage Renal Disease (ESRD) receiving hemodialysis on Tuesday, Thursday and Saturdays.</p> <p>Observation, on 08/03/11 at 8:30 AM, revealed during the medication pass Resident #11 had a gauze dressing taped to his right arm. The hemodialysis provider utilized his/her right arm shunt for treatment.</p> <p>Interview with Director of Nursing (DON), on 08/03/11 at 1:00 PM in her office, revealed assessing a dialysis shunt would be common nursing practice.</p> <p>Interview with Assistant Director of Nursing (ADON), on 08/03/11 at 5:00 PM, revealed she was not able to locate the transfer forms or written reports from the hemodialysis provider in the clinical record for Resident #11.</p> <p>Interview with Resident #11, while in his/her room, on 08/03/11 at 5:20 PM, revealed "They do nothing when I come back". The nursing staff did</p>	F 309	<p>Staff Development Nurse has educated RNs and LPNs on the new Facility policy entitled Assessments prior to leaving facility and upon return to assure proper documentation of vitals and conditions before and after scheduled appointments.</p> <p>How the Facility plans to monitor its performance to make sure that the solutions are maintained:</p> <p>The DON will develop a monitoring tool for the new policy to assure adherence and will include this in the Quality Assurance program for two quarters and then as necessary.</p> <p>Responsible Party: Director of Nursing</p>	



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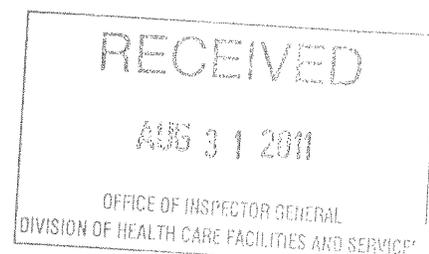
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F 309	<p>Continued From page 10</p> <p>not check blood pressure, heart rate or shunt site or the dressing " The hemodialysis center did not provide anything written to hand off to the facility staff after hemodialysis treatment.</p> <p>Interview with License Practical Nurse (LPN) #8, on 08/04/11 at 8:00 AM, at the nurses' station revealed Resident #11 was signed back in by facility staff the days he/she went out for hemodialysis. She worked the first shift and this resident returned to the facility on the second shift. If she worked second shift she would have checked the resident's dressing on his/her right arm, and checked his/her vital signs. These vital signs would then be recorded in the resident's medical record.</p> <p>Interview with LPN #9, on 08/04/11 at 4:05 PM and LPN #11 on 08/04/11 at 4:25 PM, in the conference room, revealed neither was provided with training for hemodialysis residents in the facility or received verbal or written report from hemodialysis center after the resident's treatments.</p> <p>Interview with the ADON, on 08/04/11 at 4:38 PM, in the conference room revealed she was not aware of any special training for staff nurses caring for Hemodialysis residents, but hemodialysis residents should be checked after returning to the facility after treatment. This would include checking the dressing for bleeding and checking for a thrill (vibration that can be felt over the shunt).</p> <p>Interview with the Staff Development Registered Nurse (RN), on 08/04/11 at 5:25 PM, in the conference room revealed her role was training</p>	F 309			



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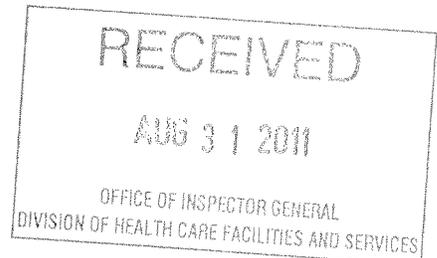
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F 309	Continued From page 11 for all staff. Training for Hemodialysis residents was not provided to facility staff. She stated that following standard nursing care for Hemodialysis residents would include checking the shunt site and getting vital signs.	F 309		9/02/2011	
F 371 SS-E	489.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation, and interview, it was determined the facility failed to prepare and serve food under sanitary conditions as observed in the kitchen and in the main dining room. Observation of the kitchen revealed two (2) cartons of opened products in the refrigerator which were not dated when opened. A dietary aide was sweeping the floor within four (4) feet of food preparation with opened packages of cheese, bread, and meal on a table, two Certified Nurse Assistants (CNA's) were observed touching residents' food with their bare hands in the main dining room, and eight (8) staff were in the main dining room serving food without hair restraints. In addition, observation of the kitchen during the sanitation tour revealed a bin of thickener without a lid and a can of marinara	F 371	The Facility maintains that it provides food from sources approved or considered satisfactory by Federal, State or local authorities, and does store, prepare, distribute and serve food under sanitary conditions. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice: No specific residents were identified as having been affected by the alleged deficient practice. The Dietary Manager has spoken with the staff that were involved in the alleged deficient practice and re-interviewed all dietary staff on proper sanitary procedures and proper dating and labeling of opened food products. The Dietary Manager and the Administrator have met concerning the policy on Hair Restraints that was dated 8/24/05, subtitled Dietary Procedures. The Policy has been revised. The intent of the policy was meant to require Hair Restraints for all employees in the food service areas of the Kitchen and at the serving stations. All employees coming into those areas are to have hair restraints. However, hair restraints are not required in the dining room(s).		



