

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

PRINTED: 03/17/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185335</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/27/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1120 CRISTLAND ROAD LOUISVILLE, KY 40214</b>
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F 000	INITIAL COMMENTS  Amended 03/17/15	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum	F 272	F 272  Resident #5: Resident discharged on 3/9/15. He is not expected to return to this facility.  All active Residents with Comprehensive Assessments and CAAs completed have the potential to be impacted by the deficient practice. These active Resident's most recent CAAs will be audited, reviewed and revised as needed by 4/1/15 by the IDT, including DON, ADONs, MDS Coordinators, Quality of life, SSD, and RD to ensure that they meet the RAI requirements for comprehensive, accurate,	4-2-15

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>X Kara Mendenhall</i>	TITLE  <i>X Administrator</i>	(X6) DATE  <i>X 4-1-15</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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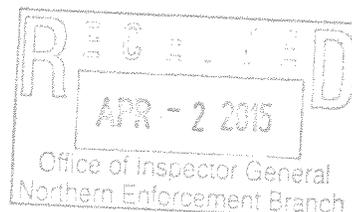
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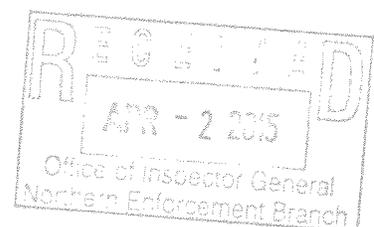
F 272	Continued From page 1 Data Set (MDS); and Documentation of participation in assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to further evaluate areas of concern that triggered during the resident assessment for one (1) of twenty (20) sampled residents (Resident #5). The facility determined Resident #5 could improve with some Activities of Daily Living (ADLs); however, the MDS process failed to determine what those ADLs were or how the staff would assist the resident in attaining increased ability in ADLs.  The findings include:  Interview with the Director of Nursing, on 02/27/15 at 2:00 PM, revealed the facility followed the Resident Assessment Instrument for completing the Minimum Data Set (MDS) and the Care Area Assessment (CAA).  Review of Resident #5's clinical record revealed the facility admitted the resident with diagnoses of Aphasia, Cerebral Vascular Accident with Left Hemiplegia, Aphonia, Cancer of the Throat with Metastasis, and Tracheotomy. The Physician orders dated 11/07/14 revealed the resident had extensive tissue dissections from the throat and neck for the cancer which resulted in a blow-out	F 272	F 272  standardized reproducible assessment of each resident's functional capacity. If Resident is identified to need a significant change in status assessment, it will be scheduled.  Training completed on 3/19/15 by the Director of Clinical Reimbursement with all IDT members who are assigned to complete CAAs, This includes, MDS Coordinators, RD, SSD, and Quality of Life Director. Training consisted of Chapter 4 of the RAI manual related to Care Area Assessment (CAA) process and care planning. Further training on CAAs, Care plan development, and Line by Line coding has been made available to the same IDT members through the American Association of Nurse Assessment Coordinators website.  Clinical Reimbursement Consultant will audit 10% of active Resident's CAA's three times a year to ensure continued compliance with plan of correction and RAI requirements. The results of these audits will be reviewed in facility's QAPI meeting for three audits or one full year for recommendations and further follow up as indicated.	
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F 272	<p>Continued From page 2 of the right carotid artery. The resident had a tracheotomy with a mask for oxygen.</p> <p>Review of the admission MDS assessment, dated 11/11/14, revealed the facility assessed Resident #5 with severely impaired cognition through the Brief Interview for Mental Status (BIMS) with a score of three (3). The facility further assessed the resident to require total care with transfers, dressing, hygiene, nutrition, was nonambulatory and frequently incontinent of bowel and bladder. The resident had aphasia and aphonia which caused the resident to be totally mute. Documentation was noted to show the facility and Resident #5 felt the resident was capable of gaining some independence in activities of daily living.</p> <p>Review of the CAAs for Resident #5, revealed the facility did not further assess the deficit in performance of Activities of Daily Living to determine a plan to improve the resident's performance, although the MDS data identified the facility and the resident felt the resident was capable of assisting more with care. There was no evidence in the CAAs to determine which skills could improve. In addition, the CAAs did not contain information regarding the level of assistance the resident required and how that assistance could or would be provided. The resident was non-compliant with turning and repositioning in bed; however, there was no further assessment in the CAA to determine how the facility could address this non-compliance. In addition, the CAAs did not address any further assessment of activities in order to determine what activities the resident enjoyed or would participate in.</p>	F 272			



