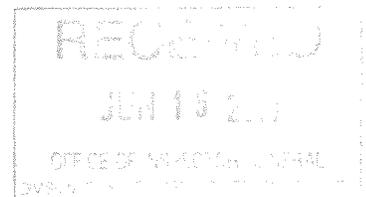


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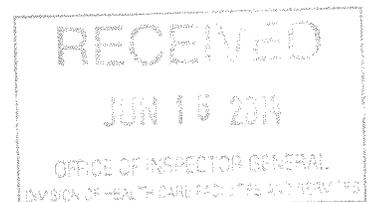
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NAME OF PROVIDER OR SUPPLIER  <b>SPRINGHURST HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241</b>		
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F 312	Continued From page 37 resident's finger nails on both hands. Observation, on 05/07/14 at 8:00 AM, revealed a dried brown substance on the right thumb nail as well as a brown substance under all finger nails.  Observation of Resident #11, on 05/06/14 at 10:05 AM, revealed a brown line under the finger nails on both hands. Observation, on 05/07/14 at 8:12 AM, revealed a brown substance under the finger nails on both hands.  Observation of Unsampled Resident A, on 05/07/14 at 11:50 AM, revealed the resident had thick, yellow jagged nails on both hands. Observation on 05/08/14 at 8:45 AM, revealed finger nails continued to be broken and jagged,  Observation of Unsampled Resident B, on 05/07/14 at 11:55 AM, revealed the resident had long stained and soiled nails with a brown substance under the nails on the right hand. Observation, on 05/08/14 at 8:55 AM, revealed the finger nails continued to have a brown substance under the nails on the right hand.  Interview with Certified Nurse Aide (CNA) #2, on 05/08/14 at 12:10 PM, revealed nail care was completed for the residents on shower/bath day and as needed. She stated this included cleaning under the nails and filing nails to smooth them to prevent injury to the resident. She stated the residents were not able to provide nail care independently.  Interview with the Unit Manager on 05//08/14 at 12:35 PM, revealed the residents were not able to provide their own care and depended on the staff for care. She stated the nails should be smooth and clean.	F 312	4. The unit managers, Staff Development Director and Director of Nurses will each check 2 residents per day for proper grooming and nail care for 1 month then 2 residents per week for 2 months. The findings will be reported during QA quarterly meeting. The QA committee will determine continued frequency of nail checks.	6/21/14	



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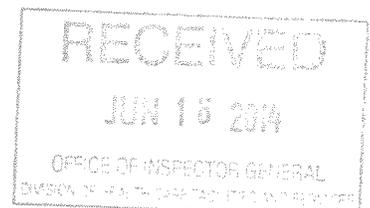
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F 312	Continued From page 38  Observation of Resident #1, on 05/06/14 at 4:17 PM and 05/07/14 at 2:35 PM, revealed Resident #1 had a dark substance under the fingernails.  Review of Resident #1's physician orders, revealed Resident #1 was to have showers on Wednesday and Friday of every week.  Interview with CNA #4, on 05/08/14 at 11:06 AM, revealed she had completed nail care on Resident #1 that morning. CNA #4 stated she liked to make sure the residents nails were clean and hygiene was complete. CNA #4 stated when cleaning Resident #1's nails that morning she had seen food and dirt under his/her nails. CNA #4 stated she provided nail care when giving a shower or bed bath. CNA #4 stated we wash the residents nails to ensure that the nails were clean and possibly to prevent the spread of infection.  Interview with Certified Nursing Assistant (CNA) #3, on 05/08/14 at 11:00 AM, revealed she had given Resident #1 a shower on 05/07/14 (Wednesday). CNA #3 stated she cleaned Resident #1's hands, but did not provide nail care. CNA #3 stated when giving residents showers she did not clip the resident nails or provide nail care. CNA #3 stated the restorative department went around and provided nail care.  Interview with Registered Nurse #1, on 05/08/14 at 11:12 AM, revealed she expected the aides to provide nail care to residents when giving a shower. RN #1 stated she cleaned resident nails for infection control purposes.  Interview with the Administrator, on 05/08/14 at 6:30 PM, revealed staff should clean hands when	F 312			



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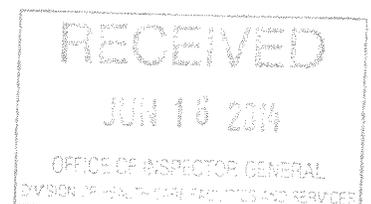
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F 312	Continued From page 39 bathing residents. The Administrator stated he was not aware that restorative was responsible to provide hand hygiene.	F 312			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure 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 policy review, it was determined the facility failed to provide adequate supervision to prevent falls for two (2) of sixteen (16) sampled residents, Residents #6 and #9. The facility failed to track and trend Resident #9's and Resident #6's falls to determine the association with the falls and toileting. The facility failed to complete additional bladder assessments with each fall and failed to develop an individualized toileting program to assist in the management and prevention of falls. Resident #9 sustained six (6) falls in the month of January, 2014 during self transfer to the restroom. The sixth fall resulted in an injury, which required an acute hospital visit and the placement of three (3) staples to the back of his/her head. Resident #6 sustained six (6) falls from the bed without injury; however, the resident was found wet with five (5) of those falls.  The findings include:	F 323 1. Residents #6 and #9 were reassessed to ensure appropriate interventions are in place. Resident #6 had a three day bowel and bladder assessment due to pattern of incontinence and falls. An overnight brief will be applied on last 2-10pm rounds. Resident will be checked for incontinence at 3am and 5am with brief changes if wet or soiled. Resident #6 has been referred to the psychiatrist and LCSW for possible counseling due to the possibility that some of the falls are attention seeking behavior. Resident #9 will have a 3 day bowel and bladder assessment completed, by 6/6/14, to note patterns in voiding so an individual check / change schedule can be initiated.  2. All residents at risk for falls could be affected by this deficient practice.			