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F 371	<p>Continued From page 12 sauce with the opened lid half submerged in the sauce.</p> <p>The findings include:</p> <p>Review of the facility's policy Dietary Procedures/Hair Restraints dated 08/24/05 revealed Procedure: Any person entering the kitchen area or serving food in the main dining room shall be required to keep their hair restrained at all times. No other policy regarding kitchen sanitation was provided by the facility.</p> <p>Observation of the kitchen, on 08/01/11 at 3:00 PM, during the initial tour revealed one (1) carton of liquid eggs and one (1) carton of whipping cream which had been opened but not dated in one of the refrigerators. Observation at that time also revealed a dietary aide sweeping the kitchen floor within four (4) feet of a table with opened packages of cheese, bread, and meat and a dietary worker preparing these items for service. In addition, another table was within one (1) foot of the sweeping and food preparation was underway at that table with raw vegetables.</p> <p>Observation in the main dining room, on 08/03/11 at 12:45 PM, revealed CNA #1 touching an unsampled resident's bread with her bare hands.</p> <p>Observation of the main dining room, on 08/04/11 at 12:20 PM, revealed eight (8) staff without hair restraints serving food to the residents.</p> <p>Observation of the kitchen during the sanitation tour, on 08/04/11 at 12:18 PM, revealed a bit of thickener without a lid and a can of marinara sauce with the opened lid half submerged in the sauce.</p> <p>Interview with the Dietary Aide, on 08/02/11 at</p>	F 371	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>The Dietary Manager has spoken with the staff that were involved in the alleged deficient practice and re-inserviced all dietary staff on proper sanitary procedures and dating and labeling of opened food products. The Dietary Manager and the Administrator have met concerning the policy on Hair Restraints that was dated 8/24/05, subtitled Dietary Procedures.</p> <p>The Policy has been revised. The intent of the policy was meant to require Hair Restraints for all employees in the food service areas of the Kitchen and at the serving stations. All employees coming into those areas are to have hair restraints. However, hair restraints are not required in the dining room(s).</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur:</p> <p>The Dietary Manager has reviewed the sanitary procedures with the Dietician and Clinical Dietary Manager. All Staff have been inserviced on proper sanitation Techniques and proper dating and labeling of opened food products. The Dietary Manager has revised the cleaning schedules and instructed staff in proper procedures.</p>		



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F 371	<p>Continued From page 13</p> <p>12:06 PM, who was sweeping during food preparation, revealed he had worked at the facility for two months and he was hired to be a stock person. He stated he had five (5) to six (6) hours of training for that job and it was his responsibility to sweep the stock area but there was a new dietary manager and this person had not instructed him on when and where to sweep.</p> <p>interview with the Dietary Team Leader/Cook, on 08/03/11 at 12:06 PM, revealed the cook was responsible to clean the entire kitchen floor at the end of the shift and it took about twenty (20) minutes to do this. He stated they did not have time to stop food preparation during the floor cleaning. In addition, he stated the stirring up of dust could create a contamination of the food.</p> <p>Interview with CNA #1, on 08/04/11 at 1:30 PM, revealed it was her usual responsibility to assist with food service in the main dining room every day. She had been inserviced on Infection Control during the past year but did not remember being told not to touch residents' foods with her bare hands. She also stated she had never worn a hairnet in the main dining room.</p> <p>Interview with the Infection Control Nurse/Staff Development Nurse, on 08/04/11 at 2:00 PM, who was responsible to train staff revealed she did not train them to not touch residents' food with bare hands. She stated the rules have changed over time and she thought it was okay to touch the residents' food with bare hands because the dining experience was to be homelike.</p> <p>Interview with the Dietary Manager, on 08/04/11 at 3:30 PM, revealed dietary staff were trained on</p>	F 371	<p>How the Facility plans to monitor its performance to make sure that the solutions are maintained:</p> <p>The Dietary Manager will develop a monitoring tool for the revision to the policy on hair restraints and sanitary procedures. This will be reported in the Quality Assurance committee for the next two quarters and adjusted according thereafter.</p> <p>Responsible Party: Dietary Manager and Clinical Dietary Manager.</p>		