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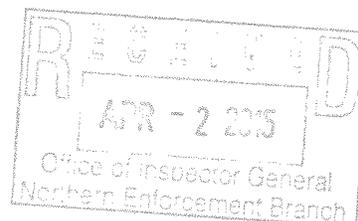
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F 272	<p>Continued From page 3</p> <p>Observation of Resident #5, on 02/27/15 at 3:06 PM, revealed the resident was in bed with the head elevated 30 degrees. The resident's eyes were closed, the call light was in reach, and an oxygen mask covered the resident's tracheotomy. A tube feeding was in place and infusing at 60 cc/hr. The resident had a number of healed and healing incisions across the right shoulder extending from behind the shoulder to the front of the shoulder. The resident was wearing a brief with a small part of a sheet covering the groin area. A wheelchair was noted in the room.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 02/25/15, revealed Resident #5 was able to get out of bed for short periods of time, but was resistive. She stated she thought the resident needed a lot of encouragement to get up into a wheelchair. She stated she was not sure of the last time she saw the resident out of the bed in a wheelchair. She indicated the resident was offered to be turned; however, the resident refused. She stated she was not aware of any plan or agreement with the resident to be out of bed. In addition, she was not able to relate a plan to increase the resident's skills for dressing and bathing. She stated there were no instructions on the care plan for assisting the resident to regain lost skills.</p> <p>Interview with CNA #5, on 02/26/15 at 9:40 AM, revealed Resident #5 resisted turning and repositioning. She stated the nurses had not given any instructions about what to do when the resident refused. She stated she left the resident and would come back later to try again. She stated she could not recall when she had last seen the resident turned to either side. In addition, she stated there was nothing on the</p>	F 272		



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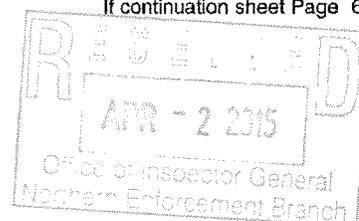
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F 272	Continued From page 4 nurse aide care plan instructing staff to have the resident assist with bathing or dressing.  Interview with MDS Nurse #1, on 02/26/15 at 10:14 AM, revealed the CAAs for Resident #5 did not identify the need to improve the resident's skills with dressing or bathing. She stated the CAAs were to include further assessment of triggered areas so as to determine causes and resolve as much as possible.  Interview with the Administrator, on 02/26/15 at 2:08 PM, revealed she supervised the MDS Coordinators. She stated she would have to review the clinical records; however, information should be collected in order for the individual residents to have a care plan specific to them.	F 272			
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	F 279	F 279  Resident #5 Resident discharged on 3/9/15. He is not expected to return to this facility.  Resident #6 Comprehensive Care plan was developed on 3-8-2015 by the IDT to ensure it meets RAI requirements of a comprehensive care plan that includes measurable objectives and timetables to meet his medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment. Care plan was	4-2-15	



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F 279	<p>Continued From page 5</p> <p>§483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and the facility's policy, it was determined the facility failed to develop and initiate a care plan for two (2) of twenty (20) sampled residents, (Resident #5 and #6). The facility failed to develop a comprehensive care plan for Resident #5 to address task segmentation, activities, prevention of skin breakdown, and getting out bed. In addition, the facility failed to initiate an admission care plan for Resident #6 to prevent falls.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care Planning, not dated, revealed an admission care plan would be initiated to address resident needs until a comprehensive care plan was developed. A comprehensive care plan would be developed within 21 days.</p> <p>1. Observation of Resident #5, on 02/24/15 at 11:10 AM, revealed the resident was in bed with the head of the bed elevated. The resident wore an adult brief and the groin area was partially covered with a sheet. Oxygen tubing with a tracheotomy mask was on the floor. The resident had scarring around the throat, neck and right shoulder and a gastric tube was in place. The resident was nonverbal. The resident did not move the left arm and leg. A wheelchair with a high back was in the room.</p>	F 279	<p>F 279</p> <p>developed to describe the services that are furnished to attain or maintain his highest practicable physical, mental, and psychosocial well-being. Any services that would otherwise be required, but are not provided due to the resident's right to refuse treatment are care planned.</p> <p>All comprehensive care plans on active Residents, as of 3-5-2015 will be reviewed by the DON/ ADONs, MDS Coordinators /Interdisciplinary team including the SSD, Quality of life Director, RD by 4-1-2015 to ensure appropriate identification and interventions that would require a change in their plan of care and to ensure that interventions that are no longer applicable are discontinued from the care plan.</p> <p>All active Resident's that do not have comprehensive care plans developed yet, will be audited by MDS Coordinators by 4-1-2015 to ensure immediate plans of care are in place with appropriate interventions in place to accommodate needs until comprehensive care plans are instituted.</p>	