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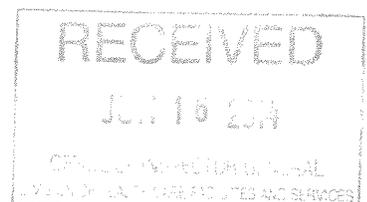
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F 323	Continued From page 40  The facility did not provide a policy and procedure for prevention and management of falls as requested by the State Survey Agency (SSA).  Interview with the Director of Nursing (DON), on 05/08/14 at 2:08 PM, revealed the facility did not have a fall prevention and management policy and procedure.  1. Observation of Resident #9, on 05/06/14 at 1:10 PM, revealed Resident #9 was in his/her room standing at the bedside. Interview at this time with Resident #9, revealed he/she had the intention of going to the bathroom unassisted. A Certified Nursing Assistant (CNA) was located and the resident was then assisted after surveyor intervention.  Review of Resident #9's clinical record revealed the facility admitted the resident on 10/14/13 with a diagnoses of Cataract Right Eye, Urinary Tract Infection, Lack of Coordination, Osteoporosis, Debility, Symptoms of Insomnia, Difficulty Walking, and Anxiety. Review of the Minimum Data Set (MDS) Admission Assessment, dated 10/23/13, revealed the facility assessed Resident #9 with a Brief Interview for Mental Status (BIMS) score of eight (8) and was assessed to require extensive assistance of one (1) person physical assist. In addition, the MDS stated the resident had sustained falls since admission with no injuries. Review of Resident #9's Care Area Assessment (CAA) for falls, revealed the facility identified Resident #9 was at risk for falling related to history of falls both before and after admission. In addition, the facility assessed the resident as always continent. According to the CAA a comprehensive care plan was to be	F 323	3. An inservice was conducted by the Director of Nursing and the Staff Development Director on 5/28 – 5/30/14 for the nurses regarding incident reports for falls, asking the resident the right questions, proper documentation, placing appropriate interventions for each fall and updating the care plan with interventions to prevent future falls. When the root cause of the fall is indentified, care plans will be updated to address that root cause. Nursing will be inserviced on 5/28 – 5/30/14 by Staff Development Director, Director of Nursing and Unit Managers, on bladder assessments and how to monitor a toileting program to ensure compliance with the care plan. All current residents at risk for falls will be reassessed to ensure if an additional bladder assessments or an individualized toileting program is in order to prevent future falls. If the root cause is related to toileting, a bowel and bladder assessment will be completed for 3 days to establish a pattern.		



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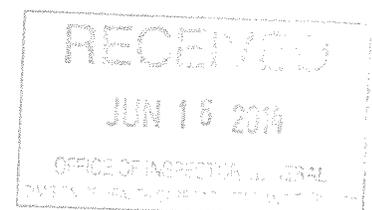
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F 323	<p>Continued From page 41</p> <p>initiated by the Interdisciplinary Team (IDT) to address falls risk management.</p> <p>Review of the resident's comprehensive plan of care revealed a fall care plan was not developed. However, an initial care plan developed on admission, dated 10/14/13, revealed the resident was at risk due to an unsteady gait at times and weakness. The goal was to be no injury and this was to be achieved by: a call light in place; encourage resident to use; assist with mobility and ADLs; place personal items within reach; and a therapy screen. The initial care plan further revealed the resident had a fall on 10/20/13 without injury and staff was to place the resident in a wheelchair for meals and obtain stool samples for C-Diff. The resident sustained another fall on 10/30/13 and received an abrasion to the knee and the staff was to wake the resident at 3:30 AM to toilet. The resident fell on 11/16/13 without injury and staff was to start a toileting plan upon rising, before and after meals and at bedtime. In addition, the resident fell on 12/13/13 without injury and staff was to place the walker in reach.</p> <p>Review of Resident #9's Toileting Plan Monthly Progress Note, dated 12/11/13 through 05/08/14, revealed the first month assessment indicated Resident #9 would need to be toileted every hour. The Progress Note, revealed Resident #9 had increased falls related to going to the bathroom unassisted and was to begin a toileting plan.</p> <p>Record review revealed Resident #9 sustained six (6) falls from 01/04/14 through 01/16/14. Five (5) of the six (6) falls occurred when Resident #9 was going to or coming back from the bathroom.</p>	F 323	<p>Once a pattern is established, a care plan will be added to toilet the resident at specific times. The nurses and C.N.A.s will sign the shift assignment sheet stating they provided care per the care plan.</p> <p>4. Weekly, the Administrator and the Director of Nursing will look at specific residents who have fallen 2 or more times during the week to discuss and review the interventions implemented to prevent future falls. Monthly, our Standards of Care committee will review all residents with 2 or more falls in a month to ensure appropriate and effective interventions have been implemented. The Director of Nursing will present a report to the QA committee, quarterly, to discuss results and make suggestions for future efforts.</p>	6/21/14



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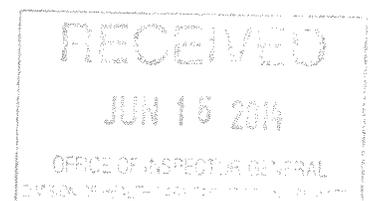
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F 323	<p>Continued From page 42</p> <p>Review of the facility's investigation Fall Circumstance Form for Resident #9, event date 01/04/14 at 2:04 PM, revealed Resident #9 had a fall in his/her room. Staff documented Resident #9 attempted an unwitnessed self transfer to the walker to use the rest room. At the time of the fall Resident #9 was wet and assessed by staff with no injury. Per the form the resident had last been toileted at 9:00 AM. Review of the Certified Nursing Assistant plan of care, dated 03/26/14, revealed the staff was to toilet the resident at 1:00 PM, 2:00 PM, 3:00 PM and 4:00 PM. The Fall Circumstance form continued to indicate Resident #9 had a history of falls in the past three (3) months and required assistance to transfer and ambulate safely. The facility determined the root cause analysis was the resident had reported increased weakness in legs at the time of the fall. A new intervention was staff would speak with therapy regarding plans to transfer. The Interdisciplinary Team (IDT) summary stated to place a sign on the walker telling the resident to put shoes on before walking and gripper strips on the floor. Therapy was already seeing resident under Part B. There was no evidence the facility reassessed the resident for a toileting program</p> <p>Review of facility's investigation Fall Circumstance Form, event date 01/05/14 at 4:50 AM, revealed Resident #9 had an unwitnessed fall in his/her room when he/she stumbled coming back from the bathroom. The resident was last toileted at 2:00 AM. He/she was found sitting on his/her bottom leaning against the wheelchair. At the time of the fall Resident #9 was found to be clean and dry. The form continued to reveal Resident #9 had been encouraged to call for standby assistance to ambulate, but Resident #9 felt he/she had to go to the bathroom right away.</p>	F 323			



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F 323	<p>Continued From page 43</p> <p>No injuries were observed at the time of fall. The facility determined the root cause analysis was an unsteady gait, weak and urgency of urine. A new intervention was to strongly encourage the resident to call for assistance and allow staff to stand by to prevent falls and the staff was to obtain an urine specimen for a urinalysis. There was no evidence the facility reassessed the resident for a toileting program.</p> <p>Review of the facility's investigation Fall Circumstance Form, event date 01/05/14 at 12:34 PM, revealed Resident #9 had an unwitnessed fall in his/her room. Resident #9 had slipped in urine and fell on his/her way to the bath room. Resident #9 was found on his/her buttocks sitting at a ninety (90) degree angle by the bathroom. Per the form the resident was last toileted at 10:00 AM. The resident was assessed with no injuries identified. The facility determined the root cause analysis was the resident attempted to self transfer and slipped in urine. There was no new intervention identified on the form. The IDT summary on the Fall Circumstance form stated therapy was to assess the walker for appropriateness. There was no evidence the facility reassessed the resident for a toileting program.</p> <p>Review of the facility's investigation Fall Circumstance Form, event date 01/14/14 at 2:35 PM, revealed Resident #9 was trying to self transfer to the toilet and slid to the floor on his/her bottom unwitnessed. Resident #9 was observed to be clean and dry. The form indicated the resident was last toileted at 1:00 PM. Review of the CNA plan of care revealed the resident was to be toileted at 1:00 PM, 2:00 PM, 3:00 PM and 4:00 PM. The staff assessed the resident with no</p>	F 323			