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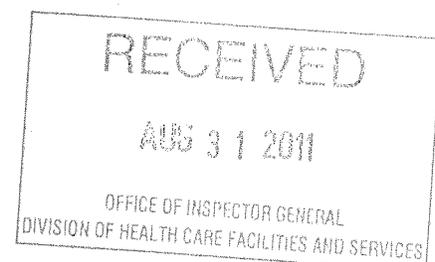
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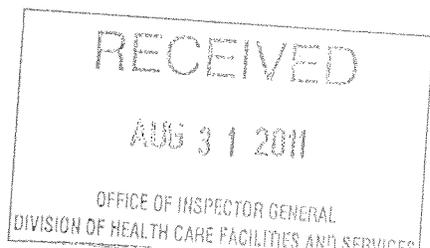
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F 371	Continued From page 14 infection control and cross contamination, and the food preparation areas of the kitchen were to be free of dirt and dust. She stated staff should not have been sweeping the kitchen floor when food preparation was in progress. She also stated her staff had been trained to date/label all opened containers of foods in the refrigerators, staff should not touch residents' food with bare hands, and the policy regarding wearing hairnets in the dining room to serve food was not followed.	F 371		08/02/2011
F 431 SS-E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431	The Facility maintains that it uses the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all drugs is maintained and periodically reconciled. The Facility further maintains that drugs and biological are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice: The Administrator has met with the Pharmacy Consultant and the Director of Nursing to review the Policy entitled specific procedures for all medications that was referred to during the annual survey. It was determined that the policy referred to needs to be clarified to only apply to those medicines that do not have expiration dates on the packaging for multi dose items. The Advair inhaler, Keppra liquid bottle, megestrol liquid bottles, xanax liquid bottle, and milk of magnesia bottles had expiration dates on the bottle that were not yet expired. These items would not need to be dated and initialed as the bottle itself has an expiration date on it that serves as the end date for	



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F 431	<p>Continued From page 15</p> <p>Comprehensive Drug Abuse Prevention and Control Act of 1978 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of the facility's policy it was determined the facility failed to date and initial open medications and failed to discard expired biologicals. For two (2) of four (4) medication carts and on two (2) of four (4) treatment carts. One (1) of four (4) treatment carts had expired biologicals.</p> <p>The findings include:</p> <p>Record review of the facility policy titled "Specific Medication Administration Procedures", item E, stated to check the expiration date on the package/container. When opening a multi-dose container, place the date on the container.</p> <p>Observation, on 08/03/11 at 8:55 AM, with Certified Medication Tech (CMT) #2 revealed opened multi-dose container medications without dates and initials from the medication cart for rooms 127 through room 144: One (1) Advair inhaler, one (1) Keppra liquid bottle, three (3) megestrol liquid bottles, one (1) Xanax liquid bottle, one (1) Mi-acid liquid bottle expiration date 03/13/10, two (2) Milk of Magnesia liquid bottles</p>	F 431	<p>which the product can be used safely until that date.</p> <p>The items that had expiration dates that had passed, such as the Mi-acid bottle, critic aid, and the lemon glycerin swabs have been discarded.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>The consultant Pharmacist has inspected the medication carts, treatment carts, and medication rooms to review the expiration dates on all items and discarded any expired items and replaced them.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur:</p> <p>The consultant Pharmacist and the Staff Development Nurse have inserviced all RNs, LPNs and CMTs on the revised policy and procedure entitled all medications. The revisions clarify which multi dose containers require initials and the date opened.</p>		



