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

PRINTED: 06/16/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185305		R-C 06/02/2011

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 An onsite revisit was conducted on 06/02/11 and it was determined the Immediate Jeopardy had been removed as of 06/01/11, at F221, F280, F323, and F490 based on an Acceptable Allegation of Compliance dated 06/02/11. Continued non-compliance remaining at a scope and severity of an "E" at 42 CRF 483.13 Resident Behavior, F221, at 42 CRF 483.20 Resident Assessments, F280, at 42 CRF 483.25 Quality of Care, F323 and at 42 CRF 483.75 Administration, F490. The Administration of the facility failed to have a system in place to ensure continued compliance of the deficient practice. The facility has not analyzed the data from the completed audits and has not presented the data to the Quality Assurance Committee for review. The non-Immediate Jeopardy deficiencies cited during the abbreviated/partial extended survey on 05/13/11 were not reviewed for compliance during the 06/02/11 revisit as the facility had not submitted a plan of correction (POC). Therefore, the statement of deficiencies details deficient practice remaining at F221, F280, F323, and F490 and also includes the non-Immediate Jeopardy deficiencies identified during the 05/13/11 abbreviated/partial extended survey.	{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 221} SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced	{F 221}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Richard Flowers
TITLE: X Administrator
(X6) DATE: X 6/23/11

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

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{F 221}	Continued From page 1 by: Based on interview, it was determined the immediate Jeopardy identified during an abbreviated survey (05/13/11) had been removed; however, non-compliance continued to exist as the facility had not completed the evaluation of the restraint audits and assessment by the Quality Assurance Committee. The findings include: 1.Interview with the DON, on 06/02/11 at 12:45pm, revealed she had completed side rail assessments on all residents. No residents were identified as using side rails as a restraint. Five (5) residents were identified as using restraints, four (4) residents had lap buddies and one (1) resident had a low chair. She confirmed the monthly nursing summaries were not completed correctly regarding the use of side rails as a restraint. The DON stated she has not conducted quarterly audits regarding restraints and any concerns addressed in the (QA) meetings. Interview with the Administrator, on 06/02/11 at 3:00pm, revealed the Director of Nursing (DON) had completed the audits regarding side rails and restraints. The findings are to be presented to him and discussed in the June 2011 Quality Assurance (QA) meeting. According to the Administrator, there has not been a QA meeting since the audits had been completed.	{F 221}	F221 The Facility maintains that it protects the rights of the residents to be free from physical or chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the medical symptoms of the residents. For the residents who were determined to have been affected by the alleged deficient practice, the ADON, Lead LPN and MDS Coordinator completed side rail assessments, under the direction of the Director of Nursing. Based upon the side rail assessments that were completed on May 10, 2011, it was determined that none of the alleged affected residents were restrained by the use of side rails. Additionally, side rail assessments were completed for all the residents in the facility. The side rail assessments that were completed for all residents of the facility on 5/10/11 determined that side rails were not being used as restraints for any of the residents of the facility. The side rail assessment form that was used to evaluate the use of side rails confirmed that the side rails that were being used were enablers and not restraints. In the event that the side rail assessment determines that the side rails are being used as restraints, the Facility will follow its policy and procedure in the use of restraints. For the sixty-three (63) residents who were still using side rails, the families were informed about the risks and benefits of continued side rail use and consent was received. The nurses, licensed practical nurses, certified medication tech and	6/8/11
{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.	{F 279}		

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certified nursing assistants were inserviced on side rail assessments as part of the Bed Safety with Emphasis on Entrapment inservice. The Staff Development Coordinator completed this inservice which included side rail assessment instructions for all nurses, licensed practical nurses, certified medication techs, and certified nursing assistants on 5/12/2011. A list of Residents was developed to identify those Residents who have special instructions for the use of side rails, i.e. one rail up, one rail down or both rails down. The list of specialty instructions is kept current by the Director of Nursing and is located on both nursing units and noted in the care plans and in the CNAs care plan. The DON has assigned the administrative nursing assistant to perform daily rounds to assure the side rails are in proper position. The DON has also provided the ADON, Lead LPN, and Staff Development Coordinator with this list to make daily rounds to monitor for proper positioning of the side rails. This action began on 5/13/11. Subsequent to a conference call on 6/1/11 with CMS on the Facility's allegation of compliance, side rail monitoring was increased to occur each shift to further assure proper positioning of side rails. This action has been performed during the report rounds for the incoming nurse and outgoing nurse on the unit. Each nurse signs and dates this action has been completed and turns the sheet into the DON daily. This monitoring will continue q shift for one month beginning 6/1/11. The DON will continue to report to the Administrator the results of the monitoring of proper side rail positioning. This information has been

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reported at the weekly Safety Committee meetings by the DON.

