

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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

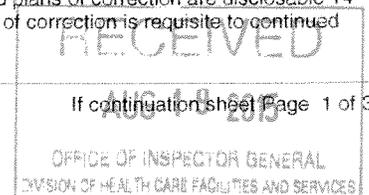
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	--	--	--

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	F 000	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
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 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, record review, and review of facility's policy, it was determined the facility failed to develop a care plan for one (1) of sixteen sampled residents, Resident #6. Resident #6 developed a Urinary Tract Infection	F 279	Criteria 1: Resident #6 has had review of current assessments and orders by D.O.N. with review/revision of the care plan to reflect the resident's current status, which includes but is not limited to history of UTIs. This was completed on 7/20/15. The resident's UTI has resolved, and isolation precautions are no longer indicated. Criteria 2: An audit has been completed by D.O.N. on 07/30/15 to determine that the care plans for all residents with a current UTI or with orders for isolation precautions, have these issues addressed with appropriate interventions on their care plans. This was completed on 07/30/15. There is only one resident with current orders for isolation precautions. Criteria 3: The staff nurses and Administrative nurses have received inservice education from 7/26-31/15 by staff development coordinator on the need to develop, review and revise the resident's comprehensive plan of care by using the results of the resident assessments and current orders, including but not limited to addressing UTI's and orders for isolation precautions.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Leslie J Butterfield</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>X 08-19-15</i>
--	-------------------------------------	------------------------------------

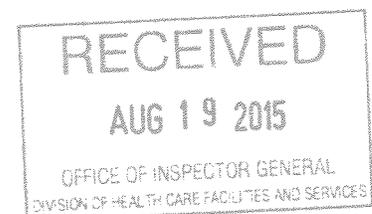
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

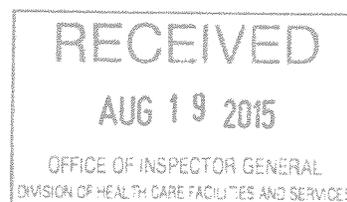
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2015
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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 279	<p>Continued From page 1 (UTI) with Contact Precautions ordered; however, the facility failed to develop interventions.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Completion of the Resident Assessment Instrument (RAI) process, dated 06/20/15, revealed the facility would have created the care plan within twenty-one (21) days of admission. The admitting nurse would have initiated the initial care plan.</p> <p>Interview with the Director of Nursing (DON), on 07/16/15 at 4:30 PM, revealed the facility used the Resident Assessment Instrument (RAI) Version 3.0 Manual, dated September 2010, as policy for reviewing and completing Minimum Data Set (MDS) Assessments and care planning. According to the RAI Version 3.0 Manual, Chapter 4 Page 8, the comprehensive care plan must include measurable objectives and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The manual revealed the care plan should be oriented towards preventing avoidable declines and managing risk factors to the extent possible.</p> <p>Review of the clinical record for Resident #6 revealed the facility admitted the resident on 03/03/15 with the following diagnoses: Urinary Retention, History of Stroke with Right Hemiparesis, Acute Kidney Failure, and Depression. Review of the admission MDS, dated 03/12/15, revealed the resident was non-ambulatory and needed extensive assistance with bed mobility, transfers, and toileting needs. The resident had an indwelling catheter upon</p>	F 279	<p>Criteria 4: The facility will utilize a QA tool for the monitoring of use of the resident assessment and orders to develop, review and revise the resident's comprehensive plan of care. This will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the DON. This tool prompts review of 5 randomly selected care plans to determine that they reflect the resident assessments and orders, including but not limited to those for UTIs and isolation precautions. Any issues identified by the audits will be reviewed by the QA committee with development of a plan of action. (See QAPI tool # N-19).</p> <p>Criteria #5:</p>	8- 21-2015	



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

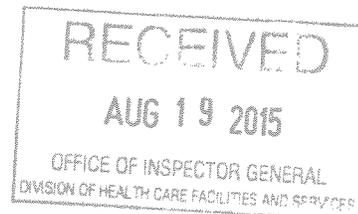
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2015
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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 279	<p>Continued From page 2</p> <p>admission with a Suprapubic catheter placed on 03/27/15. Review of the physician's orders revealed a Urinalysis (U/A) was ordered on 07/07/15 related to foul smelling urine odor from the resident's Suprapubic catheter leakage. Review of the U/A lab report, dated 07/09/15, revealed the urine had Methicillin Resistant Staphylococcal Aureus (MRSA) and Proteus bacteria growth. The facility notified the resident's physician and he ordered an antibiotic treatment for ten (10) days and ordered for the resident to be placed in Contact Precautions.</p> <p>Review of the comprehensive care plan for Urinary Incontinence, dated 03/18/15, revealed the resident had the Suprapubic catheter and the goal was for the resident not to have any infections in the urine or at the site of the catheter. There was no documented evidence a care plan had been developed to address the UTI and Contact Precautions. On 07/16/15, a care plan was developed to address the UTI; however, the care plan did not mention the Contact Precaution order with no interventions related to the precautions.</p> <p>Interview with the South Unit Manager, on 07/16/15 at 1:30 PM, revealed she did not develop the care plans, neither the MDS Coordinator or the staff nurse would have developed the care plan for Contact Precautions. She stated the staff nurse who contacted the physician and received the order was not available for interview. She stated when something was new or an incident occurred with the resident, the staff nurse was responsible for developing a care plan or revising the existing care plan. She stated infections and the order for the Contact Precautions should be on the care</p>	F 279			



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

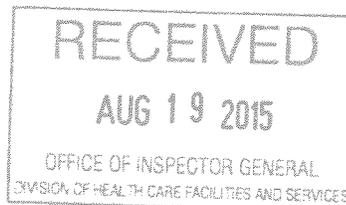
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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 279	Continued From page 3 plan. Interview with the MDS Coordinator, on 07/16/15 at 2:48 PM, revealed the care plan was revised by the staff nurses between the assessment reviews. She stated the nurse who took the order for the Contact Precaution should have developed the care plan.	F 279		
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the	F 280	Criteria 1: The comprehensive care plans and C.N.A assignment sheets for residents #1 and # 9 were reviewed/revised by D.O.N. and Unit Managers on 07/21&22/15 to address the residents' history of a fall, and the appropriate interventions to address the identified fall risk management. For resident #1 this included assistance of two staff for transfers with the sliding board. For resident #9 this included the use of a Dycem mat on the wheelchair cushion, and to encourage the resident to be out in the hallway/supervised areas. Criteria 2: An audit was completed of the care plans and C.N.A assignment sheets of in-house residents with a history of falls in the last 60 days by D.O.N. and unit managers on 07/22/15 to determine that these reflect the history of falls, and the appropriate interventions to address fall risk management.	



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2015
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 280	<p>Continued From page 4</p> <p>facility failed to revise the care plan for two (2) of sixteen (16) sampled residents after a fall, Residents #1 and 9. Resident #1 and #9 sustained a fall and the facility failed to revise the care plan with new interventions to prevent further falls.</p> <p>The findings include:</p> <p>Review of the facility's policy, Completion of the Resident Assessment Instrument (RAI) process, dated 06/20/15, revealed the facility would have made updates to the paper copy of the care plan as needed. The facility would have reviewed the care plan for accuracy as needed, quarterly, and at the annual review date.</p> <p>Interview with the Director of Nursing (DON), on 07/16/15 at 4:30 PM, revealed the facility used the Resident Assessment Instrument (RAI) Version 3.0 Manual, dated September 2010, as policy for reviewing and completing Minimum Data Set (MDS) Assessments and care planning. According to the RAI Version 3.0 Manual, Chapter 4 Page 8, the comprehensive care plan must include measurable objectives and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically. The manual revealed the care plan should be oriented towards preventing avoidable declines and managing risk factors to the extent possible.</p> <p>1. Review of Resident #1's clinical records revealed the facility admitted the resident on 12/07/12 with diagnoses of Cerebral Vascular</p>	F 280	<p>Criteria 3: The Staff nurses and Administrative nurses have received inservice education from staff development coordinator from 7/26-31/15, on the need to address residents with a history of a fall, and the appropriate interventions to address fall risk management on the care plan, and to update these as orders change.</p> <p>Criteria 4: A QA tool for the monitoring of the development and revision of care plans will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the DON. This tool prompts review of 5 randomly selected care plans to determine that they reflect the resident assessments and orders, including but not limited to those for fall risk management. Any issues identified by the audits will be reviewed by the QA committee with development of a plan of action. (See QAPI tool # N-21).</p> <p>Criteria 5:</p>	8-21-2015	



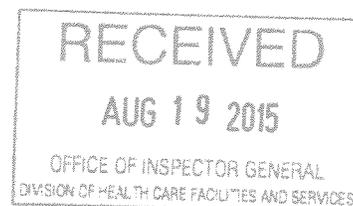
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	---	--	---