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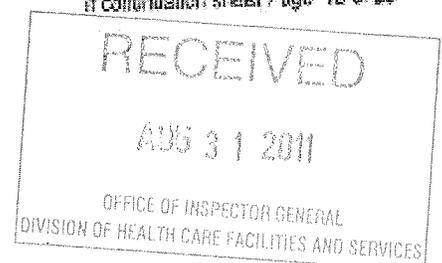
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F 431	<p>Continued From page 16</p> <p>The treatment cart for these same rooms revealed open and undated items including two (2) Nutrashield tube, one (1) Vasolex tube, one (1) Calazime, one (1) antifungal powder, one (1) Nystop, and one (1) Betamethasom Valerate.</p> <p>Observation, on 08/03/11 at 10:00 AM, of the medication cart for rooms 118 through 140 with Licensed Practical Nurse (LPN) #5 revealed opened medications without dates and initials: Three (3) antacid, two (2) Miralax bottles, two (2) lactulose liquid bottles, two (2) Mintox liquid bottles, one (1) Milk of Magnesia, one (1) Childrens Allergy ALC/FR liquid bottle, one (1) lactulose liquid bottle, one (1) potassium liquid bottle, one (1) docusate liquid bottle, one (1) Keppra, and two (2) Robitussin DM liquid bottle.</p> <p>The treatment cart for these same rooms revealed opened and undated items including one (1) Flexall bottle, one (1) triamcinolone, one (1) Granulex spray, one (1) Voltaren 1% cream, one (1) Lotrimin AF 2% spray, one (1) hydrocort, one (1) Calazime, one (1) Remedy skin repair, two (2) Nutrashield, and one (1) Giotrimazole 1% cream.</p> <p>interview, on 08/03/11 at 9:00 AM, with Certified Medication Tech (CMT) # 2, revealed she was to date and initial multi-dose medications.</p> <p>interview, on 08/03/11 at 10:20 AM, with Licensed Practical Nurse (LPN) #5 revealed open medication should be dated and initialed when opened. She would have to refer to the facility's policy about expiration dates after opening as she was new and could not remember.</p> <p>Observation, on 08/03/11 at 10:25 AM, revealed</p>	F 431	<p>How the Facility plans to monitor its performance to make sure that the solutions are maintained:</p> <p>The Consultant Pharmacist will include the revised procedure in the quality assurance program for the next two quarters to assure this alleged deficiency does not recur.</p> <p>Responsibility: Director of Nursing and Consultant Pharmacist</p>	

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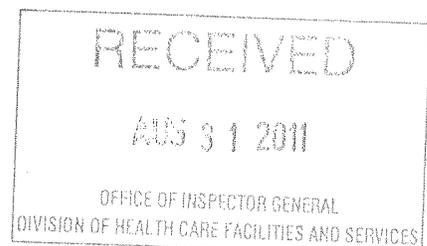
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2011
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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 431	<p>Continued From page 17</p> <p>thirty-three (33) Critic Aid with expiration dates of March 2010.</p> <p>Interview, on 08/03/11 at 10:25 AM, with Licensed Practical Nurse (LPN) #5, revealed there were thirty-three (33) Critic Aid packs in the treatment cart with expiration dates of March 2010. She would have removed any expired items.</p> <p>Observation, 08/04/11 at 2:25 PM, revealed seven (7) expired Lemon Glycerin Swabs dated 10/04/10.</p> <p>Interview, on 08/04/11 at 02:25 PM, with Licensed Practical Nurse (LPN) # 7 revealed seven (7) Lemon Glycerin Swabs had expiration dates 10/04/10 stamped on the end of package. She stated she would follow her policy on expired medications and throw these away.</p> <p>Interview, on 08/04/11 at 3:15 PM, with consultant pharmacist, per phone, revealed the pharmacy does written medication cart audits for the facility monthly. Copies of those audit sheets are given to the Director of Nursing and should be available to review. The consultant pharmacist stated for those multi-dose medications that required a date and initial when opened have a blank sticker on the bottle as a reminder, to alert the staff to date and initial when medications are opened.</p> <p>Record review of the pharmacy audit sheets revealed on cart N-1 06/28/11 insulin was opened, uncapped and pulled from cart. Cart N-2 had expired insulin.</p> <p>Review of the Pharmacy audit sheets for 07/10/11 revealed in printed notes that multi-use items</p>	F 431		