For other residents that utilize physical restraints, such as lap buddies or low chairs, four residents were identified that use these devices at the Facility. The DON maintains a list of residents who use restraints. All four charts were reviewed by the DON and it was confirmed that prior to applying the restraint, other less restrictive interventions had been tried and documented. Each chart had updated care plans, MD orders and consent forms that the family/guardian had been notified of the risks and benefits of the device. This action was completed on 5/30/11.

For other residents who may use these devices going forward, per facility policy the procedure for the use of these devices is as follows: the interdisciplinary team meets to discuss the appropriateness of the device to ensure less restrictive means have been attempted without success. Once the determination has been made that a physical restraint is needed, the family is consulted about the device and the risks and benefits of that device are provided. Written consent is obtained from the family and a physician order is also obtained detailing the medical justification for the use of the restraint. Nursing Staff are then notified that the restraint is to be used and the Care Plan and C.N.A. Care Plan are updated to reflect the use of the restraint. Per Facility policy, the restraint elimination assessment will be completed quarterly and prn.

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DON monitors 100% of physical restraints for updated care plans, family consent and physician orders and reports this information quarterly to the regularly scheduled Quality Assurance Committee.

Finally, the Staff Development Coordinator under the direction of the DON has developed an in-service for all nurses, licensed practical nurses, certified medication techs, and certified nursing assistants on the definition and use of physical restraints. This inservice was completed on 6/7/11.

This information has been reported to the specially called QA Meeting on 6/7/11. The frequency of this monitoring may change after the scheduled July QA meeting dependent on the outcome of the results to daily or weekly. The results of this monitoring was reported by the Administrator to the QA Committee.

Regarding the Bed Safety Policy, the Director of Nursing and Administrator met to review and modify this policy to assure its accuracy. The Facility's Bed Safety Policy was revised effective 5/13/2011. The Safety Committee reviewed the revised Bed Safety Policy on 5/13/2011. The Quality Assurance Committee reviewed the revised Bed Safety Policy on 5/13/2011.

According to the revised Bed Safety Policy, the Director of Nursing and Safety Director shall inspect all hospital beds at least quarterly to identify areas of potential

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entrapment. As part of the corrective action for the facility to assure this policy is being followed, all facility beds have been inspected weekly by the Safety Director for one month beginning the week of May 9th and finishing the weekly monitoring, the week of May 30th. A Bed Dimensional Check off sheet has been used to measure the distance between the zones of the bed system and the mattress to assure proper positioning to meet FDA guidelines and address potential entrapment zones. The results of these inspections have been reported to special called meetings of the Safety Committee focused on Bed Safety.

These specially called Safety Committee meetings have been conducted for four weeks beginning on May 13th and continued weekly through June 6th. The Safety Committee chairperson has also met weekly and as needed regarding the bed safety checks with the Administrator. The weekly meetings began the week of May 9th and continued through the week of May 30th. The Quality Assurance Committee has met and reviewed the information that has been collected over the past 4 weeks. The Administrator has reported the findings to the QA Committee at a specially called QA Meeting on Bed Safety held on 6/7/11.

The Quality Assurance Committee has recommended that the frequency of the monitoring activity change from weekly to monthly for the next three months. Once that timeline has been completed and the information presented to the QA Committee.

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the monitoring frequency will possibly be moved back to quarterly, depending upon the outcomes of the monthly monitoring activity.

Responsibility: Director of Nursing and the Administrator.