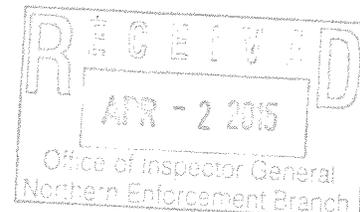
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F 279	<p>Continued From page 6</p> <p>Observation of Resident #5, on 2/24/15 at 2:34 PM, 3:15 PM, and 5:10 PM, revealed the resident was in bed. Observation of the resident, on 02/25/15 at 8:05 AM, 9:20 AM, 10:06 AM, 1:32 PM and 3:11 PM, revealed the resident continued to lay on the bed. The resident did not engage in any activity during observations and was not seen out of the bed.</p> <p>Review of the clinical record for Resident #5, revealed the facility admitted the resident with diagnoses of Cancer with Metastasis, Hypertension, Diabetes, Aphasia, Cerebral Vascular Accident with Left Hemiplegia, Dysphagia, Injury to the Right Carotid Artery and Aphonia. The resident had metastatic cancer and a carotid blow-out resulting in damage after cancer surgery to remove the larynx</p> <p>Review of the admission Minimum Data Set (MDS) assessment, dated 11/11/14, for Resident #5 revealed the facility assessed the resident with a severe cognitive impairment through the Brief Interview for Mental status (BIMS) with a score of three (3); however, the resident understood what others said. The resident was not able to communicate with others verbally. The facility assessed the resident as requiring total assistance with bed mobility, transfers, walking, dressing, eating, hygiene and the resident was frequently incontinent of bowel and bladder. The resident received feedings via a gastric tube and was to have no food or water by mouth. Staff provided the resident with tracheostomy care, suctioning, and oxygen therapy. The MDS stated the staff believed the resident was capable of increased independence in some areas of self care and documented the resident also felt capable of increased independence.</p>	F 279	<p>F 279</p> <p>Any changes to the residents care needs will be reviewed and discussed in clinical meeting Monday through Fridays (excluding holidays). Care plans and CNA care records will also be reviewed in this meeting to ensure that the care plan has been updated by the MDS Coordinators nurse/ADON's/IDT team and corresponds to the residents' needs.</p> <p>All newly admitted Residents will have immediate plans of care developed within 24 hours of admission to the facility. DON, ADON's, or MDS Coordinator will review and make revisions as necessary in clinical meeting Monday through Friday (excluding holidays.)</p> <p>Residents care needs who are returning to the facility from an acute care setting will be reviewed and discussed in the clinical meeting. Their care plans (immediate or comprehensive) and the CNA care records will be updated accordingly by the Interdisciplinary team and implemented on the comprehensive care plan or immediate care plans as appropriate.</p> <p>An in-service education was completed on 3-19-2015 by the Director of Clinical Reimbursement for the Interdisciplinary team; Director of Nursing, Social Services,</p>	