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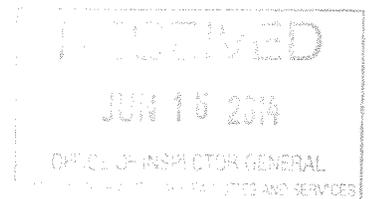
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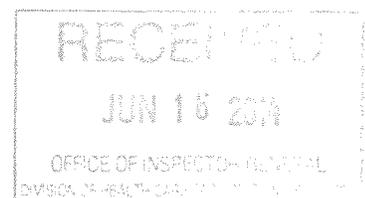
F 323	<p>Continued From page 44</p> <p>injuries. The facility determined the root cause analysis was the resident did not ask for assistance when transferring to the restroom and lost balance. The new intervention was for staff to assist the resident when ambulating to the bathroom. The IDT summary stated the staff was to ask the resident to stand one (1) to two (2) minutes before transfers. There was no evidence the facility reassessed the resident for a toileting program.</p> <p>Review of Resident #9's Fall Circumstance Form, event date 01/16/14 at 3:20 PM, revealed Resident #9 was observed on his/her bilateral buttocks beside his/her bed and the fall was unwitnessed. The resident was last toileted at 3:00 PM and there were no injuries identified. The root cause analysis was determined to be the resident's move to another room on 01/14/14 and the resident was adjusting to the new room. The new intervention was to allow the resident to adjust to the new room. The IDT summary stated to see other page which stated to see new fall report. However, there was no new information on the fall report. There was no evidence the facility reassessed the resident for a toileting program.</p> <p>Review of Resident #9's Fall Circumstance Form, event date 01/16/14 at 9:45 PM, revealed Resident #9 was observed on the floor with his/her head on the bedside table and was assessed without injury. The fall was unwitnessed. Resident #9 stated he/she was returning from the bathroom and fell. Per the Fall Circumstance Form the resident was last toileted at 9:40 PM; however, review of the Resident Level of Control and Bladder Function form dated 01/16/14, revealed Resident #9 was toileted at</p>	F 323		
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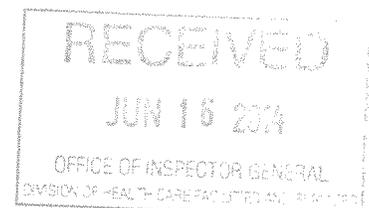
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F 323	<p>Continued From page 45</p> <p>10:25 AM and 5:01 PM. The facility determined the root cause analysis was suspect altered depth perception from recent cataract surgery. The new intervention and IDT summary revealed a new appointment would be made to follow up on vision. There was no evidence the facility reassessed the resident for a toileting program.</p> <p>Review of Resident #9's Progress Note, revealed on 01/16/14 at 9:45 PM, the nurse was called into the room by the CNA. Resident #9 was observed in a supine position beside the bed with his/her head resting on the corner of the bedside table. Resident #9 was observed with copious amounts of blood on the floor from a laceration on the back of his/her head. The nurse was unable to determine the length and depth due to the bleeding. A cool compress was applied. The resident did not have any complaints of pain and neurological checks were within normal limits. The physician was notified and authorized Resident #9 be sent to the Emergency Room for treatment and evaluation.</p> <p>Review of Resident #9's Emergency Room Summary, dated 01/16/14, revealed Resident #9 had obtained a mechanical fall (that means the resident had slipped, tripped or lost balance) which resulted in a laceration to the scalp.</p> <p>Interview with CNA #5, on 05/08/14 at 2:17 PM, revealed she remembered taking care of Resident #9 on 01/16/14 and found Resident #9 around 9:45 PM screaming for help. CNA #5 stated she went into Resident #9's room and then retrieved the nurse. Resident #9 was lying with his/her head facing the door, and was observed to have hit his/her head on the bottom of the bedside table. There was a lot of blood observed</p>	F 323			



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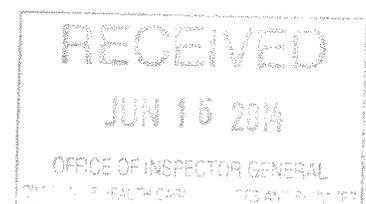
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185305</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/08/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SPRINGHURST HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241</b>		
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F 323	<p>Continued From page 46</p> <p>on the floor. She could not remember toileting the resident before the fall. CNA #5 stated she could not remember if Resident #9 was on a toileting program back in January.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 05/08/14 at 2:00 PM and 5:29 PM, revealed she remembered Resident #9 had two falls on 01/16/14. LPN #6 stated Resident #9 had a fall around 4:09 PM in which he/she did not sustain any injuries and another fall at 9:45 PM in which Resident #9 needed staples. Per LPN #6, Resident #9 received three (3) staples due to the laceration. Resident #9 could walk around in his/her room and could also get up by him/herself. LPN #6 stated she remembered Resident #9 was not on an hourly toileting program during this time period. LPN #6 stated Resident #9 was dry and returning from the bathroom unassisted when he/she fell. She could not recall if she asked CNA #5 about assisting Resident #9 to the bathroom. LPN #6 stated she knew she did not assist Resident #9 to the bathroom before the fall.</p> <p>Interview with the South Unit Manager, on 05/08/14 at 4:50 PM, revealed to her knowledge Resident #9 was a one (1) assist to the bathroom. The South Unit Manager stated she remembered there was a time in the middle of the night that Resident #9 was toileted hourly back in January 2014; however, there was no documented evidence to validate the staff toileted Resident #9 every hour. Resident #9 was able to ambulate on his/her own to and from the bathroom. However, review of the initial care plan, dated 10/14/13, revealed the staff was to assist the resident with transfers as needed. The South Unit Manager stated she "could talk to Resident #9 a thousand</p>	F 323			



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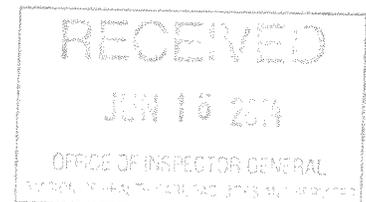
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F 323	<p>Continued From page 47</p> <p>times and the resident would do his/her own thing". The Unit Manager stated when the fall on 01/16/14 occurred she thought Resident #9 was having difficulties with depth perception because of his/her prior cataract surgery. The UM further stated she was not thinking of toileting as potential cause of the falls, though Resident #9 had multiple falls related to going to the bathroom. The South Unit Manager stated when she looked at the bowel and bladder assessment form she was looking for patterns, and Resident #9 should of had a new assessment completed to see if there was a new pattern to the resident's toileting. The South Unit Manager stated a lot of Resident #9's falls were from him/her going to and coming from the bathroom.</p> <p>Interview with the Director of Nursing (DON), on 05/08/14 at 3:51 PM, revealed when there was an accident the nurses were to fill out an event form and the next morning or Monday she would go over the falls in the morning meeting. When discussing falls she checked to see if there was a care plan. The DON stated she could not remember why Resident #9 did not have a plan of care. The DON stated she had "educated and educated Resident #9 about falls, but Resident #9 did what he/she wanted to do". Review of the initial care plan, dated 10/14/13, and the Comprehensive Care Plan, dated 01/16/14, did not reveal any reference to resident education. The DON stated the resident's falls had diminished in the last few months. Further interview with the DON, on 05/08/14 at 5:56 PM, revealed the DON felt she had done everything that needed to be done for Resident #9, though she could not ensure the staff was toileting Resident #9 as planned or that Resident #9 had a comprehensive care plan before the fall.</p>	F 323			