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{F 279}	Continued From page 2 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure a comprehensive plan of care was developed for one (1) of twelve (12) sampled residents (Resident #5). The facility assessed Resident #5 as being at risk for falls; however, there was no evidence a plan of care had been developed. The findings include: Record review revealed the facility admitted Resident #5 on 04/05/11, with diagnoses of status post Fractured Right Humerus, Urinary Retention, and Hypertension. The fall assessment dated 04/05/11 assessed the resident as a twelve (12)-high risk for falls. The admission MDS dated	{F 279}	F279 The Facility maintains that it develops comprehensive care plans for each resident that include measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. For the resident who was determined to have been affected by the alleged deficient practice, the ADON, Lead LPN and MDS Coordinator completed a falls assessment, under the direction of the Director of Nursing. This action was completed on 5/10/11. *The Falls Assessment indicated that this resident was at high risk of falls and a care plan was developed to reflect this and interventions were in place to minimize the risk of falls. This residents care plan and c.n.a. care plan were updated to reflect this change.* *In order to assure the facility continues to be in compliance with the regulation, the ADON, Lead LPN, and MDS Coordinator completed Falls Assessments on all residents of the facility on 5/10/11. All Care Plans were updated as necessary at that time to reflect a falls care plan was in place for all residents identified to be at high risk for falls.* *All registered nurses and licensed practical nurses were reeducated on the use of the fall risk assessment tool and updating the care plans as required as part of the inservices.*	6/8/11

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{F 279}	Continued From page 3 04/18/11 coded the resident as having a fall in the last month prior to admission and a fall in the last two (2)-six (6) months prior to admission that resulted in a fracture. There was no documented evidence of a fall care plan in the record. Observation on 05/13/11 at 11:30am, revealed the resident sitting in a chair in the room. A one quarter (1/4) side rail was raised on the left side of the bed and one half (1/2) side rail was raised on the right side of the bed. Interview with the MDS Coordinator, 05/09/11 at 3:55pm, revealed a fall care plan should have been completed on Resident #5 because the resident was assessed as a high fall risk on 04/05/11.	{F 279}	*given on bed safety awareness by the Staff Development Coordinator on 5/12/11.* The Director of Nursing has developed a monitoring tool going forward to assure that those residents who are identified as being at high risk for falls have a current comprehensive care plan that corresponds with the falls assessment. Falls assessments are performed per Facility policy at admission, readmission, quarterly, and as needed. The Director of Nursing will include the results of these audits quarterly at the regularly scheduled quality assurance committee meetings to ensure continued compliance with this regulation. Responsibility: Director of Nursing	
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	{F 280}		

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(F 280)	Continued From page 4	(F 280)	F280	6/8/11

This REQUIREMENT is not met as evidenced by:
Based on interview, it was determined the Immediate Jeopardy identified during an abbreviated survey (05/13/11) had been removed; however, non-compliance continued to exist as the facility had not evaluated the care plan audits by the Quality Assurance Committee.
The findings include:

1. Interview with the Director of Nursing, on 06/02/11 at 12:45pm, revealed she conducted audits on the care plans to ensure the information was complete and accurate. According to the DON, side rail assessments were completed and the comprehensive care plan and the Certified Nursing Assistant care plans were updated to reflect the correct number of side rails and the specific type of speciality mattress to be utilized by the resident. The DON stated she will visually inspect all specialty mattress to ensure correctness. Audits of the care plans will be completed monthly. The results of the audits will be discussed in the QA meetings to ensure continued compliance.

On 06/02/11 at 3:00pm, Administrator interview revealed the DON was responsible for completing the audit tool to ensure care plans were completed and revised with current resident information. He will review the audit tools and discuss any concerns in the Quality Assurance (QA) meeting in June 2011. According to the Administrator, the QA committee meetings will

The Facility maintains that it provides the resident the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

For the Residents who were determined to be affected by the alleged deficient practice, the facility has no low air loss mattresses in the facility. The facility has two overlays for residents who were determined to meet the clinical standards of care for the use of mattress overlays. The Resident's Care Plans have been updated to reflect the use of the overlay mattress and the C.N.A Care plans have also been updated to reflect the use of overlay mattresses for these residents. The Facility has a policy that outlines the guidelines for the safe use of specialty mattresses and overlays. This action was completed on 5/10/11. Inservices were conducted to educate the nurses, licensed practical nurses, certified medical techs, and certified nursing assistants on the proper use of overlay mattresses by the manufacturer's representatives on 5/10/11. The content of these inservices included the manufacturer's suggested specifications. This information is readily available at each nurse's station and is also housed in the Director of Nursing's office as part of the Bed Safety Awareness packet. The Staff Inservice Director will conduct inservices on overlay mattresses going forward in orientation for new hires and as needed to assure ongoing compliance for this regulation.