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

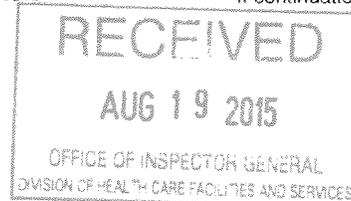
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	<p>Continued From page 5</p> <p>Accident (CVA), Paraplegia, Neurogenic Bladder, Anxiety, Depression, Kidney Disease, Atrial Fibrillation, and Congestive Heart Failure.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS) assessment, completed on 05/04/15, revealed the resident required extensive two person physical assist with all transfers. A Brief Interview for Mental Status (BIMS) exam was conducted with a score of fifteen (15) out of fifteen (15), indicating the resident was interviewable.</p> <p>Review of the Comprehensive Care Plan for Resident #1, dated 12/27/12, revealed the resident was at risk of falls and used a sliding board for transfers. The Care Plan further revealed nursing staff were to provide assistance with transfers between the bed and wheelchair. However, the care plan did not state how many staff were to assist with the transfers.</p> <p>Review of Event Report, dated 11/14/14, revealed Resident #1 sustained a fall on 11/01/14 while transferring on the sliding board with one person staff assistance. The report stated the CNA was unable to prevent the resident from falling and lowered the resident to the floor. Resident #1 sustained no injury.</p> <p>Review of the Physical Therapy Discharge Summary, dated 12/28/12, revealed the facility discharged Resident #1 from physical therapy with a recommendation the facility provide two (2) caregiver assistance in transferring the resident to prevent the resident from sliding off the slideboard.</p> <p>Review of the most recent Therapy Screen, dated</p>	F 280		



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

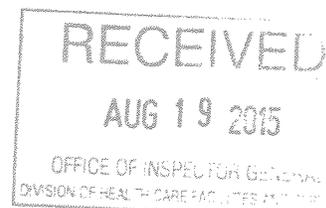
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
F 280	<p>Continued From page 6</p> <p>04/29/15, revealed Physical Therapy continued to recommend the resident be transferred with the slideboard and assistance of two (2) staff. Interview with the Therapy Manager, on 07/16/15 at 3:35 PM, revealed the facility screen residents quarterly. Resident #1's screen revealed no need for therapy but continued to need the assistance of the sliding board for transfers with a minimum assist of two (2) caregivers.</p> <p>Review of the CNA Assignment Sheet for Resident #1, undated copy obtained 07/16/15, revealed CNAs were to transfer the resident using a sliding board and an assist of one (1). However, interview with CNA #3, on 07/16/15 at 9:03 AM, and interview with CNA #2, on 07/16/15 at 9:14 AM, revealed the CNAs would request additional staff assistance with transfers for safety.</p> <p>Interview with Resident #1, on 07/15/15 at 12:00 PM, revealed the staff assisted Resident #1 with transfers from the bed to the wheelchair using a sliding board. The resident stated sometimes one (1) person assisted with the transfer and sometimes (2) people assisted with transfers.</p> <p>Observation of staff assisted transfer of Resident #1 from the bed to the wheelchair using the slideboard, on 07/16/15 at 11:30 AM, revealed two (2) staff assisted the resident with the transfer.</p> <p>Interview with Resident #1 after a transfer, on 07/16/15 at 11:30 AM, revealed the staff completed the transfer in the way he/she felt most comfortable (assist of two). The resident stated the nursing staff sometimes completed transfers with one (1) staff and sometimes with two (2)</p>	F 280	



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

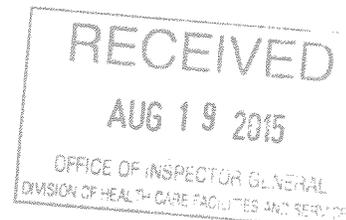
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015	
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	<p>Continued From page 7</p> <p>staff. The resident stated he/she was unsure which way the nursing staff was supposed to complete the transfer. Resident #1 stated the facility did invite him/her to care plan meetings, but that he/she did not attend those meetings.</p> <p>Interview with Registered Nurse (RN) #2, on 07/16/15 at 1:30 PM, revealed the nurses updated the care plans. She stated if a resident had a fall, the nurses would updated the care plan with new interventions. The Restorative Nurse and the Unit Manager were to ensure the care plan was revised with appropriate interventions.</p> <p>Interview with the North Unit Manager, on 07/16/15 at 2:00 PM, revealed she was responsible for oversight of the staff nurses and CNAs on the North Unit. The Unit Manager stated the facility had assessed Resident #1 at risk for falls and a sliding board was to be utilized when the resident was transferred from the bed to the wheelchair. The Unit Manager stated the nursing staff should have transferred the resident with the assistance of two (2) and the care plan and nurse aide assignment sheet was confusing.</p> <p>Interview with DON, on 07/16/15 at 4:30 PM, revealed therapy did complete a quarterly screening of Resident #1 and had assessed the level of needed assistance for transfers as total assist. In addition, physical therapy indicated the resident required assistance of two (2) for transfers from the bed to the wheelchair using the sliding board. The DON reviewed the Event Report for the fall on 11/01/14 and revealed one CNA was assisting the resident with the transfer at the time of the fall. She stated the resident was assessed needing the assistance of two (2);</p>	F 280		



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

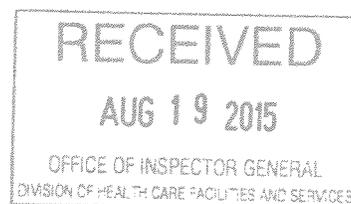
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2015
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	<p>Continued From page 8</p> <p>however, the care plan did not indicate how many staff was needed and had not been revised since the fall.</p> <p>2. Review of Resident #9's clinical record revealed the resident had resided at the facility since 2012. Review of the most recent diagnoses included Hypertension, Dementia, Immobilization Syndrome, and Chronic Pain. Review of the annual MDS assessment, dated 07/13/15, revealed the facility had assessed Resident #9 as needing extensive assistance with Activities of Daily Living (ADL), including toileting; locomotion on and off the unit; and to transfer between surfaces. Additionally, at the time of this assessment, the facility determined the resident weighed 128 pounds. A Brief Interview for Mental Status (BIMS) exam was conducted during the assessment and the resident scored a nine (9) out of fifteen (15) meaning the resident was interviewable.</p> <p>Review of the Care Plan, category falls, dated 08/09/12, revealed the resident had a history of falling due to unsteady gait and a diagnosis of Dementia. The facility documented eight (8) interventions, all dated for August 2012. The facility added no new interventions to the care plan after August 2012.</p> <p>Review of the Event Report, dated 02/20/15, revealed Resident #9 sustained an unwitnessed fall in his/her room. The resident was found on the floor. Nursing completed an evaluation of the resident and determined the resident suffered no injury. In a follow-up meeting, the facility determined the resident slipped out of the wheelchair and decided to add the intervention of</p>	F 280			



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2015
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 280	<p>Continued From page 9</p> <p>placing a Dycem mat on top of the wheelchair cushion and to encourage the resident to spend time in the hallway for increased supervision; however, the facility failed to revise the care plan with those interventions.</p> <p>Review of the CNA Assignment Sheet for July 2015 revealed the form did not give direction to the CNAs to keep or encourage resident to stay in supervised area. In addition, the Dycem mat was not included on the assignment sheet.</p> <p>Interview with CNA #3, on 07/16/15 at 9:03 AM, revealed she followed the CNA Assignment Sheet to care for each resident. CNA #3 also revealed she was familiar with Resident #9 and stated the resident did have a decline in functioning in the past year.</p> <p>Interview with RN #2, on 07/16/15 at 1:30 PM, revealed the nurses could update the care plans. She stated if a resident had a fall, the nurse would have initiated a fall packet and updated the care plan. The Restorative Nurse and the Unit Manager should check to ensure the care plan had been updated and that the interventions were appropriate.</p> <p>Interview with the North Unit Manager, on 07/16/15 at 2:00 PM, revealed the facility did not place the new interventions on the care plan or the CNA Assignment Sheet. The North Unit Manager reviewed the fall Resident #9 sustained on 02/20/15 and stated the Interdisciplinary Team determined new interventions were needed in the Care Plan Meeting on 02/23/15. However, no new interventions were added to the care plan after the resident's fall.</p>	F 280			



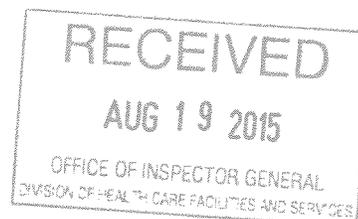
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	--	--	--

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

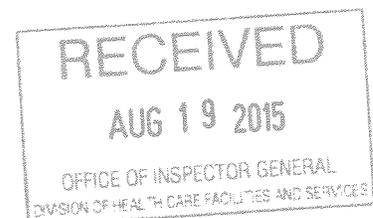
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 10 Interview with DON, on 07/16/15 at 4:30 PM, revealed the facility did not place new interventions on Resident #9's care plan after the fall on 02/20/15. The DON stated this placed the resident at increased risk of falling again. The DON further stated the documentation shows no evidence that the new interventions discussed in the care plan meeting was ever communicated to the direct care staff. The DON stated she had completed spot checks of some care plans to ensure all interventions were in the care plans. However, she stated she did not audit all of the care plans in the facility and was unaware Resident #9's care plan had not been revised after the fall. Observation, on 07/15/15 at 8:20 AM, revealed Resident #9 was sitting in his/her wheelchair alone in the bathroom with the lights off and calling out for help. The resident stated she was stuck in the bathroom. Observation, on 07/16/15 at 10:00 AM, revealed Resident #9 was in his/her's bathroom, standing transferring self from the wheelchair to the toilet. No staff was present to assist with the transfer.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by:	F 282	Criteria 1: Residents #3 and #13 have skin assessments performed and documented weekly in accordance with their care plan as determined by care observations completed by the DON/Wound Nurse on 7/31/15.	