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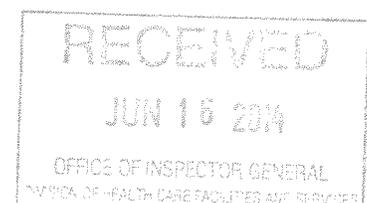
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F 323	Continued From page 48  Further interview with the DON, on 05/08/14 at 5:56 PM, revealed staff chart by exception, which meant the nursing staff charted if there were any bowel and bladder accidents, and not if the resident was continent.  Interview with the Administrator, on 05/08/14 at 6:30 PM, revealed they talked about falls on a daily basis. Resident #9 had a lot of falls and they all involved the bladder. He stated he was not aware staff was not toileting the resident. He further stated he expected the staff to follow the care plan and the care plan could be a problem if not updated.  2. Observation of Resident #6, on 05/05/14 at 7:12 PM, revealed the resident was seated in a wheelchair. The resident was not oriented to person, place, or time.  Review of the clinical record for Resident #6, revealed the facility admitted the resident with diagnoses of Dementia with Behavior Disturbance, Diabetes, Contractures. The facility completed an Annual MDS on 04/15/13 and a Quarterly MDS on 01/13/14 and assessed Resident #6 non-ambulatory and was extensive assistance of two person physical assist for transfers.  Review of the Comprehensive Care Plan for Resident #6, initiated on 04/25/13 revealed the resident had a history of falling related to poor balance and decreased safety awareness. The goal for the resident was to remain free from serious injury. Interventions by the staff included: avoid use of a restraint; equip resident with a device that monitors rising; give resident verbal	F 323			



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F 323	<p>Continued From page 49</p> <p>reminders not to ambulate/transfer without assistance; keep bed in lowest position with brakes locked; keep call light in reach at all times; observe frequently and place in supervised area when out of bed; place resident in a fall prevention program; and provide toileting assistance as needed.</p> <p>Review of the facility's investigative Fall Circumstance Forms for Resident #6, revealed the resident had multiple falls. The facility completed a Fall Risk Assessment on 10/07/13 that determined the resident was disoriented; required the use of assistive devices; was dependent for mobility; no referrals were necessary; and the current care plan would be continued. The facility completed a second Fall Risk Assessment on 01/09/14, which indicated the resident was at risk for falls; had a history of falls; was not on a Falls Prevention Program; and that no referrals were necessary. The facility documented that the current care plan would be continued.</p> <p>Review of the facility's Fall Circumstance Form revealed on 01/17/14 at 7:51 AM, the resident was found sitting on the floor beside the bed and was wet. The fall was unwitnessed. Resident #6 was toileted at 9:30 PM on 01/16/14. The facility determined the root cause of the fall was the resident was uncomfortable due to being soiled, thus attempted to transfer self out of the bed. There was a small one (1) centimeter skin tear on the resident's buttocks. The new intervention was marked not applicable. The IDT summary stated remain free of injury related to fall. There was no evidence the care plan was revised. There was no evidence the facility reassessed the resident for a toileting program.</p>	F 323			



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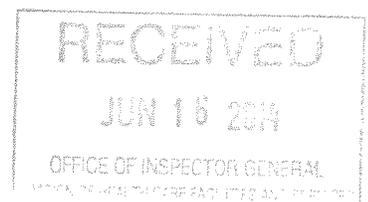
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F 323	Continued From page 50  Review of the facility's investigation Fall Circumstance Form, revealed on 02/09/14 at 4:09 AM, Resident #6 was found sitting on the floor next to the bed and was wet. The fall was unwitnessed and there were no injuries. The resident was last changed at 9:26 PM on 02/08/14. The facility determined there was no injury and the root cause of the fall was documented as the resident slid out of bed. The facility documented that the resident had not sustained a fall in the last three (3) months. The new intervention was continue to monitor. The IDT summary stated continue with current care plan which was no injury from falls. There was no evidence the facility reassessed the resident for a toileting program.  Continued review of the facility's investigation Falls Circumstance Form revealed on 02/17/14 at 2:02 AM, the resident was found sitting on the floor next to the bed and was wet. The last time the resident was checked and changed was 9:00 PM on 02/16/14. The fall was unwitnessed and there were no injuries. The facility determined the root cause of the fall was the resident attempted a self-transfer. The IDT summary stated possibly being awakened by roommate, will bring out of room when awake. The care plan was updated to reflect a fall on 02/16/14 the day before the fall on 02/17/14, the care plan did not reflect a fall on 02/17/14 and there were no interventions dated for 02/16/14 or 02/17/14. There was no evidence the facility reassessed the resident for a toileting program.  Review of the facility's Fall Circumstance Form revealed on 03/18/14 at 3:00 PM, Resident #6 was found on the floor by the bed, wet and soiled.	F 323			

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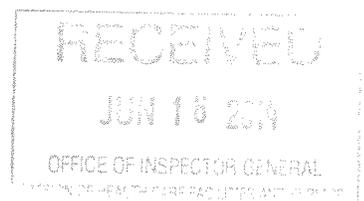
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F 323	<p>Continued From page 51</p> <p>The fall was unwitnessed and there were no injuries. The facility documented the resident was last checked and changed at 1:34 PM. The facility documented the root cause as the resident attempted self-transfer. The care plan was updated to reflect the perimeter mattress was placed on the resident's bed on 03/20/14. The IDT summary concurred with the new intervention. There was no evidence the facility reassessed the resident for a toileting program.</p> <p>Review of the facility's investigative Fall Circumstance Form revealed on 04/06/14 at 4:30 PM, Resident #6 was found on the floor by the side of the bed without any injuries. The facility documented that a staff member sat the resident on the side of the bed, then turned away to get supplies, and the resident fell to the floor. The facility determined the root cause of the fall was the resident attempting self-transfer and staff was to be educated on having supplies ready. The IDT summary revealed staff was to be educated on readiness of supplies before sitting resident on the side of the bed.</p> <p>Review of the Annual MDS assessment completed on 04/14/14, revealed the facility assessed the resident with moderate cognitive impairment with no behaviors. The resident was rarely understood when speaking. The resident was nonambulatory and required extensive assistance of two (2) to transfer from the bed to the chair. The resident was incontinent of bladder.</p> <p>Review of the CAAs of the 04/14/14 MDS for Resident #6, revealed the facility determined the resident was at a high risk for falls and had a history of falls due to transferring self from the</p>	F 323			