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The Director of Nursing has included an audit tool for the use of overlay mattresses. The Care Plans reflect the use of the mattresses and the C.N.A. Care Plans are updated to reflect the use of the overlays. The overlay mattresses have been monitored weekly over the course of the past month to assure accuracy in the care plans and C.N.A. care plans. The results of this monitoring have been reported to the Safety Committee specialty meetings on Bed Safety by the Director of Nursing. The Administrator has reported the findings. The Quality Assurance Committee has recommended that the frequency of the monitoring activity change from weekly to monthly for the next three months. Once that timeline has been completed and the information presented to the QA Committee, the monitoring frequency will possibly be moved back to quarterly, depending upon the outcomes of the monthly monitoring activity.

Responsibility: Director of Nursing and Administrator.

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{F 280}	Continued From page 5	{F 280}		
	ensure continued compliance.			
{F 286} SS=E	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to maintain resident MDS assessments, completed within the previous fifteen months, in the resident's active record or easily accessible to the staff and/or survey team for ten (10) residents (#1, #2, #3, #4, #5, #8, #9, #10, #11 and #12) of the twelve (12) sampled residents. The findings include: The facility could not provide evidence of a policy regarding the accessibility and storage of the MDS assessments. Record review revealed Quarterly MDS assessments dated: 02/28/11 for Resident #9; 03/14/11 for Resident #10; 03/21/11 for Resident #11; 03/18/11 for Resident #12; 04/08/11 for Resident #1 and #8; 04/14/11 for Resident #4; 04/25/11 for Resident #3; and Admission MDS assessments dated: 03/11/11 for Resident #2 and 04/14/11 for Resident #5, were not located in the clinical record or stored where staff could readily obtain them.	{F 286}	F286 The Facility maintains that it maintains all completed resident assessments within the previous 15 months in the resident's active record. Upon review of the information of the alleged affected residents, it was determined that the Facility does maintain 15 months of MDS in the computerized system. The Facility policy was developed October 25, 2010, and states the RAI will be maintained electronically and is accessible at all times to those authorized to review them, including the unit nurse. *The alleged deficient practice for the group of residents that were determined to not have the MDS information available was corrected through the education that was provided by the computer software vendor on 5/11 and 5/12. Each of the nursing units has a printer available to use for printing off MDS as needed.* *The education that was provided on site by the computer software vendor on 5/11 and 5/12 included instruction on looking up the MDS information and printing off the MDS on all residents.* The Director of Nursing printed out the requested MDS forms for the surveyor who had requested them on 5/11/11 and they were in her office on the morning of 5/12/11. The Facility has been transitioning toward utilizing electronic clinical records for the past several months.	6/8/11

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{F 286}	Continued From page 6 The MDS Coordinator was not available for interview. Interview with the Director of Nursing (DON), on 05/11/11 at 3:00pm, revealed the MDS assessments were not available to staff. The DON and MDS Coordinator had to pull the MDS assessments off the computer. Staff nurses did not have access to the computer. Presently, if an MDS was needed off hours, the staff must call the DON or MDS Coordinator at home to come in and print off the MDS. The MDS Coordinator was not available and the DON was the only person who could print the MDS assessments at this time. Interview with LPN #2, on 05/11/11 at 3:30pm, revealed he did not know where the MDS assessments were kept, and stated when the state surveyor found out, would they let him know. Interview with the Assistant Director of Nursing (ADON), on 05/11/11 at 3:45pm, revealed she did not know how to access the MDS assessments off the computer. Interview with the MDS Assistant, on 05/12/11 at 8:15am, revealed she was part time and only worked on the quarterly MDS assessments. She stated she was not sure how to print the assessments for the surveyor. Interview with the Administrator, on 05/12/11 at 8:35am, revealed accessibility of the MDS was an issue. He did not know if the MDS requested on 05/11/11 had been printed or not. The DON was contacted to see when she would be in the	{F 286}	The nurses and licensed practical received in house training on the computerized system on 5/11/11 and 5/12/11. The computers were installed on the nursing units and are accessible for reviewing. Ongoing training for new hires and agency staff will be completed by the Staff Inservice Director, MDS Coordinator, or the Lead LPN. This action was completed on 5/31/11. *The Facility will assure that the MDS Assessments continue to be readily available by monitoring the Staff's capabilities of accessing and printing the MDS through random checks of the registered nurses and licensed practical nurses. The results of the audits will be reported quarterly by the Staff Education Coordinator at the regularly scheduled quality assurance committee meetings.* Responsibility: MDS Coordinator and Staff Education Coordinator.	