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2015
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 282	<p>Continued From page 11</p> <p>Based on interview, record review, and facility policy review, it was determined the facility failed to implement the care plan for two (2) of sixteen (16) sampled residents, Residents #3 and #13. The residents were care planned for monitoring of the skin with comprehensive skin assessments to be conducted weekly per facility policy; however, those assessments were not consistently performed.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing, on 07/16/15 at 4:55 PM revealed the facility used the Resident Assessment Instrument (RAI) Version 3.0 Manual, dated September 2010, as policy for reviewing and completing Minimum Data Set (MDS) Assessments and care planning. Review of the RAI Version 3.0 Manual, the facility would have communicated the goals and their accompanying approaches to direct care staff. The manual revealed the care plan should be oriented towards preventing avoidable declines and managing risk factors to the extent possible.</p> <p>1. Review of Resident #3's clinical record revealed the facility admitted the resident on 07/22/14 with diagnoses of Left Side Hemiplegia, Gastrostomy Tube, Abnormal Weight Loss, Malnutrition, History of Infections, and Venous Insufficiency.</p> <p>Review of the Significant Change in Status Assessment, completed on 07/29/14, revealed the facility assessed the resident to be at risk for pressure ulcer formation.</p> <p>Review of the Care Area Assessments (CAA's) dated 08/06/14, revealed risk factors that</p>	F 282	<p>Criteria 2: All residents have skin assessments performed and documented weekly in accordance with their care plan as determined by random care observations completed by the DON/Wound nurse on 7/30/15.</p> <p>Criteria 3: Licensed Nursing staff have received inservice education by the DON/Staff Development Coordinator from 7/26-31/15 on the revised coding documentation for weekly skin assessments, and the need to complete these weekly in accordance with the resident care plan.</p> <p>Criteria 4: The QA tool for the monitoring of performance of weekly skin assessments will be utilized monthly X 2 months and then quarterly thereafter under the direction of the Director of Nursing. This tool includes review of skin assessments and other skin documentation to determine that skin care is provided in accordance with the resident care plan. (See QAPI tool # N-3). Five skin assessment observations will be performed by administrative nurses weekly X 1 month, monthly X 2 months, and then quarterly thereafter to determine that skin assessments are being provided in accordance with resident care plans and facility policy.</p> <p>Criteria 5:</p>	8-21-2015	



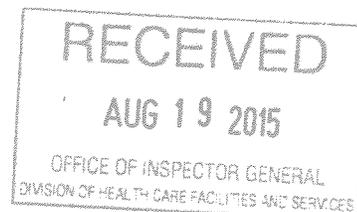
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	--	--	--

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

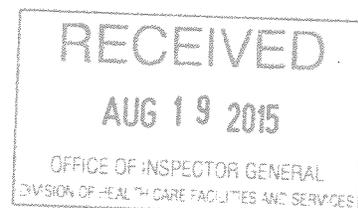
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 12</p> <p>included: staff assistance needed to help relieve pressure; confined to a bed or chair most of the time; requires regular turning and repositioning; immobility; incontinence; poor nutrition; medications; functional limitations; pain; devices that could cause pressure; and' newly or readmitted status. The CAA summary under the Pressure Ulcer revealed weekly skin checks were to be completed by the nurse and would proceed to care plan to address the risk for pressure ulcer formation.</p> <p>Review of the Comprehensive Care Plan for Resident #3, dated 03/25/15, with updated goals dated 07/16/15, revealed the facility identified the resident was at risk for skin breakdown. One of the approaches for this resident was to monitor the resident's skin for any signs and symptoms of breakdown and report to nursing.</p> <p>Continued review of the care plan revealed the facility developed a care plan on 02/19/13, with updated goals dated 07/16/15 that identified problems with the resident refusing showers with interventions to encourage the resident to shower twice a week and notify the family whenever the resident refused. The only goal was for the resident's skin to remain intact.</p> <p>Observation of a skin assessment, on 07/15/15 at 9:20 AM, revealed the resident's Gastrostomy Tube site was clear without redness or drainage. The skin assessment revealed the resident had no open areas or redness to the rest of the body.</p> <p>2. Review of Resident #13's clinical record revealed the facility admitted the resident on 08/02/06 with diagnoses of Alzheimer's Disease, Renal Dialysis Status, Diabetes Mellitus,</p>	F 282		



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

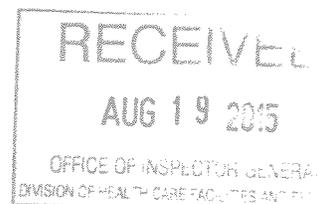
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015	
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 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 282	<p>Continued From page 13</p> <p>Coronary Artery Disease, Congestive Heart Failure, Obesity, Hypertension, Anxiety, Pain, Difficulty walking, and Kidney Cancer.</p> <p>Review of the annual Minimum Data Set (MDS) assessment, completed on 04/16/15, revealed the facility assessed the resident's skin to be at risk for pressure ulcers.</p> <p>Review of the comprehensive care plan for Resident #13 revealed the facility developed a care plan on 04/20/12, with updated goals and targeted approaches dated 07/09/15. Problems on the care plan included resident was at risk for pressure ulcer related to decreased mobility; incontinence; and, poor nutrition; with a goal for the resident's skin to remain intact. One of the approaches was to conduct a systematic skin inspection weekly.</p> <p>Review of Resident #13's electronic clinical record of weekly skin checks (located under the observation section) from 04/02/15 to 07/07/15 revealed ten (10) out of (14) weekly skin assessments had been completed.</p> <p>On 07/16/15 at 2:00 PM, Resident #13 refused the request for a skin assessment observation.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 07/15/15 at 9:20 AM, revealed weekly comprehensive skin assessments were to be conducted.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/16/15 at 9:50 AM, revealed skin assessments were done weekly and recorded in the electronic record under the section titled Observation. Most resident's skin assessments</p>	F 282		



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

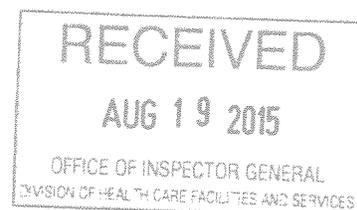
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 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 282	Continued From page 14 are scheduled on his/her shower days. If a resident refused a skin assessment, the refusal was to be documented in the nurse's notes and an event report was to be completed. Certified Nursing Assistants were to report any skin conditions to the nurse. Interview with the Director of Nursing (DON), on 07/15/15 at 5:00 PM and 07/16/15 at 4:55 PM, revealed weekly skin assessments were scheduled for each resident. If a resident was at risk for pressure ulcer formation not conducting the weekly skin assessment could increase the risk for developing pressure ulcers.	F 282	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure staff monitored the progression and/or development of pressure areas for two (2) of sixteen (16) residents identified to be at risk for pressure ulcer formation, (Residents #3 and #13). The facility failed to conduct weekly skin assessments	F 314	Criteria 1: Residents #3 and #13 have skin assessments performed and documented weekly in accordance with their care plan as determined by care observations completed by the DON/Wound Nurse on 7/22/15. Criteria 2: All residents have skin assessments performed and documented weekly in accordance with their care plan as determined by random care observations completed by the DON/Wound nurse from 7/26-31/15. Criteria 3: Licensed Nursing staff have received inservice education by the DON/Staff Development Coordinator from 7/26-31/15 on the revised coding documentation for weekly skin assessments, and the need to complete these weekly in accordance with the resident care plan.