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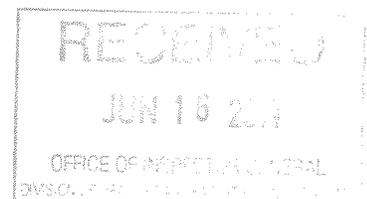
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F 323	Continued From page 52 bed and from the chair. The resident had poor balance, Advanced Dementia and received antidepressant medication. The resident had not experienced any serious injuries from falling. The focus of the care plan would be to prevent serious injury.  Review of the Comprehensive Care Plan revised on 01/10/14, and not on 04/14/14 with the Annual MDS, revealed the use of a lap buddy; verbal reminders not to rise; sensor alarm while in bed; keep the call light in reach; one-fourth (1/4) side rails; keep personal items in reach; place in supervised area when out of bed; do not awaken to change during the night; check every two (2) hours during the night; and toilet as needed. The resident had functional incontinence and required extensive assistance for transfers. The goal for the resident was not to sustain skin breakdown. Interventions included: perineal care after incontinent episodes; and take resident to the bathroom before and after meals, and at bedtime.  Review of the facility's investigative Fall Circumstance Form revealed on 04/27/14 at 8:05 AM, Resident #6 was found on the floor and was wet. The fall was unwitnessed. The facility documented the last time the resident was toileted or changed was 9:00 PM on 04/26/14. The Fall Risk Assessment completed at this time determined the root cause of the fall was restlessness. The resident was agitated and orders were obtained from the physician for a urinalysis. The IDT summary stated to await evaluation and treatment. There was no evidence the facility reassessed the resident for a toileting program.  Interview with CNA #1, on 05/07/14 at 10:35 AM,	F 323			



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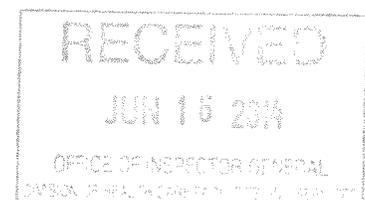
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F 323	<p>Continued From page 53</p> <p>revealed Resident #6 fell frequently and was confused. She stated the resident was incontinent of bladder and tried to get out of bed and toilet self. She stated the resident did not use the call light. She indicated the resident was checked and changed every two hours and she was not aware the resident was on a toileting program. She stated the resident fell mostly from the bed. She stated the resident could injure him/herself from so many falls.</p> <p>Interview with CNA #2, on 05/07/14 at 2:15 PM, revealed Resident #6 usually fell when in the room in bed. She revealed the resident was at risk for falls according to care guide lines provided to staff. She stated the resident tried to self-transfer out of bed and could be injured from falling. She was not aware of any type of toileting program being used for the resident. Continued review of the CNA care plan revealed the resident was to wear pull ups per family request. Continued review of the Comprehensive Care Plan revealed on 03/03/13 the Functional Incontinence Care Plan was updated to include take to bathroom before and after meals, at bedtime and as needed. This was discontinued as resolved on 02/14/14.</p> <p>Interview with LPN #2, on 05/07/14 at 2:45 PM, revealed Resident #6 did fall from bed most of the time. She stated the facility did not like to use alarms and she was not aware of any special safety interventions to prevent the resident from falling from the bed. She stated the resident was placed at the nursing station when out of bed so staff could watch the resident. She stated she had been in-serviced several weeks ago on fall prevention; however, she could not identify how this information was put to use for Resident #6.</p>	F 323			



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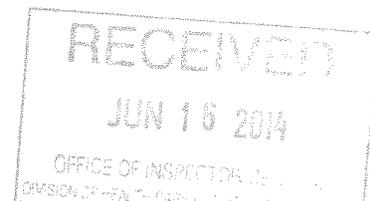
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F 323	<p>Continued From page 54</p> <p>She stated the resident could have a serious injury from frequent falling.</p> <p>Interview with the North Unit Manager, on 05/07/14 at 3:19 PM, revealed Resident #6 did have a history of falls and nothing more could be done to prevent the resident from falling. She could not specifically say how the facility planned to decrease the number of falls for Resident #6. She stated the resident could sustain an injury from any fall.</p> <p>Continued interview with the DON, on 05/08/14 at 2:08 PM, revealed she was aware of the falls for Resident #6 and added the resident had not sustained a serious injury. She indicated that the root causes for the falls of Resident #6 was the resident attempting self-transfers. She stated the resident did have a significant cognitive impairment and might not retain staff instructions to use the call light. She was not aware the resident was incontinent when found after a fall five (5) out of six (6) times or that all the falls occurred while the resident was in bed. The DON could not verbalize how this information was missed when reviewed on a daily basis.</p> <p>Continued interview with LPN #2, on 05/07/14 at 2:45 PM, revealed the facility tried to prevent injuries from falls and not the falls themselves.</p> <p>Continued interview with the North Unit Manager, on 05/07/14 at 3:19 PM, revealed the facility focused on preventing injuries from falls. She stated if a resident fell and was uninjured, there was no concern.</p> <p>Continued interview with the DON, on 05/08/14 at 2:08 PM, revealed the facility's fall rate had</p>	F 323			



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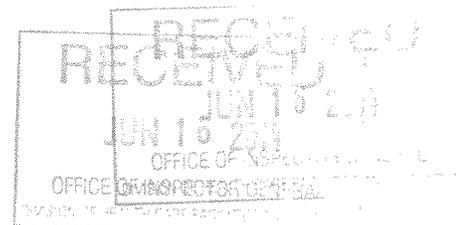
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F 323	Continued From page 55 declined in the last quarter. She indicated the facility met each week day morning to review any falls. She stated falls were impossible to prevent and she had not trended the falls for Resident #6. She stated she did not know what else the facility could do to increase the safety of the resident and prevent further falls.  Interview with the Administrator, on 05/08/14 at 6:30 PM, revealed he attended the morning meetings and the staff talked about falls at that time Monday through Friday. The Administrator stated the DON was tracking falls each shift and went line by line through the event reports. The Administrator stated that he was responsible to ensure residents were safe.	F 323			
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	1. No resident was cited as having been affected by this deficient practice.  2. All residents could be affected by this deficient practice.  3. All Med Carts and Pill Crushers were cleaned by Staff Development Director on 5/12/14. All med carts will be cleaned weekly and PRN by the night medication nurse. All nurses and certified medication technicians were educated buy the Director of Nursing and the Staff Development Director on 5/22 - 5/28/14 regarding the cleaning schedule for the medication carts, pill crushers and refrigerators.		



