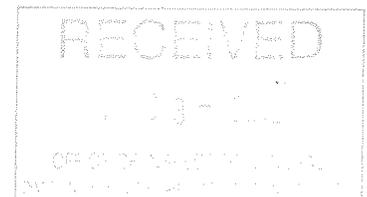


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2012
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 029	Continued From page 3 (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		8/2/12
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit signage in accordance with NFPA standards. This deficiency had the potential to affect each of the six (6) smoke compartments, residents, staff and	K 038	K038 The Facility will continue to maintain its exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1 19.2.1. <i>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:</i> Facility's Maintenance Director has corrected the alleged deficiency by installing No Exit Signs on the doors leading out to the Courtyard areas per the alleged deficiency. <i>The facility will identify other residents having the potential to be affected by the same alleged deficient practice by doing the following:</i> Facility's Maintenance Director has inspected all the remainder of the building and found no other areas that had the same concerns. <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 Administrator met with Facility's Maintenance Director and reviewed to re-educate on the requirements of NFPA 7.10.1.4 No Exit requirement on 8/1/12. Facility's Maintenance Director will continue to assure that the No Exit signs are in place by performing monthly inspections of the doors to the courtyard area.	



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K 038	<p>Continued From page 4</p> <p>visitors The facility is licensed for ninety (90) beds and the census was sixty-one (61) on the day of the survey.</p> <p>The findings include:</p> <p>Observations on 06/26/12 between 9:05 AM and 11:30 AM, with the Maintenance Director revealed the two (2) doors located in the East and West wings, opening into the enclosed courtyard could be confused as an exit in the event of an emergency. The doors were not identified as "NO EXIT".</p> <p>Interviews, on 06/26/12 between 9:05 AM and 11:30 AM, with the Maintenance Director revealed he was unaware of proper signage being required at any door leading to the exterior of the building.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.</p> <p>NFPA 101 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an</p>	K 038	<p>The Facility will implement the corrective action and monitor them in the following manner:</p> <p>The plan of corrections will be integrated into the Facility's QA program. Maintenance Director will include this in the Quarterly reports for the next two quarters and adjust them as needed.</p>		



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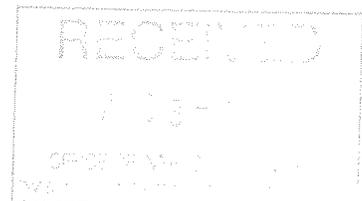
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 06/26/2012
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, 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 038	Continued From page 5 exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approve existing signs. NFPA 101 LIFE SAFETY CODE STANDARD	K 038		8/2/12	
K 062 SS=F	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the sprinkler system was being maintained and tested according to NFPA Standards. The deficiency has the potential to affect all smoke compartments, residents, staff, and visitors. The facility is licensed for ninety (90) beds and the census was sixty-one (61) on the day of the survey. The findings include: Record review, on 06/26/12 at 12:35 PM, with the Maintenance Director revealed the last interior pipe inspection for the automatic sprinkler system was unknown.	K 062	The Facility will continue to monitor its automatic sprinkler system and continuously maintain in reliable operating condition with inspection and periodic testing. <i>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:</i> Facility's Maintenance Director has corrected the alleged deficiency by ordering the 5 year pipe inspection be completed with Simplex. The Pipe Testing was completed on 7/18/12 and indicated no concerns with the Facility's sprinkler system. <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 ordered the pipe inspection be completed by Simplex. The Pipe Testing was completed on 7/18/12 and indicated no concerns with the Facility's sprinkler system. <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 this testing be performed every 5 years in accordance with the requirement and has put it on an auto reoccurring schedule with Simplex.		



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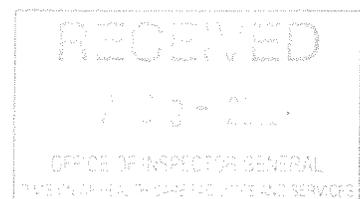
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 06/26/2012
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, 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)	OSI COMPLETION DATE	
K 062	Continued From page 6 Interview, on 06/26/12 at 12:35 PM, with the Maintenance Director revealed he was unaware of the interior pipe inspection not being performed within the past five (5) years. Reference: NFPA 25 (1998 Edition). 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections. 10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. NFPA 101 LIFE SAFETY CODE STANDARD	K 062	<i>The facility will implement the corrective action and monitor them in the following manner:</i> Maintenance Director has added 5 year pipe testing on the annual preventative maintenance calendar and reports this to the Safety Committee on a monthly basis. A summary of the monthly maintenance safety reports are provided to the QA committee on a quarterly basis. Responsible Party(ies): Maintenance Director, Safety Committee Chairperson, Administrator.		
K 072 SS=E	Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072			