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{F 286}	Continued From page 7 building. The surveyor received the requested MDS on 05/12/11 at 8:45am.	{F 286}	F323	6/8/11
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, it was determined the Immediate Jeopardy identified during an abbreviated survey (05/13/11) had been removed; however, non-compliance continued to exist pending the evaluation of the bed safety checks, the care plan audits, side rail/fall assessment audits and completion of information on the fall circumstance forms, had not been addressed by the Quality Assurance Committee. The findings include: 1.Interview with the DON, on 06/02/11 at 3:00pm, revealed all low air loss mattresses have been removed from the facility. The bed safety checks have been completed on all beds and will be completed weekly for four weeks. The results will be discussed in the bed safety committee meetings held weekly. Side rail assessments, care plan revisions, fall circumstance forms, speciality mattresses, and staff education will be discussed at the next QA meeting in June 2011 to ensure continued compliance.	{F 323}	The Facility maintains that it ensures that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Regarding the specific instance that occurred with Resident #1, the Facility self reported the incident in accordance with State and Federal regulations. The Facility took immediate action on5/1/11 to assure that the incident not reoccur by investigating the circumstances surrounding the incident. The findings were inconclusive regarding the root cause of the incident. However, the Facility changed out the low air loss mattress to a low air loss mattress with bolsters and lowered the electric bed and placed a mat on the floor to assure resident safety. This was accomplished on 5/1/11. In response to the alleged deficiency, the Facility removed the low air loss mattresses from the building and is utilizing mattress overlays. One of the residents affected by the alleged deficiency had the low air loss mattress discharged and no additional interventions were determined necessary. Therefore, there are two (2) mattress overlays in the facility. Additionally, the ADON, Lead LPN, and MDS Coordinator, as directed by the DON, completed side rail assessments on all residents in the facility effective 5/10/11. The Facility collected information on the Evaluation for Use of Side Rails form. This form collects information on a resident's physical,	

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cognitive or feeling of security, information from the personal preference of the resident or legal representative and includes a thorough analysis of multiple factors for side rail use. The information collected on this form is then used to determine the risks versus benefits of side rail use in conjunction with a physician order. Also, care plans were updated effective 5/10/11 to reflect the side rail assessments that were completed. The results of this process were documented by the ADON, Lead LPN and MDS Coordinator as directed by the DON into the resident care plans. The DON, ADON, and Lead LPN advised and trained the RNs, LPNs, CMTs and CNAs on the updated care plans effective 5/10/11. The C.N.A Care Plans were updated to reflect the proper positioning of the side rails. The Facility also completed bed safety checks for all beds in the facility. The bed safety checks were conducted to assure proper positioning of the mattress in the frame to meet FDA guidelines and address potential entrapment zones. Bed safety checks were conducted by the Safety Committee chairperson, social services director, ADON, and Lead LPN. This action was initially completed on 5/11/11. These assessments were reviewed with the Administrator on 5/11/11.

The Administrator and DON reviewed and modified the Facility Bed Safety Policy effective 5/13/11. The DON also developed a Specialty Mattress/Overlay Policy for the overlay mattresses effective 5/10/11. Inservices were conducted by the manufacturer's representatives effective

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5/10/11. All nurses, CNAs and CMTs attended. The content of the inservices included the manufacturer's suggested specifications and this information resides at each nurse's station as well as in the DON's office. Going forward the Staff Inservice Director will conduct inservices for new employees and as needed. The Bed Safety Policy and the Specialty Mattress/Overlay policy were presented to the Safety Committee on 5/13/11 for review. The QA Committee had a specially called meeting to discuss the modified Bed Safety Policy and Specialty Mattress/Overlay policy, discuss the care plans updates, side rail assessments and falls assessments related to the immediate jeopardy that had been cited. This meeting occurred on the afternoon of 5/13/11. The Facility Medical Director was in attendance.