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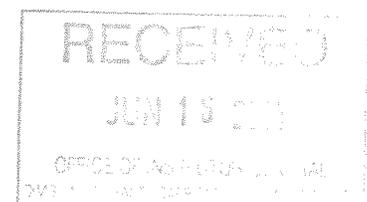
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F 431	Continued From page 56 controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure medications were stored and dispensed in a sanitary manner. Four (4) of four (4) medication/treatment carts were soiled on the inside and four (4) of four (4) pill crushers on each cart were soiled.  The findings include:  Interview with the Director of Nursing, on 05/08/14 at 6:20 PM, revealed the facility had no policy for cleaning the medication carts and the pill crushers.  Observation of the medication cart on the Northwest Unit, on 05/08/14 at 3:10 PM, revealed the pill crusher had black sticky substances and white residue. The inside of the medication cart revealed particles, white, brown and tan in the bottoms of the drawers. The drawer with liquid medications had dried sticky substances in the	F 431	4. Med carts and pill crushers will be checked by the Infection Control Nurse for weekly infection control QA. Finding will be provided to the Director of Nursing, monthly, who will maintain results and provide finding to the quarterly QA committee meeting.	6/13/14	



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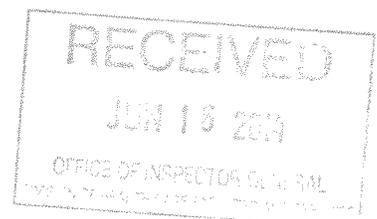
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F 431	<p>Continued From page 57 bottom.</p> <p>Observation of the medication cart on the Northeast Unit, on 05/08/14 at 3:30 PM, revealed the outside of the cart had a tan dried substance spilled down the front. The liquid medication drawer contained a bottle of wound cleaner, and the bottom of the drawer had dried spilled substances. The pill crusher was soiled with a black sticky substance and white powdery particles.</p> <p>Observation of the medication cart on the Southeast Unit, on 05/08/14 at 3:46 PM, revealed the pill crusher was soiled with a black sticky substance and white powdery substances. The inside of the drawer used to hold treatment liquids was heavily soiled with 2X2 guaze pads saturated with Betadine and stuck to the bottom of the drawer. Debris and brown and white particles were present in the bottom of drawers.</p> <p>Observation of the medication cart on the Southwest Unit, on 05/08/14 at 4:05 PM, revealed a soiled pill crusher with black, brown and white dried substances present. The inside of the cart revealed debris and particles of black, white and brown in the bottoms of the drawer.</p> <p>Interviews with Licensed Practical Nurses (LPN) #2, #4, #6 and #8, on 05/08/14 at 3:30 PM, revealed there was no schedule for cleaning the medication carts and staff tried to clean the carts at the end of the shift. They stated sometimes there was not enough time to do this task and no one knew who was responsible for completing thorough cleanings. They stated the medication carts should be clean to prevent the spread of infection.</p>	F 431			



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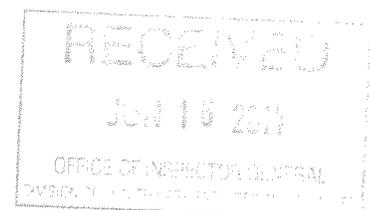
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F 431	Continued From page 58	F 431			
F 441 SS=E	<p>Interview with the Director of Nursing, on 05/08/14 at 4:00 PM, revealed there was no one assigned to ensure the carts were cleaned.</p> <p><b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens</p>	F 441	<p>1. The residents in beds 168-1 and 129 have their oxygen masks and supplies which were in bags immediately removed from the floor and replaced with new supplies. No other residents were identified by the deficient practices.</p> <p>2. All residents could be affected by these deficient practices. All resident's areas were checked for proper storage of oxygen supplies on 5/12/14. No supplies or equipment were found on the floor.</p> <p>3. All nurses were inserviced on 5/28 - 5/30/14 by our Staff Development Director on proper cleaning techniques for stethoscopes and our new policy of not permitting stethoscopes to be worn around the neck. Staff nurses were also taught to look for resident supplies that may have fallen to the floor and to replace supplies when found.</p>		



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F 441	<p>Continued From page 59</p> <p>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 observations, and interviews, it was determined the facility failed to maintain an infection control program as evidenced by one (1) of one (1) resident's oxygen supplies in contact with the floor, three (3) of four (4) staff wearing stethoscopes and blood pressure equipment around their necks and two (2) of eleven (11) food trays delivered to residents' rooms then brought out and placed back on carts with trays that had not yet been delivered.</p> <p>The findings include:</p> <p>The facility did not provide policies for handling oxygen equipment, delivering food trays or sanitary use of communal stethoscopes and blood pressure equipment.</p> <p>Observation of the breakfast tray delivery, on 05/07/14 at 7:21 AM, revealed Dietary Aide (DA) #1 delivered a meal tray to a resident in Room 146. She returned to the hallway and asked where the resident was and was told the resident was in the hospital. She returned to the room and brought the tray out and placed it back on the cart with other trays not yet delivered. At 7:28 AM, she was observed delivering a tray to Room 120. A staff member told DA #1 to go get the tray as the resident was still sleeping and would eat later. DA #1 retrieved the tray and placed it back on the cart with trays not yet served.</p>	F 441	<p>CNAs and dietary workers will be re-inserviced on 6/9 – 6/13/14 by our Staff Development Director regarding the importance of knowing which carts to use when returning trays from a resident's room even if the tray was not touched.</p> <p>4. The Director of Nursing, Staff Development Director, and Unit Managers will daily observe staff nurses for proper stethoscope cleaning and will weekly do a round to check for resident supplies in resident rooms to ensure proper storage. The Dietary Manager will observe one meal by bi-weekly for three months to ensure staff understands infection control procedures at meal times. All finding will be added to their existing QA report and will be presented, quarterly, to the QA committee for analysis.</p>	6/13/14	



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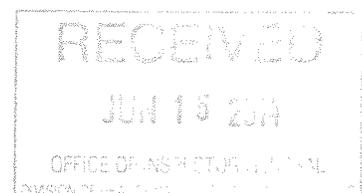
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F 441	<p>Continued From page 60</p> <p>Interview with DA #1, on 05/07/14 at 7:28 AM, revealed she had been trained on infection control and not to worry as new trays would be delivered. She stated she was not trained to understand how the practice was an infection control issue. She stated she understood after a staff member explained how bacteria could be spread by the cross contamination.</p> <p>Interview with CNA # 2, on 05/07/14 at 7:30 AM, revealed trays delivered and placed on resident furniture could not be returned to the cart if there were still trays to be delivered. She stated germs could be spread to other residents that could cause illness.</p> <p>2. Observation of Room 168-1, on 05/07/14 at 11:21 AM and 3:10 PM, revealed the oxygen mask for the minineb machine in a plastic bag was lying directly on the floor.</p> <p>Observation of Room 129, on 05/07/14 at 11:26 AM and 2:15 PM, revealed the oxygen tubing for the minineb in contact with the floor and the plastic bag of oxygen supplies was on the floor.</p> <p>Observations of Licensed Practical Nurses (LPN) #1, #4, #6, #8, on 05/6/14 at 11:30 AM and on 05/07/14 at 10:00 AM, revealed they were wearing their stethoscopes around their necks.</p> <p>Observation of LPN #4, on 05/07/14 at 9:20 AM, revealed the nurse wearing a stethoscope around her neck. She was observed to take a resident's blood pressure, sanitizing the bell afterward, then replaced the stethoscope back around her neck.</p> <p>Observation of LPN #1, on 05/07/14 at 11:00 AM,</p>	F 441		