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

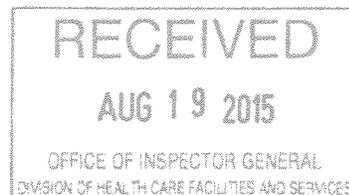
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2015
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 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 314	<p>Continued From page 15 consistently for Residents #3 and #13.</p> <p>The findings include:</p> <p>Review of the Skin Program Policy, revised on 10/10/11, revealed the resident's skin was assessed upon admission, readmission, and weekly thereafter. The skin assessment would be recorded in the resident's electronic chart. Care plan interventions were developed to prevent or treat pressure ulcers. The interventions would be updated and changed as appropriate.</p> <p>1. Review of Resident #3's clinical record revealed the facility admitted the resident on 07/22/14 with diagnoses of Left Sided Hemiplegia, Gastrostomy Tube, Malnutrition, Lower Leg Edema with Venous Insufficiency.</p> <p>Review of the Significant Change in Status Assessment, completed on 07/29/14, revealed the facility assessed the resident's skin to be at risk for pressure ulcer formation.</p> <p>Review of the Care Area Assessments (CAA's), dated 08/06/14, revealed risk factors included: staff assistance needed to relieve pressure; confined to a bed or chair most of the time; required regular turning schedule; immobility; incontinence; poor nutrition; medications; functional limitations; pain; devices that could cause pressure; and, newly or readmitted status.</p> <p>Review of the CAA's worksheet, dated 06/06/14, revealed weekly skin checks would be done by the nurse.</p> <p>Review of Resident #3's weekly skin checks</p>	F 314	<p>Criteria 4: The QA tool for the monitoring of performance of weekly skin assessments will be utilized monthly X 2 months and then quarterly thereafter under the direction of the Director of Nursing. This tool includes review of skin assessments and other skin documentation to determine that skin care is provided in accordance with the resident care plan. (See QAPI tool N-3). Five skin assessment observations will be performed by administrative nurses weekly X 1 month, monthly X 2 months, and then quarterly thereafter to determine that skin assessments are being provided in accordance with resident care plans and facility policy.</p> <p>Criteria 5:</p>	8-21-2015



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2015
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 314	<p>Continued From page 16 (located under the observation section in the electronic clinical record) from 01/07/15 to 07/15/15 revealed seven (7) out of (27) weekly skin assessments had been completed.</p> <p>Observation of a skin assessment, on 07/15/15 at 9:20 AM, revealed the resident's Gastrostomy Tube site was clear without redness or drainage. The skin assessment revealed the resident had no open areas or redness to the rest of the body.</p> <p>2. Review of Resident #13's clinical record revealed the facility admitted the resident on 08/02/06 with diagnoses of Alzheimer's Disease, Renal Dialysis Status, Diabetes Mellitus, Coronary Artery Disease, Congestive Heart Failure, Obesity, Hypertension, Anxiety, Pain, Difficulty walking, and Kidney Cancer.</p> <p>Review of the annual Minimum Data Set (MDS) assessment, completed on 04/16/15, revealed the facility assessed the resident's skin to be at risk for pressure ulcers.</p> <p>Review of the CAA, dated 04/09/15, revealed risk factors for skin breakdown to included: confined to a bed or chair most of the time; immobility; incontinence; medications; functional limitations; pain; shortness of breath; and contributing medical diagnoses.</p> <p>Review of the comprehensive care plan for Resident #13 revealed the facility developed a care plan on 04/20/12, with updated goals and targeted approaches dated 07/09/15. Problems on the care plan included resident was at risk for pressure ulcer related to decreased mobility; incontinence; and, poor nutrition; with a goal for the resident's skin to remain intact. One of the</p>	F 314		



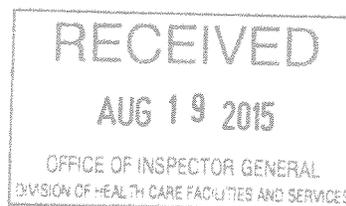
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	---	--	---

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 314	<p>Continued From page 17</p> <p>approaches was to conduct a systematic skin inspection weekly.</p> <p>Review of the CAA's worksheet, dated 04/19/15, revealed weekly skin checks would be done by the nurse.</p> <p>Review of Resident #13's electronic clinical record of weekly skin checks (located under the observation section) from 04/02/15 to 07/07/15 revealed ten (10) out of (14) weekly skin assessments had been completed.</p> <p>Resident #13 refused, on 07/16/15 at 2:00 PM, to allow the surveyor to observe a skin assessment.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/16/15 at 9:50 AM, revealed skin assessments were done weekly and recorded under the observation section of the electronic record. Most resident's skin assessments were scheduled on his/her shower days. If a resident refused a skin assessment, the refusal was to be documented in the nurse's note and an event report was to be completed. Certified Nursing Assistants were to report any skin conditions to the nurse.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 07/16/15 at 1:50 PM, revealed skin assessments were done weekly and recorded under the observation section of the electronic record. If there was a new skin area, the wound/skin nurse would be notified in addition to the weekly skin assessment. If the resident refused a skin assessment it was documented in the nurses notes, event reporting and the treatment record. If the refusals became consistent the facility will notify the responsible</p>	F 314		



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	--	--	--

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 314 Continued From page 18 party, physician/nurse practitioner and Quality Assurance Committee.

Interview with the Director of Nursing (DON), on 07/16/15 at 4:55 PM, revealed the skin assessment policy was outdated and needed to be revised to reflect the expectation of the nurses to record the weekly skin assessment in the clinical record. She stated every resident was to have a weekly skin assessment completed and performing skin assessments inconsistently could increase the resident's risk for developing pressure ulcers.

F 323 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

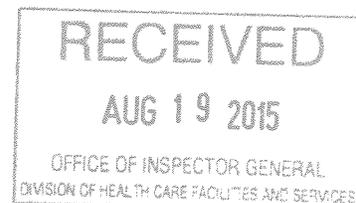
The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of facility's policy, it was determined the facility failed to identify appropriate safe transfer mode and provide supervision to prevent falls for two (2) of sixteen (16) sampled residents, Resident #1 and #9. Resident #1 sustained a non-injurious fall during a transfer with a one (1) person assist when they were assessed for assistance of two (2). Resident #9 sustained a non-injurious fall from the wheelchair.

F 314

F 323 Criteria 1: The comprehensive care plans and C.N.A assignment sheets for residents #1 and # 9 were reviewed/revised by D.O.N. and Unit Managers on 7/21/15 to address the residents' history of a fall, and the appropriate interventions to address the identified fall risk management. For resident #1 this included assistance of two staff for transfers with the sliding board. For resident #9 this included the use of a Dycem mat on the wheelchair cushion, and to encourage the resident to be out in the hallway/supervised areas.

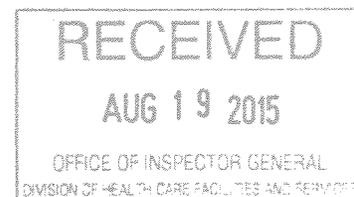
Criteria 2: An audit was completed of the care plans and C.N.A assignment sheets of in-house residents with a history of falls in the last 60 days by D.O.N. on 7/28/15 to determine that these reflect the history of falls, and the appropriate interventions to address fall risk management.



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2015
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 323	<p>Continued From page 19</p> <p>The findings include:</p> <p>The facility did not provide a policy pertaining to the evaluation and determination of appropriate means and mode of transfers between surfaces for residents.</p> <p>The facility provided a falls checklist, not dated, with no specific fall policy.</p> <p>1. Review of Resident #1's clinical record revealed the facility admitted the resident on 12/07/12 with diagnoses of Cerebral Vascular Accident (CVA), Paraplegia, Neurogenic Bladder, Anxiety, Depression, Kidney Disease, Atrial Fibrillation, and Congestive Heart Failure.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS) assessment, completed on 05/04/15, revealed the resident needed extensive assistance of two person for all transfers. The facility completed a Brief Interview of Mental Status (BIMS) exam and determined the resident scored a fifteen (15) out of fifteen (15) meaning the resident was interviewable.</p> <p>Review of the comprehensive care plan, under the titled Falls and dated 12/27/12, revealed the resident was at risk for falls and required a sliding board for transfers. The intervention on this care plan pertaining to transfers stated to give the resident verbal reminders not to attempt transfer without assistance. Review of the Activity of Daily Living (ADL) care plan, dated 08/22/13, revealed staff was to provide assistance with transfers to the wheelchair. The intervention does not state what type or mode of assistance was required for transfers to the wheelchair and how many staff</p>	F 323	<p>Criteria 3: The Staff nurses and Administrative nurses have received inservice education from Staff Development Coordinator from 7/26-31/15, on the need to address residents with a history of a fall, and the appropriate interventions to address fall risk management on the care plan, and to update these as orders change. Staff nurses will accomplish this by completion of the fall risk assessment for each resident with each MDS assessment, to identify the functional, supervision and environmental risk factors that need to be addressed on the care plan. Staff nurses will also include information derived from the root cause analysis conducted for all resident falls that occur.</p> <p>Criteria 4: The Administrative Nursing staff will be monitoring resident fall management interventions by performing checks of 5 randomly chosen residents to determine that the fall management interventions are consistently in place and match the resident orders, care plan and C.N.A care plan are effective, and do not need modification/revision. This will be done weekly X 4 weeks, and then every 2 weeks X 4 weeks, and then monthly thereafter.</p> <p>A QA tool for the monitoring of the development implementation of care plan interventions for fall management will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the DON.</p>		



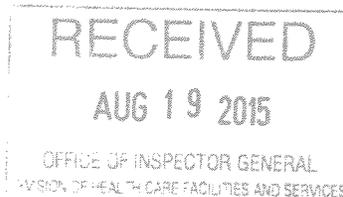
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	---	--	---