The Facility has been monitoring its performance related to this alleged deficiency to assure that solutions are sustained. According to the revised Bed Safety Policy, the Director of Nursing and Safety Director shall inspect all hospital beds at least quarterly to identify areas of potential entrapment. As part of the corrective action for the facility to assure this policy is being followed, all facility beds have been inspected weekly by the Safety Director for one month beginning the week of May 9th and finishing the weekly monitoring, the week of May 30th. A Bed Dimensional Check off sheet has been used to measure the distance between the zones of the bed system and the mattress to assure proper positioning to meet FDA

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guidelines and address potential entrapment zones. The results of these inspections have been reported to special called meetings of the Safety Committee focused on Bed Safety. These specially called Safety Committee meetings have been conducted for four weeks beginning on May 13th and continued weekly through June 6th. The Safety Committee chairperson has also met weekly and as needed regarding the bed safety checks with the Administrator. The weekly meetings began the week of May 9th and continued through the week of May 30th. The Quality Assurance Committee has met and reviewed the information that has been collected over the past 4 weeks. The Administrator has reported the findings. The Quality Assurance Committee has recommended that the frequency of the monitoring activity change from weekly to monthly for the next three months. Once that timeline has been completed and the information presented to the QA Committee, the monitoring frequency will possibly be moved back to quarterly, depending upon the outcomes of the monthly monitoring activity.

The Director of Nursing has included an audit tool for the use of overlay mattresses. The Care Plans reflect the use of the mattresses and the C.N.A. Care Plans are updated to reflect the use of the overlays. The overlay mattresses have been monitored weekly over the course of the past month to assure accuracy in the care plans and C.N.A. care plans. The results of this monitoring have been reported to the Safety Committee

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specialty meetings on Bed Safety by the Director of Nursing. The Administrator has reported the findings. The Quality Assurance Committee has recommended that the frequency of the monitoring activity change from weekly to monthly for the next three months. Once that timeline has been completed and the information presented to the QA Committee, the monitoring frequency will possibly be moved back to quarterly, depending upon the outcomes of the monthly monitoring activity.

Additionally, side rail assessments were completed for all the residents in the facility. Based upon the side rail assessments that were completed on May 10, 2011, it was determined that none of the alleged affected residents were restrained by the use of side rails. The side rail assessments that were completed for all residents of the facility on 5/10/11 determined that side rails were not being used as restraints for any of the residents of the facility. The side rail assessment form that was used to evaluate the use of side rails confirmed that the side rails that were being used were enablers and not restraints. In the event that the side rail assessment determines that the side rails are being used as restraints, the Facility will follow its policy and procedure in the use of restraints. For the sixty-three (63) residents who were still using side rails, the families were informed about the risks and benefits of continued side rail use and consent was received. The nurses, licensed practical nurses, certified medication techs and certified nursing assistants were trained on

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side rail assessments as part of the Bed Safety with Emphasis on Entrapment inservice. The Staff Development Coordinator completed this inservice which included side rail assessment instructions for all nurses, licensed practical nurses, certified medication techs, and certified nursing assistants on 5/12/2011. A list of Residents was developed to identify those Residents who have special instructions for the use of side rails, i.e. one rail up, one rail down or both rails down. The list of specialty instructions is kept current by the Director of Nursing and is located on both nursing units and noted in the care plans and in the CNAs care plan. The DON has assigned the administrative nursing assistant to perform daily rounds to assure the side rails are in proper position. The DON has also provided the ADON, Lead LPN, and Staff Development Coordinator with this to make daily rounds to monitor for proper positioning of the side rails. This action began on 5/13/11. Subsequent to a conference call on 6/1 with CMS about the Facility's allegation of compliance, side rail monitoring was increased to occur each shift to further assure proper positioning of side rails. This action has been performed during the report rounds for the incoming nurse and outgoing nurse on the unit. Each nurse signs and dates a form at shift change indicating this action has been completed and turn the sheet into the DON daily. This monitoring will continue q shift for one month beginning 6/1/11. The DON will continue to report to the Administrator the results of the monitoring of proper side rail positioning.

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This information has been reported at the weekly Safety Committee meetings by the DON.

For other residents that utilize physical restraints, such as lap buddies or low chairs, four residents were identified that use these devices at the Facility. The DON maintains a list of residents who use restraints. All four charts were reviewed by the DON and it was confirmed that prior to applying the restraint, other less restrictive interventions had been tried and documented. Each chart had updated care plans, MD orders and consent forms that the family/guardian had been notified of the risks and benefits of the device. This action was completed on 5/30/11.