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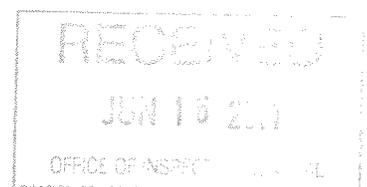
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F 441	Continued From page 61 revealed the nurse, with stethoscope around the neck, did blood pressure testing prior to administration of a medication. The nurse sanitized the bell of the stethoscope then replaced the stethoscope back around his neck.  Interviews with LPNs #1, #4, #6 and #8, on 05/07/14 at 3:30 PM, revealed the facility had not provided the staff with training regarding the sanitizing of nursing equipment used for residents. They stated they sanitized the bell of the stethoscope; however, they did not think about the tubing or the possible transmission of bacteria from their neck to the resident or from the resident to them. They indicated the tubing should be sanitized.  Interview with the Unit Manager, on 05/08/14 at 1:22 PM, revealed delivered meal trays placed in a residents rooms could not be placed back on the cart with meal trays not yet delivered. She further stated she had not been trained to sanitize stethoscope tubing between residents; however, she agreed bacteria could be transferred to a resident. Additionally, she stated resident oxygen supplies could not be in contact with the floor related to contamination of the supplies with bacteria.	F 441			
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced	F 465	1. Bedside tables in rooms 147 and 148 were immediately removed.  2. All residents could be affected by the deficient practices.		



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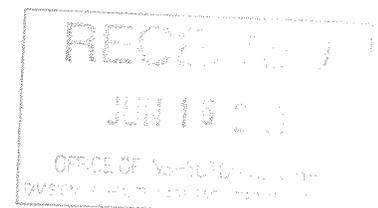
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F 465	Continued From page 62 by: Based on observation, interview, and review of the facility's policies and monthly maintenance task sheet, it was determined the facility failed to provide a safe tile floor in one (1) of one kitchen dish rooms, in addition two bedside tables on one (1) of four (4) units were observed cracked and broken and one (1) of one (1) cabinets in the main dining room was found to be in disrepair.  The findings include:  Review of the facility's policy regarding Preventative Maintenance (PM) and Inspections, not dated, revealed a preventative maintenance program had been implemented to promote the maintenance of equipment in a state of good repair and condition. Routine inspections promote safety throughout the facility and aid in keeping equipment in working order and operating in accordance with manufacturer guidelines. The PM included tests, measurements, adjustments, and parts replacement that were performed specifically to prevent faults from occurring. The PM Scheduling calendar could be daily, weekly, monthly or on an annual basis.  Review of the facility's PM monthly task sheets that were completed for 01/13/14, 02/10/14, 03/17/14, and 04/21/14 revealed they included: inspection of smoke detectors; resident room doors; toilets and sinks; climate control units; electric outlets; and electric beds.  1. Observation during the sanitation tour of the facility kitchen on 05/08/14 revealed the dish room tile floor had holes in the grout line and when walked upon water bubbled up in-between	F 465	3. The cabinet in the dining room and the two bedside tables were immediately removed. The floor in the kitchen was repaired on 5-27-14. All furniture will be checked quarterly by maintenance and a report given to the Administrator who will log receipt of said reports. The Director of Maintenance was instructed to include the Dining Room and the Activity Room on his monthly inspection task sheet. The director of maintenance was counseled on 5/10/14 regarding the need to let the administrator know if a reported repair will take more than a couple of days to complete. Staff will continue to use work orders for repairs needed between inspections. The Administrator will make a thorough inspection of all furnishing throughout the facility and repair or remove items that are in need of repair by 6/20/14.		



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F 465	<p>Continued From page 63</p> <p>the tiles. When the weight of a person was removed from the floor the water would seep back under the tiles.</p> <p>Interview, on 05/08/14 at 10:00 AM, with the Dietary Manager (DM) revealed the kitchen dish room tile floor was cracked and a work order was completed on 04/25/14.</p> <p>Review of a repair requisition slip, dated 04/25/14, revealed the DM identified and reported the need for repair of the dish room floor to the Maintenance Director. The Maintenance Director noted water under the flooring with loose tiles and placed a call to the flooring contractor the next day.</p> <p>Interview, on 05/08/14 at 11:45 AM, with the Maintenance Director revealed when he was received the work order slip he placed a call to the flooring contractor on 04/26/14. The Maintenance Director stated he did not get an appointment scheduled at the time he made the call nor had the flooring contractor called back to set a scheduled time to evaluate the dish room floor. The Maintenance Director also revealed he had not called the flooring vendor back to follow up nor had he called another flooring contractor to evaluate the kitchen dish room floor, but should have. The Maintenance Director stated the kitchen dish room tile floor was not sealed, stayed wet and could grow mold, which could affect the whole facility.</p> <p>Interview, on 05/08/14 at 11:53 AM to 12:10 PM, with the Administrator revealed another flooring vendor should be called if the current vendor had not been out to evaluate the dish room floor after two weeks. He further stated the flooring</p>	F 465	4. The Administrator will make monthly rounds to inspect furniture and the general repair of the building to be assured that the quarterly checks of furniture and the monthly rounds, made by maintenance, are sufficient. The Administrator will report finding, quarterly, to the QA committee.	6/21/14	



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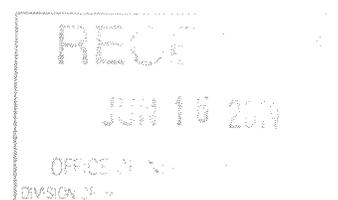
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F 465	<p>Continued From page 64</p> <p>contractor called by the Maintenance Director was used in the past to do some tile work in some of the facility bathrooms and he was unhappy about how long the job took to complete. The Administrator stated the kitchen dish room tile floor could not be sealed if standing water beneath the tiles bubbled up when walked on and this was a concern.</p> <p>2. Review of the facility's policy regarding Space and Equipment, not dated, revealed each facility resident would be provided with functional furniture appropriate to their needs.</p> <p>The Administrator stated they had no specific policy for repairs and replacement of resident furniture from Central Supply who manages the resident's furniture.</p> <p>Observation during the environmental tour, on 05/08/14 at 9:00 AM to 9:30 AM, revealed on the North Hall, two (2) bedside tables in rooms 147 and 148 which were cracked and rough to the touch.</p> <p>Interview with the Director of Maintenance, on 05/08/14 at 9:40 AM, revealed Central Supply was responsible for the bedside tables and for replacing and repairing them.</p> <p>Interview with Central Supply, on 05/08/14 at 10:00 AM, revealed he checked and replaced bedside tables quarterly. He stated that he just recently completed his quarterly inspection on 05/07/14 and his plans were to replace all the bedside tables in the facility with plastic bedside tables. He stated the order for the bedside tables had not been placed yet. He stated that he did not</p>	F 465		