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 323	<p>Continued From page 20</p> <p>was required. All interventions in the care plan was dated for 12/27/12 with no new interventions added after this date.</p> <p>Observation of Resident #1, on 07/14/15 at 2:00 PM, revealed the resident was a paraplegic and used a motorized wheelchair for locomotion.</p> <p>Review of the Event Report, dated 11/14/14, revealed Resident #1 sustained a fall on 11/01/14 while transferring on the sliding board with one person staff assistance. The report stated the CNA was unable to prevent the resident from falling and lowered the resident to the floor. Resident #1 sustained no injury.</p> <p>Review of the Physical Therapy Discharge Summary, dated 12/28/12, revealed the facility discharged Resident #1 from physical therapy with a recommendation the facility provide two (2) caregiver assistance in transferring the resident to prevent the resident from sliding off the slideboard.</p> <p>Review of the most recent Therapy Screen, dated 04/29/15, revealed Physical Therapy continued to recommend the resident be transferred with the slideboard and assistance of two (2) staff.</p> <p>Interview with the Therapy Manager, on 07/16/15 at 3:35 PM, revealed the facility screen residents quarterly. Resident #1's screen revealed no need for therapy but continued to need the assistance of the sliding board for transfers with a minimum assist of two (2) caregivers.</p> <p>Review of the CNA Assignment Sheet for Resident #1, undated copy obtained 07/16/15, revealed CNAs were to transfer the resident</p>	F 323	<p>This tool prompts review of 5 randomly selected residents that their care plans reflect the resident assessments and orders, including but not limited to those for fall risk management. Any issues identified by the audits will be reviewed by the QA committee with development of a plan of action. (See QAPI tool # N-21).</p> <p>The DON will be responsible for monitoring that our Staff Development Director educates all staff and any new staff on the proper use of any new or upgraded equipment.</p> <p>Criteria 5</p>	8-21-2015



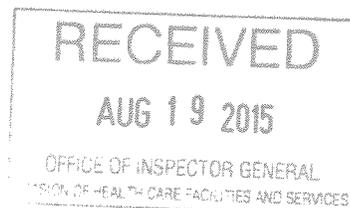
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	--	--	--

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

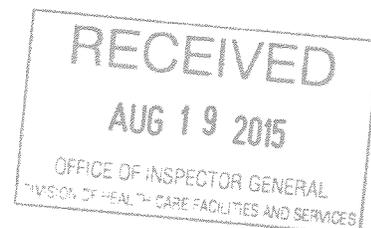
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 21</p> <p>using a sliding board and an assist of one (1). However, interview with CNA #3, on 07/16/15 at 9:03 AM, and interview with CNA #2, on 07/16/15 at 9:14 AM, revealed the CNAs would request additional staff assistance with transfers for safety.</p> <p>Interview with Resident #1, on 07/15/15 at 12:00 PM, revealed the staff assisted Resident #1 with transfers from the bed to the wheelchair using a sliding board. The resident stated sometimes one (1) person assisted with the transfer and sometimes (2) people assisted with transfers.</p> <p>Observation of a staff assisted transfer of Resident #1 from the bed to the wheelchair using the slideboard, on 07/16/15 at 11:30 AM, revealed two (2) staff assisted the resident with the transfer.</p> <p>Interview with Resident #1 after a transfer, on 07/16/15 at 11:30 AM, revealed the staff completed the transfer in the way he/she felt most comfortable (assist of two). The resident stated the nursing staff sometimes completed transfers with one (1) staff and sometimes with two (2) staff. The resident stated he/she was unsure which way the nursing staff was supposed to complete the transfer. Resident #1 stated the facility did invite him/her to care plan meetings, but that he/she did not attend those meetings.</p> <p>Interview with Registered Nurse (RN) #2, on 07/16/15 at 1:30 PM, revealed the nurses updated the care plans. She stated if a resident had a fall, the nurses would updated the care plan with new interventions. The Restorative Nurse and the Unit Manager were to ensure the care plan was revised with appropriate</p>	F 323		



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2015
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 323	<p>Continued From page 22 interventions.</p> <p>Interview with the North Unit Manager, on 07/16/15 at 2:00 PM, revealed she was responsible for oversight of the staff nurses and CNAs on the North Unit. The Unit Manager stated the facility had assessed Resident #1 at risk for falls and a sliding board was to be utilized when the resident was transferred from the bed to the wheelchair. The Unit Manager stated the instructions on how much assistance to provide Resident #1 with transfers was inconsistent and confusing.</p> <p>Interview with the Director of Nursing (DON), on 07/16/15 at 4:30 PM, revealed therapy completed a quarterly screening of Resident #1 and had assessed the level of needed assistance for transfers as total assist. In addition, physical therapy indicated the resident required assistance of two (2) for transfers from the bed to the wheelchair using the sliding board. The DON reviewed the Event Report for the fall on 11/01/14 and revealed one CNA was assisting the resident with the transfer at the time of the fall. She stated the resident was assessed needing the assistance of two (2); however, the care plan did not indicate how many staff was needed and had not been revised since the fall.</p> <p>2. Observation, on 07/15/15 at 8:20 AM, revealed Resident #9 was sitting in his/her wheelchair in the room's bathroom with the lights off and calling out for help. The resident stated she was stuck in the bathroom. The resident was facing a walker in the bathroom and was perpendicular to the toilet.</p> <p>Observation, on 07/16/15 at 10:00 AM, revealed</p>	F 323			



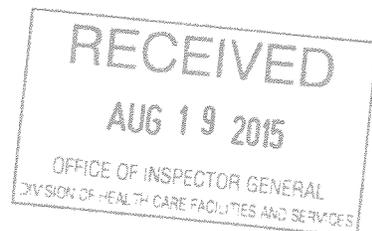
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	---	--	---

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 323	<p>Continued From page 23</p> <p>Resident #9 was in the bathroom in his/her bedroom transitioning between the wheelchair and the toilet using the walker in the bathroom. The resident's bedroom door and bathroom door were open. Staff was not present in the resident room at this time.</p> <p>Review of Resident #9's annual MDS assessment, completed on 07/28/14, revealed the resident had diagnoses of Hypertension, Dementia, Immobilization Syndrome, and Chronic Pain. The facility assessed the resident as needing limited assistance of one staff person to transfer between surfaces and to toilet. The assessment stated the resident was capable of moving about the facility in his/her wheelchair. The assessment further stated the resident was always continent of urine and bowel.</p> <p>Review of Resident #9's annual MDS assessment, completed on 07/13/15, revealed the resident required a higher level of support for functioning in several areas. The facility assessed Resident #9 as needing extensive assistance to transfer between surfaces and to toilet. The assessment also stated the resident needed extensive assistance to move about the facility in his/her wheelchair. The assessment further stated Resident #9 was occasionally incontinent of urine and frequently incontinent of bowel. A Brief Interview for Mental Status (BIMS) exam was conducted during the assessment and the facility assessed the resident with a score of nine (9) out of fifteen (15) meaning the resident was interviewable.</p> <p>Review of the Care Plan, category falls, for Resident #9, dated 08/09/12, revealed the</p>	F 323		



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

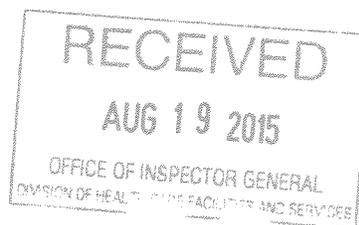
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	---	--	---

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 323	<p>Continued From page 24</p> <p>resident had a history of falling due to unsteady gait and a diagnosis of Dementia. The facility documented eight (8) interventions, all dated for August 2012. The facility added no new interventions to the care plan after August 2012.</p> <p>Review of a therapy referral made on behalf of Resident #9, dated 01/09/15, revealed the resident was getting weaker and needing assistance with transfers.</p> <p>Review of a therapy referral made on behalf of Resident #9, dated 01/12/15, revealed the resident was getting weaker, losing weight, needing help with transfers and was shuffling when walking. The resident tired easily and was unable to complete tasks.</p> <p>Review of the Event Report, dated 02/20/15, revealed Resident #9 suffered an unwitnessed fall in his/her room. The resident had fallen out of his/her wheelchair. Nursing completed and evaluation of the resident and determined the resident suffered no injury. In a follow-up meeting, the facility determined the resident slipped out of the wheelchair and decided to add the intervention of placing a Dycem mat on top of the wheelchair cushion and to encourage the resident to spend time in the hallway for increased supervision.</p> <p>Review of the CNA Assignment Sheet for Resident #9, undated copy obtained 07/16/15, revealed the facility did not direct CNAs to keep or encourage resident to stay in a supervised area and a Dycem mat not on this sheet.</p> <p>Interview with CNA #3, on 07/16/15 at 9:03 AM, revealed Resident #9 needed more assistance</p>
-------	---

F 323



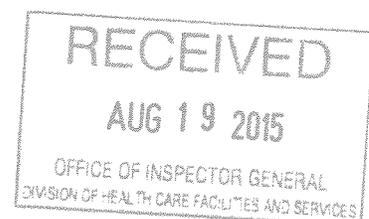
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	---	--	---