For other residents who may use these devices going forward, per facility policy the procedure for the use of these devices is as follows: the interdisciplinary team meets to discuss the appropriateness of the device to ensure less restrictive means have been attempted without success. Once the determination has been made that a physical restraint is needed, the family is consulted about the device and the risks and benefits of that device are provided. Written consent is obtained from the family and a physician order is also obtained detailing the medical justification for the use of the restraint. Nursing Staff are then notified that the restraint is to be used and the Care Plan and C.N.A. Care Plan are updated to reflect the use of the restraint. Per Facility policy, the restraint elimination assessment will be completed quarterly and prn.

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DON monitors 100% of physical restraints for updated care plans, family consent and physician orders and reports this information quarterly to the regularly scheduled Quality Assurance Committee.

This information has been reported to the specially called QA Meeting on 6/7/11. The frequency of this monitoring may change after the scheduled July QA meeting dependent on the outcome of the results to daily or weekly. The results of this monitoring will be reported by the Administrator to the QA Committee.

Responsibility: DON and Administrator

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185305		R-C 06/02/2011

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

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{F 323}	Continued From page 8	{F 323}	F490	6/8/11
	Administrator interview, on 06/02/11 at 3:00pm, revealed results of the audits would be discussed at the next Quality Assurance (QA) meeting in June 2011. The Director of Nursing will complete all audits and report to the Administrator. The audits include bed safety checks, the care plan updates, the side rail assessments, the shift report regarding bed safety checks and side rail position, and speciality mattresses. According to the Administrator, there has not been a QA meeting held to discuss the results of the audits which had been completed. He was unable to state how the facility is monitoring for continued compliance until the next QA committee meeting.		The Facility maintains that it is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. In response to the alleged deficient practice the facility has done the following: The Administrator and DON have met to review and revise the Bed Safety Policy. The Facility has determined to remove low air loss mattresses from the building and incorporate the use of mattress overlays. The Facility has developed a Specialty Mattresses/Overlay policy. The facility has performed bed safety checks on all beds in facility and educated staff on the updated Bed Safety Policy, the Specialty Mattress/Overlay Policy and procedures for keeping the care plans up to date and the C.N.A Care plans current and accurate. The Facility has completed Falls Assessments and Side Rail Assessments on all residents and updated the Care Plans and C.N.A. care plans to a reflect proper side rail positioning. *The Administrator and Director of Nursing have participated in all of the inservices given to Staff on Bed Safety, Side Rail Assessments, and Entrapment Zones to assure that they are educated as the Staff is educated on these topics. The manufacturers representative provided on site education to the Administrator and DON on proper use of overlay mattresse*	
{F 490} SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, it was determined the Immediate Jeopardy identified during an abbreviated survey (05/13/11) had been removed; however, non-compliance continued to exist as the facility had not evaluated the bed safety check, fall assessment form, care plan, siderail and restraint audits by the Quality Assurance Committee. The findings include: 1. Interview with the Administrator on 06/02/11 at	{F 490}		

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with the inservice documentation material that was provided for staff. The Administrator and DON received additional education through the Kentucky Association of Health Care Facilities (KAHCF), of which it is a member, to ensure the policies and procedures and monitoring process are sufficient to maintain continued compliance with applicable regulations.

The Medical Director has reviewed and revised policy and procedures to assure the systemic changes and policy revisions(Bed Safety Policy, Bed Overlay Policy) to ensure that all changes were clinically sound and appropriate. The Medical Director participated in quality meetings held on 5/13 and 6/7. The Administrator had multiple conversations about the policy and procedure revisions

The Administrator has reported all of the progress to the CEO of the organization who serves on the Governing Body. The Administrator has also had meetings with the Chairperson of the Board and the Treasurer with the CEO of the governing body. The CEO has been involved in Conference Calls with the KAHCF and CMS to assure that the Facility is maintained administratively to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for each resident.

DON monitors 100% of physical restraints for family consent and physician orders and reports this information quarterly to the

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regularly scheduled Quality Assurance Committee.

The Facility has developed monitoring techniques for assuring continued bed safety audits, side rail assessments, falls assessments, updated the Resident Care Plans and C.N.A. Care Plans to reflect the completed side rail assessments and falls assessments. The Facility has reviewed the use of side rails as potential restraints for all residents and discussed and obtained consent after explaining the risks and benefits of continued side rail use with the residents and or the responsible parties and obtained physician orders for these updated assessments. These actions have occurred to assure the Facility remains to be in compliance with Facility policies and standards of care for nursing facilities.