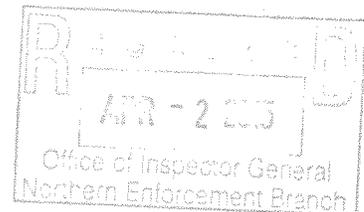
Office of Inspector General

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N 185	Continued From page 7  a severe cognitive impairment through the Brief Interview for Mental status (BIMS) with a score of three (3); however, the resident understood what others said. The resident was not able to communicate with others verbally. The facility assessed the resident as requiring total assistance with bed mobility, transfers, walking, dressing, eating, hygiene and the resident was frequently incontinent of bowel and bladder. The resident received feedings via a gastric tube and was to have no food or water by mouth. Staff provided the resident with tracheostomy care, suctioning, and oxygen therapy. The MDS stated the staff believed the resident was capable of increased independence in some areas of self care and documented the resident also felt capable of increased independence.  Review of the comprehensive care plan for Resident #5, revealed the resident would be directed on task segmentation in order to become more independent with daily care. There were no interventions located to provide staff with instructions on what tasks were segmented or how staff were to carry out these tasks. Interventions called for staff to assist as needed with ambulation, transfers and oral care, even though the resident was assessed to require total care. An activity care plan revealed interventions to determine what the resident enjoyed or had interest in prior to the illness; however, there were no interventions noted regarding the activities the resident enjoyed. In addition, there were no interventions noted for one to one visits for the resident. The care plan stated the resident was to be self-directed with activities. The care plan further noted the resident was non-compliant with turning in bed. There were no interventions to instruct staff on other ways to assist in preventing skin breakdown. There was a wheelchair in the	N 185	F 279  MDS Coordinators, Staff Development Coordinator, RD, Quality of Life Director, Assistant Director of Nursings, Wound Nurse and Restorative Nurse regarding comprehensive care planning, appropriate development, immediate plans of care, and updating of care plans for all residents.  Licensed Nursing Staff will be in-serviced by the Director of Nursing/ Assistant Director Nursings / SDC regarding appropriate development and updating of care plans (immediate and comprehensive) for all residents by 4-1-2015. Any licensed nursing staff that has not been in-serviced by 4-1-15 will not work until they have completed the in-service.  All CNAs and ADONs will be in-serviced by the Staff Development Coordinator on updating and following CNA Care records by 4-1-15. Any ADON or CNA staff that has not been in-serviced by 4-1-15 will not work until they have completed the in-service.  SDC or ADON's will educate new hired CNA's and licensed nursing stakeholders on these matters during the orientation process.	



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F 279

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revealed she had provided care to Resident #5 many times. She stated the resident refused to wear clothing, refused to turn in bed and could do little to assist with care since the left arm and leg were paralysed. She stated the Nurse Aide Care Plan stated the resident was total care and there was no indication the resident got out of bed into a wheelchair. She stated the resident was not able to do any activities alone and stayed in bed all the time.

Interview with Licensed Practical Nurse (LPN) #1, on 02/26/15 at 2:06 PM, revealed Resident #5 required total care from staff. She stated there was no other plan to prevent skin breakdown except to continue to encourage the resident to turn. She stated she had not seen the resident out of bed for several days and was not able to say what the plan was for getting the resident out of bed. She stated the resident was not able to do self-directed activities or to really assist with care related to paralysis.

Interview with MDS Nurse #1, on 02/27/15 at 4:04 PM, revealed each member of the interdisciplinary team developed a care plan for each resident based on the MDS and the Care Area Assessments (CAA). She stated the CAA on Resident #5 did not contain all the information needed to develop a care plan.

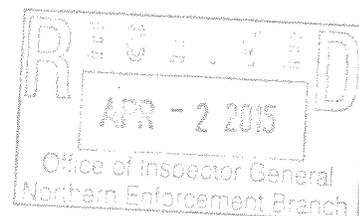
2. Observation of Resident #6, on 02/24/15 at 11:10 AM, revealed the resident was in a low bed with mats on either side of the bed. An indwelling catheter drainage bag was noted on the floor on the left side of the bed. The resident had deep purple bruising on the right forearm along with several skin tears.

F 279

F 279

The Director of Nursing and/or Assistant Directors of Nursing will complete an audit of 10% of new comprehensive care plans monthly to ensure appropriate development, and the updates reflect the residents current needs. The Director of Clinical Reimbursement will audit 10% of care plans three times a year. MDS Coordinators will audit all immediate plans of care on new/readmits Monday through Friday (excluding holidays). Any concerns identified will be addressed as appropriate at the time they are identified.

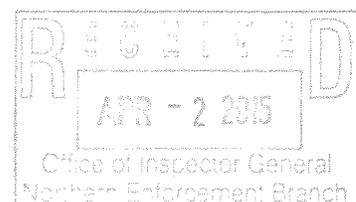
Findings of the audits regarding appropriate development and updating of care plans will be reviewed in the QAPI meeting monthly for 6 months for recommendations and further follow up as indicated until sustainability is achieved.