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

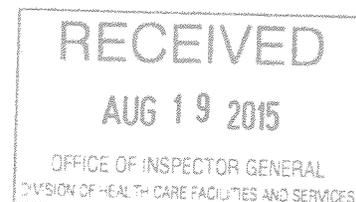
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 25 with toileting and was more confused now.</p> <p>Interview with CNA #1, on 07/16/15 at 9:30, revealed Resident #9 transferred via stand and pivot with an assist of one (1). She stated the resident was receiving Restorative Therapy. She also stated Resident #9 was continent of bowel and bladder, but the resident was not a heavy wetter. Stated the resident would decline toileting at times or not urinate much when on the toilet.</p> <p>Interview with RN #2, on 07/16/15 at 1:30 PM, revealed she supervised the CNAs by giving the CNAs report, watch what the CNAs do, and provide assistance to the CNAs as needed. The Restorative Nurse and the Unit Manager would have ensured the care plan was appropriate. RN #2 revealed Resident #9 was capable of using a call light and toileting, but would occasionally try to toilet independently. RN #2 stated Resident #9 was at risk of falling due to transferring herself without assistance.</p> <p>Interview with the North Unit Manager, on 07/16/15 at 2:00 PM, revealed Resident #9 did have a significant weight loss and decline in functioning earlier in the year. She stated Resident #9 developed Pneumonia and a Urinary Tract Infection (UTI) in the winter. The facility considered Resident #9 for Palliative Care; however, the family declined. The North Unit Manager stated Resident #9 was able to tell staff when she needed to toilet. The Unit Manager was unaware Resident #9 had been attempting to toilet himself/herself independently and stated this was a concern as Resident #9 was at risk of falling.</p> <p>Interview with Physical Therapist, on 07/16/15 at</p>	F 323		



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2015
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 323	<p>Continued From page 26</p> <p>2:55 PM, revealed Resident #9 received therapy earlier this year. Prior to becoming ill early in the year, Resident #9 had been able to toilet himself/herself independently. At that time he/she had been receiving Restorative Therapy for mobility and ROM. Resident #9 became ill early in the year and Physical Therapy picked up Resident #9 on 02/05/15. Physical Therapy discharged the resident from the therapy program to the Restorative Therapy on 03/31/15 for ambulation and ROM.</p> <p>Interview with the Therapy Manager, on 07/16/15 at 3:35 PM, revealed Physical Therapy discharged Resident #9 on 03/31/15 to Restorative Therapy for mobility and ROM. She stated the restorative aids would make a referral back to therapy if the resident started showing improvements. Restorative had not made a referral to therapy since the discharge to restorative.</p> <p>Interview with DON, on 07/16/15 at 4:30 PM, revealed Resident #9 had gotten very ill and the facility and family were discussing placing the resident on palliative care. The DON stated the facility had Standards of Care meetings weekly that consist of six (6) subjects. The team discussed one subject per week. In six (6) weeks, when the Standards of Care meeting reviewed Resident #9 again, the resident had stabilized and was no longer losing weight or declining in functional abilities. The DON revealed the facility did record Resident #9 sustained a fall in February 2015. The DON reviewed the fall documentation and revealed the interdisciplinary team did identify new interventions to prevent further falls; however, the facility failed to implement those interventions.</p>	F 323		



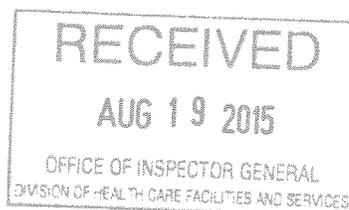
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	---	--	---

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 323	Continued From page 27 The DON stated she had completed spot checks of the care plans to ensure all interventions were in the care plans. The DON stated nursing staff did not place the new intervention on the care plan and this placed the resident at increased risk of falling again.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	Criteria 1: The UTI for resident #6 has resolved, and isolation precautions are no longer indicated. Criteria 2: Administrative nursing observations conducted on 7/26, 7/28 & 7/31/2015 indicate that nursing staff identify and implement isolation precautions in accordance with MD orders and infection control standards of practice. There is currently one resident requiring contact precautions. Criteria 3: Nursing staff have received inservice education on isolation precautions, to include but not be limited to use of PPE, identification and implementation of the correct type of isolation precautions in accordance with MD orders and CDC infection control standards of practice as provided by the Staff Development Coordinator on 7/26-31/15.	



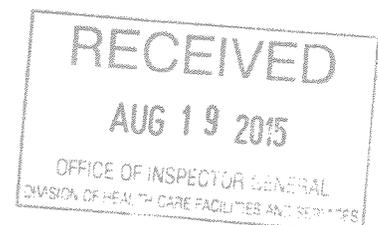
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	--	--	--

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 441	<p>Continued From page 28</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to implement their Infection Control Program in regards to contact precautions to prevent transmission of disease or infection for one of six (6) sampled residents identified with infections, out of a total sample of sixteen (16) residents, (Resident #6). A Urinalysis (U/A) was obtained on 07/09/15 that was positive for Methicillin Resistant Staphylococcal Aureus (MRSA). The physician ordered the resident to be placed in contact precautions; however, observations revealed no signage indicating contact precautions was in place and no Personal Protective Equipment (PPE) was provided to the staff or visitors.</p> <p>The findings include:</p> <p>Review of the facility's Infection Control Policy, revised 10/10/11, revealed when a resident was diagnosed with an infection, Standard (contact) Universal Precautions would be followed. A staff member would request additional PPE if they felt the need. Universal Precautions would be used with all residents. The policy gave no specific instructions for the different types of precautions</p>	F 441	<p>Criteria 4: The DON/Infection Control Nurse/Staff Development Coordinator will review all residents with new orders for isolation precautions to determine that these are implemented in accordance with CDC guidelines and facility policy, including the type of isolation precautions implemented and the correct use of PPE.</p> <p>The QA tool for the monitoring infection control standards of care, including identification and implementation of isolation precautions will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the DON. The completed tool will be reviewed by the QA committee, with development of a plan of action for any issues identified. (See QAPI tool # IC-6).</p> <p>Criteria 5:</p>	8-21-2015



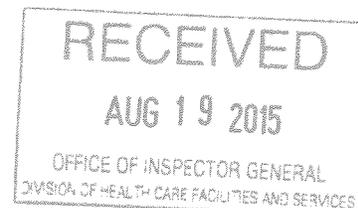
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	---	--	---

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 441	<p>Continued From page 29</p> <p>and did not instruct the staff on what type of PPE was to be used for each different type of precautions.</p> <p>Review of the Official Web site for the Center for Disease Control (CDC) revealed guidelines for Standard (Universal) Precautions and Contact Precautions (not dated). According to the CDC, Standard Precautions applied to all residents and Contact Precautions were used to prevent the transmission of an infectious agent that was not interrupted by Standard Precautions. Under III.B.1. Contact Precautions also applied where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggested an increased potential for extensive environmental contamination and risk of transmission. Healthcare personnel caring for residents on Contact Precautions should wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient room was done to contain pathogens.</p> <p>Review of Resident #6's clinical record revealed a physician's order, dated 07/07/15, for a U/A to be obtained related to a foul smelling urine odor from the resident's suprapubic catheter leakage. Review of the U/A lab report, dated 07/09/15, revealed the urine had MRSA and Proteus bacteria growth. The facility notified the resident's physician and he ordered an antibiotic treatment for ten (10) days and ordered for the resident to be placed in Contact Precautions. Review of the electronic Medication Administration Record (MAR) revealed the Contact Precaution order was transcribed onto the MAR.</p>	F 441		



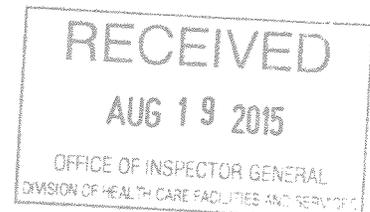
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	--	--	--

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 441	Continued From page 30 Observation during tour of the facility, on 07/14/15 at 12:40 PM, revealed Resident #6 was up in a wheelchair propelling self with his/her feet in the hallway. A catheter was observed in a dignity bag. The resident's room had no signage to indicate precautions and no PPE was available for staff or visitors. Observation revealed staff entered the resident's room without any PPE. At 4:19 PM, the resident was observed in a wheelchair in the resident's room watching television with the roommate. No PPE was available. On 07/15/15 at 2:55 PM, the resident was observed in the room after receiving bowel incontinent care from Certified Nursing Assistant (CNA) #6. Interview with CNA #6 revealed she wore gloves only and had not been told the resident was in Contact Precautions. She stated if she had known the resident was in Contact Precaution she would have used a gown. However, no gowns were available when the aide performed incontinent care. Observation of catheter care, on 07/16/15 at 8:47 AM with LPN #1, revealed no PPE available for use. The nurse donned gloves and removed the drainage sponge around the suprapubic catheter. There was a small amount of brownish colored drainage on the drainage sponge and scant amount of blood around the catheter's stoma. The nurse completed the cleaning of the catheter with gloved hands. Observation revealed large amount of sediments in the catheter's tubing and the drainage bag. Interview with LPN #1, on 07/16/15 at 8:58 AM, revealed the nurse was aware of the Contact Precaution order, but he had been told to use only Universal Precautions. He stated the facility	F 441		



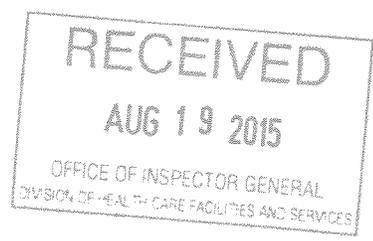
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	---	--	---