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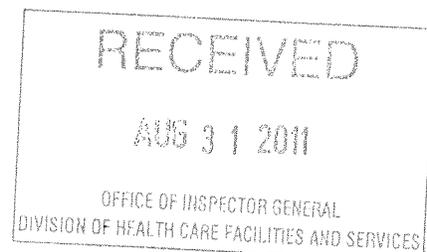
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F 431	Continued From page 18 appropriately dated when opened or punctured were checked. Expired items were removed by pharmacy staff. Review of the Pharmacy audit sheet for 08/01/11 revealed in comments for cart S-6, "Dated eye drops x 6". Cart N-2 pulled two (2) expired insulin bottles, dated eye drops.	F 431		08/02/2011
F 463 SS=0	463.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation, record review, and interview, it was determined the facility failed to ensure residents' had an accessible call light system to contact the nursing staff for two (2) of nineteen (19) sampled residents, Resident #4 and Resident #8, and seven (7) unsampled residents. The findings include: Review of the facility policy, Call Light, dated 12/03/07, revealed the Objective: 1. To respond to resident's request and needs, Equipment: 1. Functioning call bell, and Procedure: 1. Answer light promptly. Observation of the facility during survey initial tour, on 08/01/11 at 3:35 PM, revealed four (4)	F 463	F463 The Facility maintains that the nurses' station(s) are equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice: The Director of Nursing has met with the Staff Development Nurse and the lead LPN and the Assistant Director of Nursing to discuss the alleged deficient practice related to the call lights being within reach of the residents. The Assistant Director of Nursing and lead LPN and Staff Development Nurse have reviewed the care plans for the residents found to be affected by the alleged deficient practice. The RNs, LPNs, CMTs, and CNAs that provide care for those Residents have been reeducated on the Facility's policy on call lights. C.N.A. #4 is no longer employed by the Facility.	



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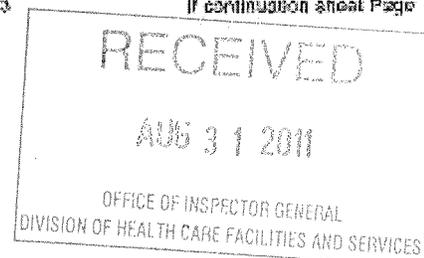
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F 463	<p>Continued From page 19</p> <p>unsampled residents who did not have their call lights within reach, the residents who were assigned to room one hundred fifty four (154) bed one (1), room one hundred fifty nine (159) bed one (1), one hundred sixty seven (167) bed two (2), and room one hundred seventy two (172) bed two (2). Observation of Resident #8, on 08/01/11 at 5:00 PM, revealed his/her call light lying the floor between the bed and the wall and not within Resident #8's reach. Observation of the facility, on 08/03/11 at 8:15 AM, revealed three (3) unsampled residents who did not have their call lights within reach assigned to room one hundred forty seven (141) bed one (1), one hundred sixty five (165) bed two (2) and one hundred sixty seven (167) bed one (1).</p> <p>Record review for Resident #8 revealed the facility admitted the resident on 02/18/11 with the diagnosis of a Left Iliac and Sacral Fracture. The facility assessed his/her cognition with a score of thirteen (13) on 05/23/11 which indicated Resident #8 was interviewable.</p> <p>Interview with Resident #8, on 08/01/11 at 5:00 PM, revealed he/she could not reach the call light to alert the nursing staff of assistance needed.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 08/03/11 at 8:30 AM, revealed she knew it was standard practice from her CNA training to make sure the resident's call light was within his/her reach each and every time she left the resident's room. She also revealed she knew it was the facility expectation from her orientation to make sure the resident's call light was within his/her reach. CNA #3 revealed she did sometimes forget to make sure the resident's call</p>	F 463	<p>How the Facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>The Director of Nursing, the Lead LPN, the Staff Development Director, and the Assistant Director of Nursing make rounds to assure that the call lights are within reach of the Residents.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur:</p> <p>The RNs, LPNs, CNAs, and CNAs have been reinserviced on the Facility policy on Call lights.</p> <p>It continues to be expected that call lights are within reach of the Residents.</p> <p>The Facility has an Ambassador Program that emphasizes customer service that is comprised of twenty staff members. The Ambassadors have been given instruction from the Administrator to emphasize the call lights being within reach.</p> <p>How the Facility plans to monitor its performance to make sure that the solutions are maintained:</p> <p>The Facility will monitor this alleged deficiency through its Quality Assurance Program for the next two quarters.</p> <p>Responsibility: Director of Nursing</p>	