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NAME OF PROVIDER OR SUPPLIER  <b>SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1120 CRISTLAND ROAD LOUISVILLE, KY 40214</b>	
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F 279	Continued From page 9 Interview with Resident #6, on 02/24/15 at 11:15 AM, revealed the resident had taken a hard fall at home and had to go to the hospital for care. The resident stated he/she did not know how the fall happened.  Review of the clinical record for Resident #6, revealed the facility admitted the resident with diagnoses of Poor Balance, Falls and Weakness on 02/14/15. Review of the Fall Risk Assessment for Resident #6, completed on 02/14/15, revealed the resident was at a high risk of falls. On 02/15/15, the resident was found on the floor of the room. There were no new injuries noted by staff.  Review of the Initial Care Plan for Resident #6, revealed a fall care plan was initiated on 02/16/15 two (2) days after the resident was assessed as a high risk for falls and had fallen.  Interview with CNA #4, on 02/25/15 at 9:20 AM, revealed Resident #6 was able to be up in a wheelchair. She stated the resident was very new and staff were not aware of the residents history. She stated the Nurse Aide Care Plan did not mention the resident's fall risks.  Interview with LPN #1, on 02/25/15 at 10:06 AM, revealed the resident fell in the room and was uninjured. She stated an initial care plan was to be written when the resident was admitted. She stated the care plan should have addressed fall prevention interventions when the fall risk assessment showed the resident was at high risk.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		



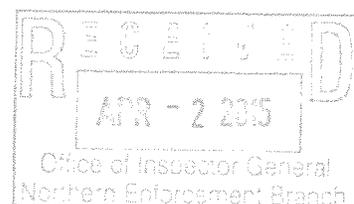
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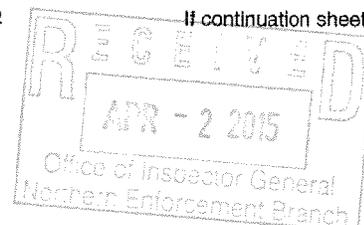
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F 280	<p>Continued From page 10</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to revise the care plans of three (3) of twenty (20) sampled residents (Residents #2, #10, and #17) after falls.</p> <p>The findings include:  Review of a facility's policy regarding Comprehensive Care Plans, revised October 2010, revealed the facility would develop and maintain a comprehensive care plan for each resident that identified the highest level of functioning the resident could be expected to</p>	F 280	<p>F 280</p> <p>Resident's # 2, #10, and #17: Comprehensive care plans were reviewed and revised as necessary on 2-27-15 by the interdisciplinary team to reflect the residents' needs, and to the extent practicable, the participation of the resident, the residents' family or the residents' legal representative. Care plan meetings have been scheduled with residents and responsible parties: Resident #2 is scheduled for 4/1/15, Resident #10's meeting was held on 3/18/15 and Resident #17 is scheduled for 4-8-15. Resident #2's care plan was changed to include anti-roll backs to wheelchair. Resident #10's care plan was changed with new interventions of refer to therapy, anti-seizure medication, air mattress with bolster sides, monitor air mattress settings and observe for change in level of consciousness. Resident #17's care plan was changed to add intervention of family education to alert staff prior to leaving due to resident attempts to follow family. Staff to ensure resident does not attempt to get up and follow family as they are leaving.</p>	4-2-15



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F 280	<p>Continued From page 11</p> <p>attain. The assessments would be ongoing and care plans would be revised as information about the resident or the resident's condition changed.</p> <p>1. Review of the clinical record for Resident #2 revealed the facility admitted the resident with diagnoses of Senile Dementia, Dysphagia, Hypertension, Hearing Loss, Anemia, and Anxiety.</p> <p>Review of the Comprehensive Care Plan, dated 11/14/13, revealed the facility assessed Resident #2 as at risk for falling and interventions were in place to monitor for appropriate non skid footwear.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/22/14, revealed the facility had assessed Resident #2's cognitive status as moderately impaired with a Brief Interview for Mental Status and obtained a score of 11, that indicated the resident was interviewable.</p> <p>Review of the facility's falls investigation, dated 08/30/14, revealed Resident #2 had an unwitnessed fall on 08/30/14. The facility had a nursing intervention of non-skid socks in place prior to the fall; however, the facility investigated the fall and determined the resident needed non-skid socks even though the intervention was already in place and had not prevented the 08/30/14 fall.</p> <p>Interview with the MDS Coordinator/MDS Nurse #1, on 02/27/15 at 4:15 PM, revealed when a resident fell, an intervention was immediately placed on the care plan for the prevention of further falls. She stated the intervention should be something not yet tried and the care plan</p>	F 280	<p>All Residents with comprehensive care plans have the potential to be impacted by the deficient practice.</p> <p>All comprehensive care plans on active Residents, as of 3-5-2015 were reviewed by the DON, MDS Coordinators / ADONs/Interdisciplinary team including SSD, Quality of Life, RD, to ensure appropriate identification and interventions that would require a change in their plan of care and to ensure that interventions that are no longer applicable are discontinued from the care plan.</p> <p>Any changes to the residents care needs will be reviewed and discussed in clinical meeting Monday through Fridays (excluding holidays).</p>	