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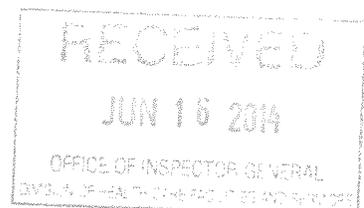
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185305</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/08/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SPRINGHURST HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241</b>		
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F 465	<p>Continued From page 65</p> <p>have a log for his quarterly inspections and he did not write down items that needed to be repaired or replaced. He stated he just remembered the items in his head.</p> <p>Interview with the Administrator, on 05/08/14 at 10:05 AM, revealed that he was not aware two (2) bedside tables in room 147 and 148, were cracked and rough to the touch. The Administrator stated he was not aware Central Supply did not keep any records of repairs and replacements; however he did not require Central Supply to do so. The Administrator stated he did expect staff to inform Maintenance and Central Supply of any damaged furniture by completing a work order.</p> <p>3. Observation during the lunch meal, on 05/08/14 at 11:00 AM to 1:00 PM, revealed a broken cabinet door in the main dining room.</p> <p>Interview with CNA #4, on 05/07/14 at 12:15 PM, revealed the cabinet mounted to the wall in the dining room had been broken for over a month. She stated the door was broken off of the hinges and hanging loosely.</p> <p>Interview with the Maintenance Director, on 05/08/14 at 9:40 AM, revealed he removed the broken cabinet from the dining room and disposed of it. He stated an aide reported the broken cabinet to him verbally in the hallway after lunch on 05/07/14 and the cabinet was immediately removed. He stated he had no knowledge of the broken cabinet nor did he receive a work order for the broken cabinet. The Maintenance Director stated the staff were to complete a work order when something needed</p>	F 465			



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F 465	Continued From page 66 replaced or repaired. The Maintenance Director stated the activities room and dining room were not on his monthly inspection task sheet for the maintenance crew to inspect.  Interview with the Administrator, on 05/08/14 at 10:05 AM, revealed he was not aware of the broken cabinet in the dining room and had not been in the dining room in the past month. He stated the Maintenance Director informed him about the broken cabinet on 05/07/14 after it was removed from the dining room wall. The Administrator further stated it was the responsibility of all facility staff to notify Maintenance with work orders when they came across situations that needed replacement or repairs.	F 465			



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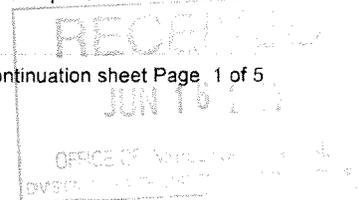
NAME OF PROVIDER OR SUPPLIER  <b>SPRINGHURST HEALTH AND REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1978, 1990</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/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 standard Life Safety Code Survey was conducted on 05/06/14. 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 Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Leslie J. Butterfield</i>	TITLE  <i>Administrator</i>	(X6) DATE  <i>6/12/14</i>
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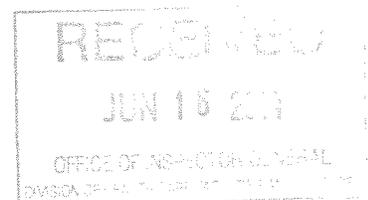
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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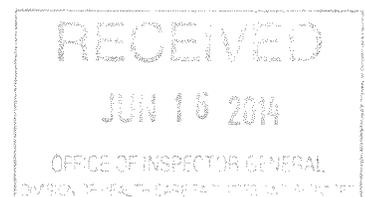
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K 000	Continued From page 1 Fire)  Deficiencies were cited with the highest deficiency identified at F level. CFR: 42 CFR 483.70(a)	K 000			
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the six (6) smoke compartments, residents, staff, and visitors. The facility has ninety (90) certified beds and the census was sixty-eight (68) on the day of the survey.  The findings include:  Record review, on 5/06/14 at 2:19 PM, with the Maintenance Supervisor revealed the facility had no documentation of fire drills being conducted	K 050	1. No residents were harmed by the deficient practice.  2. All residents have the potential to be affected by the deficient practice.  3. The Administrator and the Director of Maintenance met immediately after the survey team exited. The Maintenance Director understands that he is required to maintain records for three years and to be safe he will maintain records for at least 5 years. The Maintenance Director will bring the fire drill documentation to the administrator's office after each fire drill. The administrator will document the fire drill in a log to ensure drills have been conducted timely and that all monthly drills are present.  4. The Administrator will present a report of compliance, quarterly, to the QA Committee as a standard part of his report to the committee.	6/06/14	



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K 050	<p>Continued From page 2</p> <p>during the first, second and third shifts in the second and third quarters of 2013. Fire drills are required to be conducted, at a minimum of one (1) per shift, per quarter of the year.</p> <p>Interview, on 05/06/14 at 2:21 PM, with the Maintenance Supervisor revealed he had conducted the fire drill during the first, second and third shifts in the second and third quarters of 2013. He indicated he may have inadvertently discarded some records while purging his files. Facility records are required to be kept for a minimum three (3) year period.</p> <p>The census of sixty-eight (68) was verified by the Administrator on 05/06/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/06/14.</p> <p>Reference: NFPA 101 Life Safety Code (2000 Edition)</p> <p>19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p>	K 050		
K 076 SS=E	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p>	K 076	<p>1. No residents were harmed by the deficient practice. All empty cylinders were immediately placed in the rack for empty cylinders.</p> <p>2. All residents have the potential to be affected by the deficient practice.</p>	



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K 076	<p>Continued From page 3</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the six (6) smoke compartments, residents, staff and visitors. The facility has ninety (90) certified beds and the census was sixty-eight (68) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/06/14 at 12:40 PM, with the Maintenance Supervisor revealed nine (9) oxygen cylinders located within the oxygen storage room, were not placed in a rack to prevent falling or being knocked over and not clearly separated as empty or full cylinders.</p> <p>Interview, on 05/06/14 at 12:42 PM, with the Maintenance Supervisor revealed he was unaware of oxygen cylinders being improperly stored and acknowledged the potential hazard involved.</p> <p>Further interview, on 05/06/14 at 12:45 PM, with the South Wing Unit Manager, where the oxygen storage room was located, acknowledged the</p>	K 076	<p>Continued from the previous page</p> <p>3. Nurses are to be re-inserviced by the Staff Development Director during the week of 6/9 – 6/13/14. Signs will be place on the racks to identify the rack with full cylinders and the rack with empty cylinders by 6/6/14.</p> <p>4. The Administrator will check the oxygen closet weekly for 3 months and then monthly ongoing. He will record his finding in a log and will provide finding, quarterly, to the QA committee.</p>	6/13/14



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K 076	<p>Continued From page 4</p> <p>cylinders racks provided were full and should not have been placed in the room in an unapproved manner.</p> <p>The census of sixty-eight (68) was verified by the Administrator on 05/06/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/06/14.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>4-3.1.1.2 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use.</p> <p>4-3.5.2.2 2. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly.</p> <p>4-5.1.1.1 Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over.</p>	K 076		