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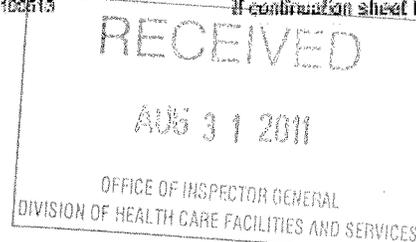
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F 463	<p>Continued From page 20</p> <p>light was within his/her reach when she left the resident's room.</p> <p>Interview with CNA #4, on 08/03/11 at 9:00 AM, revealed she had been taught to leave the resident's call light within his/her reach and she tried to remember to do so but sometimes she forgot.</p> <p>Interview with the Director of Nursing (DON), on 08/04/11 at 10:00 AM, revealed she knew it was standard nursing practice to ensure the residents' call light was within reach when leaving the residents' rooms and stated there was not a valid reason for any resident not to have his/her call light within reach to ensure they could contact the nursing staff.</p> <p>Record review for Resident #4, revealed the resident was admitted to the facility on 08/2/09, with the diagnosis of left sided hemiparesis and Cerebral Vascular Accident (CVA). Record review, for Resident #4, also revealed the facility assessed his/her cognition with a score of fifteen (15) on 05/23/11 which indicated Resident #4 was interviewable.</p> <p>Observation of Resident #4, on 08/02/11 at 10:27 AM, revealed the call light was placed on Resident #4's left side of the bed near his/her left hand. Resident #4 verified with surveyor that he/she could not move his/her left hand to reach the call light.</p> <p>Interview with Resident #4, on 08/02/11 at 10:27AM, revealed there are many times he/she cannot reach her call light.</p>	F 463			



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F 463	Continued From page 21 Interview with Licensed Practical Nurse (LPN) # 4, on 08/04/11 at 2:20 PM, revealed staff are trained to make sure call lights are within reach and was not aware the call light was not within reach for Resident #4. Interview with Assistant Director of Nursing (ADON), on 08/04/11 at 3:20 PM, revealed the call light should be within reach and was not aware Resident #4 was unable to reach the call light.	F 463	F 500 The Facility maintains that it does furnish qualified professionals to furnish specific services and that agreements pertaining to those services provided by outside services are specified in writing outlining the responsibilities of both parties that meet the standards and principles that apply to those services. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:	9/02/2011	
F 500 SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview, review of the facility roster matrix, and census and condition revealed the	F 500	The Administrator has contacted the outside Dialysis providers and obtained written agreements with them. How the facility will identify other residents having the potential to be affected by the same deficient practice: The Facility has obtained written contracts with the dialysis providers that have been utilized by Facility. What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur: Facility will assure that any Resident requiring dialysis services from outside provider have written agreements in place as necessary.		



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F 500	Continued From page 22 facility failed to ensure a written agreement for an outside dialysis agency for two residents, (Resident #11 and one (1) un-sampled resident). The findings include: Review of the roster matrix and census and condition revealed the facility had two (2) residents receiving dialysis outside of the facility. Interview with the Director of Nursing, on 08/03/11 at 1:00 PM, revealed the facility had two residents receiving dialysis. She further revealed the facility had no written dialysis agreement for outside resources. Interview with the Administrator, on 08/03/11 at 2:00 PM, revealed the facility dialysis service was furnished to residents by an outside resource. He revealed not being aware of the need for a written dialysis agreement.	F 500	How the Facility plans to monitor its performance to make sure that the solutions are maintained: Administrator will develop monitoring tool and include the results are reported in the Quality Assurance committee over the next two quarters and adjust accordingly thereafter. Responsible Party: Administrator		