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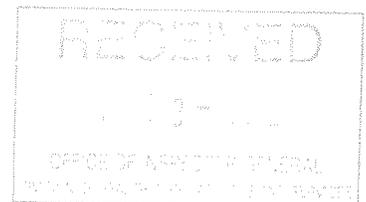
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NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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 072	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect four (4) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for ninety (90) beds and the census was sixty-one (61) on the day of the survey. The findings include: Observations, on 06/26/12 between 8:35 AM and 11:35 AM, with the Director of Maintenance revealed med carts located in the corridors of the North and South Wings were unattended and not in use for over a thirty (30) minute period. Interviews, on 06/26/12 between 8:35 AM and 11:35 AM, with the Director of Maintenance revealed the facility routinely stored med carts in the corridors, near the Nurses Stations. Further interview with the Administrator during the Exiting Conference, revealed the facility was lacking in storage space. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	K072 The Facility will continue to maintain its means of egress are free of all obstructions or impediments to full instant use in the case of fire or other emergency. <i>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:</i> Facility's DON has identified areas within the building to store the Med Carts when they are not in use. <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 DON has toured the remainder of the building to determine other areas of concern with this alleged deficient practice and identified no other areas of concern <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 DON inserviced LPNs and RNs on the requirements of NFPA 7.1.10.1 on 7/17/12. The Facility's Administrator inserviced Maintenance Director on the requirements of NFPA 7.1.10.1 on 8/1/12. The inservice covered the requirements of the means of egress being clear and unobstructed in the event of a fire or other emergency.	8/2/12	



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

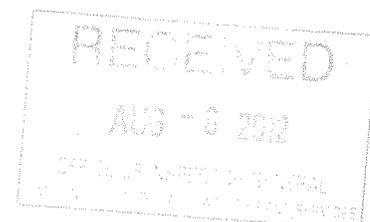
The plan of corrections will be integrated into the Facility's QA program. DON will include observations each week of the Med Carts remaining in the hallway for over 30 minutes as part of the monthly safety checks reported to the Safety Committee. A summary of the outcomes of this will be reported to the QA Committee for Med Carts observed in hallways unattended for 30 minutes or more.



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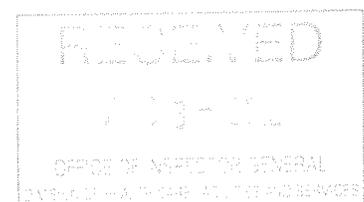
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185306	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2012
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3601 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 073 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure no combustible decorations were used in the facility, in accordance with NFPA standards. The deficiency had the potential to affect each of the six (6) smoke compartments, residents, staff and visitors. The facility is licensed for ninety (90) beds and the census was sixty-one (61) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 06/26/12 between 8:45 AM and 11:35 AM, with the Maintenance Director revealed hanging decorations mounted on the residents' room doors in various locations throughout the facility.</p> <p>Interview, on 06/26/12 at 8:45 AM, with the Maintenance Director revealed he was unaware hanging decorations were required to be treated with a fire retardant spray; and to have a written policy for documentation that wreaths and other decorations are being properly treated.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.</p>	K 073	<p>K 073</p> <p>The Facility will continue to maintain that no furnishings or decorations of highly flammable character are used. <i>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:</i> Facility's Administrator has issued a letter to the families that the hanging decorations in various locations of the building be removed due to the alleged deficient practice that was identified herein. Facility's Administrator removed the wall hangings identified as highly flammable on 8/1/12. <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 if there are hanging decorations in other areas that are similar that need to be removed and found no other issues. <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> Facility Administrator re-educated Maintenance Director on NFPA 19.7.5.4 on 8/1/12. Facility's Safety Committee will add hanging decorations to its list of items for monthly review in its checks. Also, Admission Director will instruct families about this alleged deficient practice.</p>	8/2/2012
K 130	NFPA 101 MISCELLANEOUS	K 130		



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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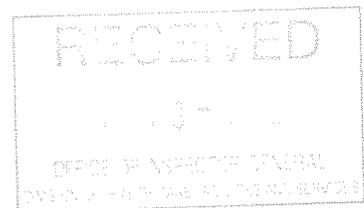
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NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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 073 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure no combustibles decorations were used in the facility, in accordance with NFPA standards. The deficiency had the potential to affect each of the six (6) smoke compartments, residents, staff and visitors. The facility is licensed for ninety (90) beds and the census was sixty-one (61) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 06/26/12 between 8:45 AM and 11:35 AM, with the Maintenance Director revealed hanging decorations mounted on the residents' room doors in various locations throughout the facility.</p> <p>interview, on 06/26/12 at 8:45 AM, with the Maintenance Director revealed he was unaware hanging decorations were required to be treated with a fire retardant spray; and to have a written policy for documentation that wreaths and other decorations are being properly treated.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.</p>	K 073	<p>K 073</p> <p>The Facility will continue to maintain that no furnishings or decorations of highly flammable character are used.</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 Administrator has issued a letter to the families that the hanging decorations in various locations of the building be removed due to the alleged deficient practice that was identified herein. Facility's Administrator removed the wall hangings identified as highly flammable on 8/1/12.</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 determine if there are hanging decorations in other areas that are similar that need to be removed and found no other issues.</p> <p><i>The Facility will put measures in place or make systemic changes to assure the alleged deficient practice does not recur by doing the following:</i> The Facility's Safety Committee will add hanging decorations to its list of items for monthly review in its checks. Also, Admission Director will instruct families about this alleged deficient practice.</p>	8/2/2012	
K 130	NFPA 101 MISCELLANEOUS	K 130			