All of these actions have been reported to the Administrator, the Safety Committee and the Quality Assurance Committee to assure continued compliance with this regulation.

Responsibility: Administrator

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{F 490}	Continued From page 9 3:00pm revealed results of the audits would be discussed at the next Quality Assurance (QA) meeting in June 2011. The Director of Nursing will complete all audits and report to the Administrator. The audits include bed safety checks, the care plan updates and revisions, the side rail and fall assessments, the shift report regarding bed safety checks and side rail position, and speciality mattresses. According to the Administrator, there had not been a QA meeting to discuss the results of the completed audits. He was unable to state how the facility is monitoring for continued compliance until the next QA committee meeting.	{F 490}		
{F 514} SS=D	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. 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. This REQUIREMENT is not met as evidenced by: Based on record review, interview, observation and review of the facility's policy on Physician Order Verification it was determined the facility failed to transcribe admission orders correctly for	{F 514}	F514 *6/8/11* The facility maintains that keeps clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. For the Resident who was affected by the alleged deficient practice, the transcription error was corrected and action was put in place to make sure the foley catheter irrigation was completed as ordered. There were no other foley catheters in the facility at the time of the alleged deficient practice. To assure that this situation does not occur again, the Director of Nursing developed a policy on MD Order Verification to have the ADON, Lead LPN, or RN Supervisor review the accuracy of 100% transcribed MD orders after they have been received by the licensed practical nurses or registered nurses on the nursing units. Any errors that are discovered are to be corrected immediately. The nurse who caused the transcription error will receive a written counseling. *The DON will perform an audit of 10% of the transcribed orders quarterly. The outcomes of this monitoring will be reported quarterly at the regularly scheduled Quality*	

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{F 514}	Continued From page 10 one resident (#5) of the twelve (12) sampled residents. The facility did not transcribe an order for irrigation of a urinary catheter; therefore, Resident #5 did not receive the irrigation for three days. The findings include: Review of the facility's policy M.D. Order Verification, effective date 05/10/11, revealed the facility must maintain accurate clinical records on each resident in accordance with accepted professional standards and practices. This policy was to provide a double check system for accuracy of transcribing M.D. orders. When an order was received it would be transcribed according to accepted standards. All orders would be reviewed by the (Assistant Director of Nursing) ADON/unit manager/RN supervisor for accuracy. The MAR/TAR (Medication Administration Record/Treatment Administration Record) or other documentation that the order was transcribed on would be dated and initialed. If an error occurred during transcription, the error would be corrected and discussion with the nurse making the error would be documented. Record review revealed the facility admitted Resident #5 on 04/05/11 with diagnoses of Urinary Tract Infection, Urinary Retention secondary to BPH (Benign Prostatic Hypertrophy), Secondary Acute Renal Failure and Dehydration. The hospital Discharge Instruction Sheet dated 04/05/11 indicated the facility was to change the residents' Foley catheter every 4-6 weeks and irrigate the catheter twice a day with sterile water. In addition, it stated see physicians' note dated 03/23/11. Review of the physicians'	{F 514}	*Assurance Committee by the DON to assure continued compliance with this regulation.* Responsibility: Director of Nursing	

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{F 514}	Continued From page 11 note dated 03/23/11 indicated the facility was to irrigate the catheter twice a day with sterile water, change catheter every 4-6 weeks, do not allow the catheter to pull on the penis and secure catheter to the thigh. The admission orders transcribed by the facility, dated 04/05/11, revealed a section for Foley Catheter size (blank), to bedside drainage-yes-no (blank), change catheter every 30 days-yes is circled, and cath diagnosis- BPH. Page 5 of 5 indicated: F/C to BSD; F/C care q shift; and change F/C q30d. The orders did not indicate the catheter was to be irrigated twice a day, secured to the thigh, and free from pulling on the penis. A nurses note and physician order dated 04/08/11 indicated the facility did not obtain the order to irrigate the catheter until 04/08/11, three days after admission. Interview with the ADON, on 05/10/11 at 12:40pm, revealed the floor nurse transcribes new admission orders. She reviews the orders the next day or as soon as she can, however, did not see the order either for three (3) days. Sometimes it might be a couple of days, especially at the end of the month, it could be three (3) days due to monthly review of the new MARs and TARs. Observation, on 05/13/11 at 11:30am, revealed Resident #5 up in a chair in his/her room. The catheter was secured to a leg bag for drainage.	{F 514}		

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