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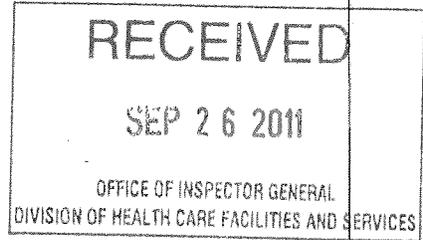
AUG 31 2011

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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{K 000}	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1978</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is LP gas.</p> <p>A standard Life Safety Code survey was conducted on 08/02/2011. Springhurst Health and Rehab was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for ninety (90) beds and the census was seventy-seven (77) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	{K 000}	<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>	



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

TITLE

(X6) DATE

X Richard Flower

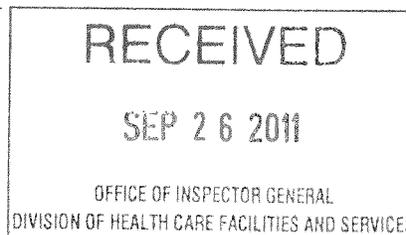
X Administrator X 9/20/2011

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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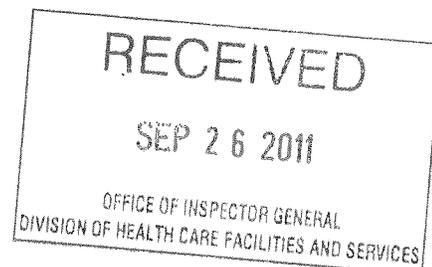
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{K 000}	Continued From page 1	{K 000}		9/22/2011
{K 056} SS=D	<p>Deficiencies were cited with the highest deficiency identified at F level. CFR: 42 CFR 483.70(a)</p> <p>A revisit survey was conducted on 09/19/11 and found the facility remained out of compliance at 42 CFR 483.70(a). K0056 remained at a S/S of a "D" and K0147 at a S/S of "D" were found not corrected.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The</p>	{K 056}	<p>The Facility will continue to maintain its automatic sprinkler system in accordance with NFPA 13.</p> <p><i>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:</i> Facility's outside contractor installed the sprinkler head in the roof overhang area outside the kitchen.</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> Facility's maintenance Director has examined the remainder of the Facility to be assured that there are no other areas that would need a sprinkler head installed. <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 will include observation of the Facility for unsprinklered areas. On a monthly basis the preventative maintenance log will include the outcome of those observations. <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</p>	



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{K 056}	Continued From page 2 facility is licensed for ninety (90) beds with a census of seventy-seven (77) on the day of the survey. The findings include: Observation, on 09/19/11 at 2:00 PM, with the Maintenance Director revealed an exterior roof overhang, outside of the kitchen, was constructed of combustible materials and was not protected with sprinkler coverage. Interview, on 09/19/11 at 2:00 PM, with the Maintenance Director revealed the sprinkler head had not been installed by the completion date of 09/01/11 as noted on the Plan of Correction. The sprinkler contractor did not deliver the correct sprinkler head and had to reorder the correct head for proper installation per NFPA 13 requirements. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	{K 056}	Department on a Quarterly Basis. This report will include the status of the sprinklered areas being covered for the building. K 147 The Facility will continue to maintain electrical wiring and equipment in accordance with NFPA 70. <i>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:</i> The alleged deficiency has been corrected by removing the power strip from the DON office and Facility Maintenance director has installed an additional outlet. <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 to determine any other power strips and removed those as necessary. <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 will include observation of extension cords and power strips. On a monthly basis the Safety Committee will include extension cords and power strips to further emphasize this alleged issue. The PM log and Safety Committee will include the outcome of those observations.	9/22/2011
{K 147} SS=D	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:	{K 147}		



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NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241		
(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 147}	<p>Continued From page 3</p> <p>Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficiency had the potential to affect each of the one (1) of (6) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety (90) beds with a census of seventy-seven (77) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 09/19/11 at 2:30 PM, with the Administrator and the Maintenance Director revealed a power strip was still being used to power a refrigerator and a microwave, located in the Director of Nursing (DON) Office.</p> <p>Interview, on 09/19/11 at 2:30 PM, with the Administrator and the Maintenance Director revealed they were unaware that the power strip was still being used.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	{K 147}	<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. Maintenance Director will report on the preventative maintenance program and Safety Coordinator will also report on power strips and extension cords on a Quarterly Basis. This report will include the status of the extension cords and power strips for the building.</p>		