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

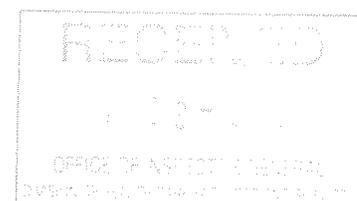
The plan of corrections will be integrated into the Facility's QA program. The monthly safety checks have been updated to include observation of hanging wall decorations of a highly flammable nature to be reported monthly to the Safety Committee. A summary of this information will be incorporated into the quarterly QA Committee for the next two quarters and adjusted as necessary thereafter.



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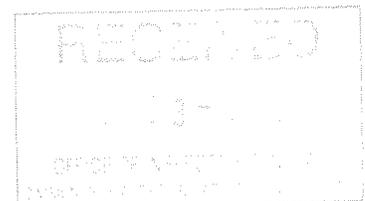
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 06/26/2012
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241		
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K 130 SS=D	Continued From page 0 OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of the six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety (90) beds and the census was sixty-one (61) on the day of the survey. The findings include: Observations, on 06/26/12 between 8:50 AM and 10:25 AM, with the Maintenance Director revealed unapproved locks (slide bolt type) were installed on the egress side of the doors to the Men's and Women's Toilet Rooms located in the North Wing, near the Director of Nursing Office. Further observation revealed the door to the public Toilet Room located in the South Wing also had a slide bolt lock installed on the egress side of the door. Interviews, on 06/26/12 between 8:50 AM and 10:25 AM, with the Maintenance Director revealed he was aware of the locks installed on the doors; however, he was not aware that slide bolt locks were prohibited by Code. He agreed that slide bolt locks could be a deterrent to exiting	K 130	K 130 The Facility will continue to maintain the Facility in accordance with Other LSC not listed on 2786. <i>How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:</i> Facility's Maintenance Director has corrected the alleged deficiency by removing the slide bolt type locks from the public restrooms identified in this alleged deficiency. <i>The facility will identify other residents having the potential to be affected by the same alleged deficient practice by doing the following:</i> Facility's maintenance Director has examined the remainder of the Facility to determine any slide type bolts on doors and located no others within the building. <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> Administrator has met with Maintenance Director to reeducate on the requirements of NFPA 101 19.7.5.4 on 8/1/12. The education included the requirement that slide bolt type locks not be used within the Facility.	8/2/12	



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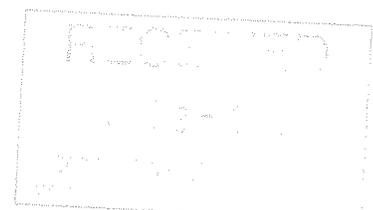
The plan of corrections will be integrated into the Facility's QA program. The monthly safety checks have been updated to include observation of slide bolts to be reported monthly to the Safety Committee. A summary of this information will be incorporated into the quarterly QA Committee for the next two quarters and adjusted as necessary thereafter.



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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)	OSI COMPLETION DATE	
K 130	Continued From page 10 the rooms in the event of an emergency. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. NFPA 101 LIFE SAFETY CODE STANDARD	K 130			
K 147 SS=D	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety (90) beds and the census was sixty-one (61) on the day of the survey. The findings include: Observation, on 06/26/12 at 1:08 PM, with the Maintenance Director revealed the electrical panel located in the West sitting area near the Sun Room, had a free-standing privacy screen located directly in front of the electrical panel. The screen prohibited easy access to the panel in the event of an emergency. Further observation	K 147	The Facility will continue to maintain the 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> Facility's Maintenance Director has corrected the alleged deficiency by removing the privacy screen in front of the electrical panel cited in the narrative. The electrical panel was locked. <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 others electrical panels are not accessible in accordance with this regulation within the building. No other issues were identified. <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> On a monthly basis the Safety Committee will include electrical panels being readily accessible in their monthly reviews.	8/2/12	



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 06/26/2012
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 11</p> <p>revealed the panel was unlocked, enabling access by unauthorized personnel.</p> <p>Interview, on 06/26/12 at 1:08 PM, with the Maintenance Director revealed the privacy screen was located within the required space for access to the electrical panel and removed it from the sitting room. He was unaware of the panel not being locked and acknowledge the panel should be locked to prohibit unauthorized access.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</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. Safety Coordinator will report data on electrical panels accessibility on a Quarterly Basis for the next two quarter and adjusted as necessary thereafter.</p>		