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 441	<p>Continued From page 31</p> <p>could not put a sign outside the resident's door because of a dignity issue. When asked about a "See nurse before entering" sign, he said he didn't know about that. He stated no PPE was provided because everyone should be using Universal Precautions. He stated there wasn't really any difference from using Universal or Contact Precaution, except you could use a gown with Contact Precautions, but didn't state when to use the gown.</p> <p>Interview with the Infection Control Nurse, on 07/16/15 at 1:23 PM, revealed she followed the CDC guidelines. She stated the facility usually did not place residents in Contact Precautions if the bacteria was 50,000 or less. However, she stated the physician had ordered the Contact Precaution and it should have been followed. She stated she was unaware of the order and she had not provided any specific training regarding Contact Precautions to the staff. She stated staff was trained on Universal Precautions during orientation, but not on any other precautions. She stated there was a difference between Universal and Contact Precautions. Contact Precaution was ordered by a physician and PPE was to be worn. A sign would be placed outside the resident's room instructing staff and visitors to see the nurse before entering. PPE would be provided and located outside the room.</p> <p>Interview with the South Unit Manager, on 07/16/15 at 1:30 PM, revealed Resident #6 was on Contact Precautions. She stated there usually was a sign outside the door to inform the staff and visitors, but didn't know why there wasn't one this time. She stated PPE was not provided because the MRSA was in the resident's urine,</p>	F 441		



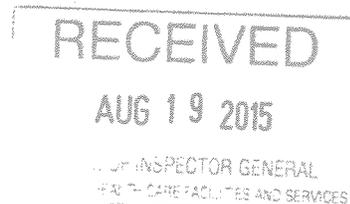
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	---	--	---

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

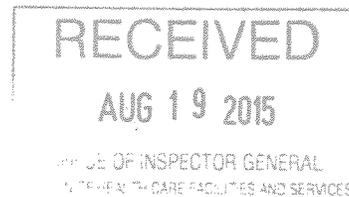
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 32</p> <p>inside a closed system. She stated staff were told to use Universal Precautions and the staff were not doing anything different with this resident then with any resident. She also stated staff had not been instructed to wear a gown when emptying the urine from the drainage bag.</p> <p>Observation, on 07/16/15 at 1:56 PM, revealed CNA #4 emptied the urine from the drainage bag into a empty urinal. There was an odor present and the urine was cloudy with sediments. She then emptied the urine into the commode and rinsed the urinal with water from the sink. The CNA wore gloves, but no gown.</p> <p>Interview with CNA #4, on 07/16/15 at 1:58 PM, revealed she had been told of the resident's infection and was told to wear gloves and wash with soap and water. She had not been instructed to wear a gown.</p> <p>A telephone interview, on 07/16/15 at 4:12 PM with Resident #6's physician, revealed he had ordered the resident to be placed on Contact Precaution until a negative culture was obtained. He stated he had not seen the resident since he had ordered the Contact Precaution and was unaware facility staff was not following. He stated there was a big difference between Universal and Contact Precautions which you would use PPE for protection and prevention of transmission of the infection.</p> <p>Interview with the Director of Nursing (DON), on 07/16/15 at 4:30 PM, revealed she could not recall if anyone had informed her Resident #6 had MRSA in the urine and the physician had ordered Contact Precautions. She stated there</p>	F 441		



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

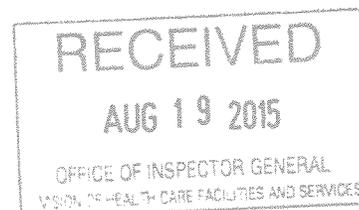
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2015
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	Continued From page 33 was a difference between Universal and Contact Precautions. She stated if she had known about the Contact Precautions, PPE would have been provided and stated again she could not recall if any nurse had informed her of the precautions. She stated the nurse who took the physician's order should have placed a sign on the resident's door and provided PPE for staff and visitors. She stated a gown should have been worn when the resident's urine was emptied from the drainage bag.	F 441			
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520	Criteria 1: The UTI for resident #6 has resolved, and isolation precautions are no longer indicated. The QA Committee met 8/18/15 to review implementation of the Plan of Correction and QA tools. The QA will meet again on October 19, 2015 to review the QA tools and monitoring findings to determine the effectiveness of the interventions. Criteria 2: Administrative nursing observations conducted on 7/26 & 7/28 & 8/01 2015 indicate that nursing staff identify and implement isolation precautions in accordance with MD orders and infection control standards of practice. There is currently one resident requiring contact precautions. During the QA Committee meeting on 8/18/15, a root cause analysis of the factors leading to each of the survey deficiencies were identified/discussed with review of the Plan of Correction interventions and QA tools to determine that all identified issues have been addressed.		



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

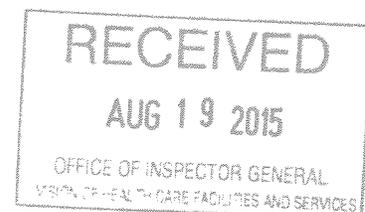
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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 520	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to have an effective Quality Assurance (QA) Committee to ensure ongoing compliance of corrected deficiencies. The facility was cited for problems with their Infection Control Program for four (4) consecutive surveys. Review of the plan of correction submitted for the 2014 survey revealed the facility was to monitor noncompliance through the QA committee. Observation during this survey (July 14-16, 2015) revealed the facility failed to consistently implement plans of actions to correct identified deficiencies and remain in compliance with state and federal regulations. The findings include: The facility did not provide a specific policy for the Quality Assurance (QA) Program. Interview with the Administrator, on 07/16/15 at 3:35 PM during the QA task, revealed infection control issues were discussed at each QA meeting. He stated infections were discussed during the clinical daily meeting (he did not attend) and the monthly Standard of Care meetings. He stated the Director of Nursing (DON) conducted audits of the problems found on last year's survey regarding infection control. The Infection Control Nurse tracks and trends infections and brings her findings to the quarterly QA meetings. He said infections are discussed in the morning meetings and what type of	F 520	Criteria 3: Nursing staff have received inservice education on isolation precautions, to include but not be limited to use of PPE, identification and implementation of the correct type of isolation precautions in accordance with MD orders and CDC infection control standards of practice as provided by the Staff Development Coordinator from 7/26-31/15. The QA Committee has received inservice education by the Administrator on 8/18/15 on the need to determine that interventions developed on a Plan of Correction or Plan of Action are consistently implemented, are effective, and if not effective, are revised and monitored until effective. The Committee will monitor that QA tools that fail to meet the established compliance threshold will be repeated monthly until compliance is achieved and maintained. Criteria 4: The QA tool for the monitoring of the facility infection control program and infection control standards of care, including identification and implementation of isolation precautions will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the DON. The completed tool will be reviewed by the QA committee, with development of a plan of action for any issues identified. (See QAPI tool # IC-6 and IC-1).	



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2015
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 520	<p>Continued From page 35</p> <p>precautions to be implemented would be determined by the physician, DON and Infection Control Nurse. He stated the infection control issues cited in previous surveys were not the same as the concerns regarding precautions on this survey.</p> <p>Review of Resident #6's clinical record revealed a physician's order, dated 07/07/15, for a U/A to be obtained related to a foul smelling urine odor from the resident's suprapubic catheter leakage. Review of the U/A lab report, dated 07/09/15, revealed the urine had MRSA and Proteus bacteria growth. The facility notified the resident's physician and he ordered an antibiotic treatment for ten (10) days and ordered for the resident to be placed in Contact Precautions. Review of the electronic Medication Administration Record (MAR) revealed the Contact Precaution order was transcribed onto the MAR.</p> <p>Observation during tour of the facility, on 07/14/15 at 12:40 PM, revealed Resident #6's room had no signage to indicate precautions and no PPE available for staff or visitors. Observation revealed staff entered the resident's room without any PPE. On 07/15/15 at 2:55 PM, the resident was received bowel incontinent care; however, the Certified Nursing Assistant (CNA) did not wear a gown.</p> <p>Observation of catheter care, on 07/16/15 at 8:47 AM with LPN #1, revealed no PPE available for use. The nurse donned gloves and removed the drainage sponge around the suprapubic catheter. There was a small amount of brownish colored drainage on the drainage sponge and scant amount of blood around the catheter's stoma. The nurse completed the cleaning of the catheter with gloved hands. Observation revealed large</p>	F 520	<p>The QA tool for the monitoring of the effectiveness of the QA program will be utilized quarterly under the supervision of the Administrator. This tool reviews the identification of issues by the facility, the development and implementation of plans of action, and the monitoring of ongoing compliance for plans of action. (See CQI audit tool).</p> <p>The Administrator will oversee the QA process to determine that the QA Committee reviews the QA tools and monitoring information in a manner that identifies quality of care issues, develops plan of action and monitors for effectiveness/compliance. The Administrator will also utilize the QA tool for monitoring the QA process as outlined above, to determine effectiveness of the committee.</p> <p>Criteria 5:</p>	8-21-2015



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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

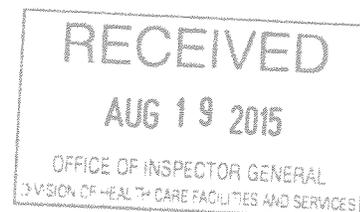
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
--	---	--	---

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 520	<p>Continued From page 36</p> <p>amount of sediments in the catheter's tubing and the drainage bag.</p> <p>Observation, on 07/16/15 at 1:56 PM, revealed CNA #4 emptied the urine from the drainage bag into a empty urinal. There was an odor present and the urine was cloudy with sediments. She then emptied the urine into the commode and rinsed the urinal with water from the sink. The CNA wore gloves but no gown. Refer to F441.</p> <p>Interview with the DON, on 07/16/15 at 4:05 PM and 4:30 PM, revealed the Infection Control Nurse tracks and trends all infections in the facility. She stated the infections are discussed during the morning meetings and the monthly Standard of Care meetings. She stated there was also huddle meetings where the Infection Control Nurse would determine what topic to discuss and provide on-the-spot training to staff. She gave an example of increased eye infections noted and education was provided to staff on how to administer eye drops properly. She stated there had been no training on types of precautions to be implemented when an infection such as MRSA was noted. She stated she conducted audits for proper storage of oxygen equipment that was cited on the last survey and took those results to the QA committee. She stated she could not recall if staff had informed her of Resident #6's infection and order for Contact Precautions. She stated there were Personal Protective Equipment (PPE) available and should have been used if the resident was supposed to be in Contact Precautions.</p>
-------	--

F 520



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

PRINTED: 07/28/2015
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 07/14/2015
--	--	--	--

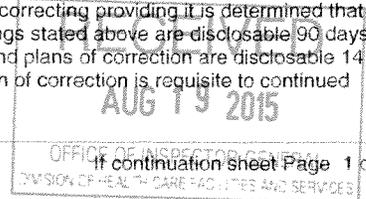
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241
--	--

(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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1978, 1990</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story, Type III Unprotected.</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier.</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 Recertification Life Safety Code Survey was conducted on 07/14/15. The facility was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Leslie J. Butterfield</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>X 8-07-2015</i>
---	-------------------------------------	-------------------------------------

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.



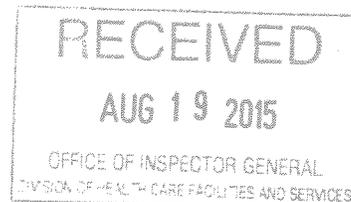
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2015
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 07/14/2015
--	---	---	---

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 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000		
K 038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress from the facility and fifteen (15) second delayed egress signage was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, residents, staff and visitors. The facility has ninety (90) certified beds and the census was seventy-nine (79) on the day of the survey.</p> <p>The findings include:</p> <p>1. Observation, on 07/14/15 at 12:44 PM, with the Administrator and the Director of Plant Operations revealed the gate to egress the East Sun Porch was not swinging in the direction of</p>	K 038	<p>Criteria 1: On July 17, 2015 the Administrator placed delayed egress signs on the two doors found to be missing the correct signage. On July 23, 2015 the gate was reinstalled to open in the direction of egress.</p> <p>Criteria 2: The facility recognizes that all residents have the potential to be affected by the deficient practice.</p> <p>Criteria 3: Maintenance will inspect all doors monthly to ensure that all exit doors display the correct signage. Signage found missing will be reported to the administrator immediately.</p> <p>Criteria 4: The maintenance director will meet with the administrator, quarterly, to inspect all exits for proper signs, lights, gates and surfaces. This will be documented by the administrator for evidence of ongoing compliance.</p> <p>Criteria 5: All defecienies have been corrected. The first dual inspection by maintenance and the administrator was completed on 8-7-2015</p>	8-7-2015



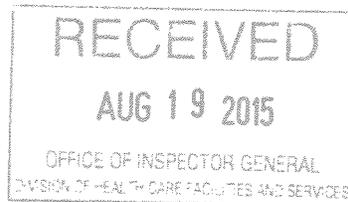
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2015
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 07/14/2015
--	---	---	---

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	<p>Continued From page 2 travel and required per Code.</p> <p>Interviews, on 07/14/15 at 12:46 PM, with the Administrator and the Director of Plant Operations revealed they were not aware of the gate being required to swing in the direction of travel for egress of the exterior Porch in the event of an emergency.</p> <p>2. Observation, on 07/14/15 at 1:12 PM, with the Administrator and the Director of Plant Operations revealed the door to exit the North-West Resident Hall was equipped with fifteen (15) second delayed egress hardware but did not display the proper signage identifying the door would open after fifteen (15) seconds upon activation of the door hardware.</p> <p>Interviews, on 07/14/15 at 1:14 PM, with the Administrator and the Director of Plant Operations revealed they were not aware the fifteen (15) second delayed egress signage was not displayed on the North-West Resident Hall and indicated the glass had recently been replaced and the proper signage had not been installed on the day of the observations.</p> <p>3. Observation, on 07/14/15 at 2:23 PM, with the Administrator and the Director of Plant Operations revealed the door to exit the South-East Resident Hall was equipped with fifteen (15) second delayed egress hardware but did not display the proper signage identifying the door would open after fifteen (15) seconds upon activation of the door hardware.</p> <p>Interviews, on 07/14/15 at 2:25 PM, with the Administrator and the Director of Plant Operations revealed they were not aware the</p>	K 038		



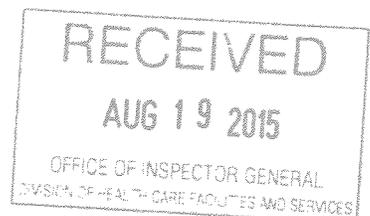
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2015
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 07/14/2015
--	---	---	---

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	<p>Continued From page 3</p> <p>fifteen (15) second delayed egress signage was not displayed on the South-East Resident Hall and indicated the glass had recently been replaced and the proper signage had not been installed on the day of the observations.</p> <p>The census of seventy-nine (79) was verified by the Administrator on 07/14/15. The findings were acknowledged by the Administrator and verified by the Director of Plant Operations at the exit interview on 07/14/15.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p>	K 038		



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

PRINTED: 07/28/2015
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 07/14/2015
--	---	---	---

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 4

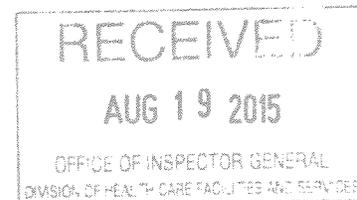
(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.

(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.
Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.

(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows:
PUSH UNTIL ALARM SOUNDS
DOOR CAN BE OPENED IN 15 SECONDS

7.10.8.1* No Exit. Any door, passage, or stairway that is neither an 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:

K 038



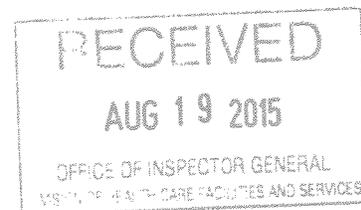
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2015
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 07/14/2015
--	--	---	--

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

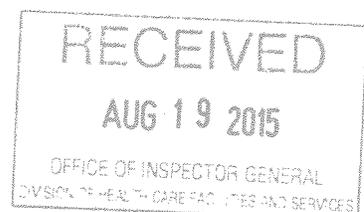
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 5 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. 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.	K 038		
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	K 147		



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

PRINTED: 07/28/2015
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 07/14/2015
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	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring and devices were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiencies had the potential to affect one (1) of six (6) smoke compartments, residents, staff, and visitors. The facility has ninety (90) certified beds and the census was seventy-nine (79) on the day of the survey. The findings include: Observation, on 07/14/14 at 12:40 PM, with the Administrator and the Director of Plant Operations revealed an electrical panel located at the entrance to the Sun Room was unlocked and permitted unauthorized access to electrical panel's circuit breakers. Interview, on 07/14/15/14 at 12:42 PM, with the Administrator and the Director of Plant Operations revealed they were aware of the requirement that electrical panels be locked where they are accessible to residents and visitors. They acknowledged that electrical work was being performed by an outside Contractor and the electrical panel should have been locked. The census of seventy-nine (79) was verified by the Administrator on 07/14/15. The findings were acknowledged by the Administrator and verified by the Director of Plant Operations at the exit interview on 07/14/15.	K 147	Criteria 1: On July 14, 2015 the maintenance director locked the electrical panel door. Criteria 2: The facility recognizes that all residents have the potential to be affected by the deficient practice. Criteria 3: Starting August 2015, maintenance will inspect all electrical panel doors weekly to ensure that all are looked and inaccessible to residents. Criteria 4: The maintenance director will meet with the administrator, quarterly, to inspect all electrical panels and review issues, if any. This will be documented by the administrator for evidence of ongoing compliance. Criteria 5: All defecienies have been corrected. The first dual inspection by maintenance and the administrator was completed on 8-7-2015.	8-7-2015



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

PRINTED: 07/28/2015
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 07/14/2015
--	---	---	---

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 7</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained about 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		