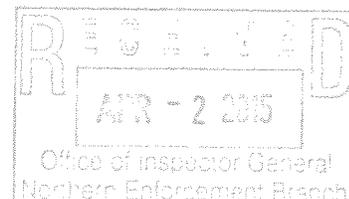
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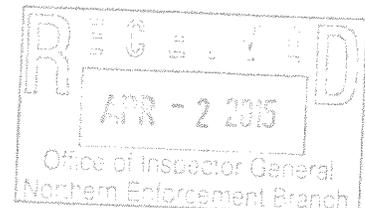
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F 280	<p>Continued From page 12 should be updated immediately.</p> <p>Interview with the Director of Nursing (DON), on 02/27/15 at 5:16 PM, revealed staff was to update the comprehensive care plan with any change in the resident's condition, including falls. She further stated the facility had some improvements to make regarding updating the comprehensive care plans and the interventions added to update the care plan needed to be more specific.</p> <p>2. Review of the clinical record for Resident #10 revealed the facility admitted the resident on 12/26/14 with diagnoses of Declining Status, Inability to Walk, Pressure Ulcers to the Buttocks and Heels, a history of falls and Intracranial Bleed prior to admission. Further review revealed the facility completed a Falls Risk Evaluation on 12/26/14 which indicated the resident was at risk for falls and environmental risk factors should be considered in the resident's interventions. The facility transferred the resident to the hospital on 01/12/15 after the resident sustained a fall resulting in a hematoma (bruise) to the head. The hospital admitted the resident on 1/12/15 and the facility re-admitted the resident to the facility on 01/28/15.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment, dated 01/01/15, revealed the facility assessed Resident #10 to be moderately cognitively impaired through a Brief Interview for Mental Status (BIMS) with a score of 11, indicating the resident was interviewable. The Admission Assessment revealed the resident was totally dependent upon staff for transfers and was unable to walk.</p>	F 280	<p>Care plans and CNA care records will also be reviewed in this meeting to ensure that the care plan has been updated by the MDS Coordinator nurse/ADONs/IDT team and include interventions that correspond to the residents' needs.</p> <p>Residents care needs who are returning to the facility from an acute care setting will be addressed and care planned upon admission. Active residents that have a change in condition will be reviewed and revised by attending nurse. These care plans will be reviewed and discussed in the clinical meeting Monday through Friday, excluding Holidays. Their care plans (immediate or comprehensive) and the CNA care records will be updated accordingly by the Interdisciplinary team and implemented on the comprehensive care plan or immediate care plans as appropriate.</p>	



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F 280	<p>Continued From page 13</p> <p>Review of Resident #10's Comprehensive Care Plan, dated 01/07/15, revealed a care plan was developed for the resident being at risk for fall injury related to assistance needed for transfers and a history of falls prior to admission. The goal for the resident was not to sustain a fall injury by using fall precautions. The interventions included: use fall risk screen to identify risk factors; report falls to responsible party and physician; observe for side effects of drugs; provide and monitor adaptive devices, cue as needed; remind the resident to lock brakes on wheelchair; monitor for appropriate footwear; side rails as an enabler; and, staff to assist with ambulation as needed.</p> <p>Review of a Physical Therapy (PT) Note, dated 01/08/15, revealed the therapist assessed Resident #10 for application of a cushion in the wheelchair. The therapist documented the resident told them the sacral wound did not hurt and Nursing was informed of the resident's positioning in the wheelchair.</p> <p>Review of a Fall Investigation Report, dated 01/12/15, revealed Resident #10 fell on 01/12/15 at 1:45 PM. Per the beautician the resident was being returned by wheelchair from the Beauty Shop to the hallway outside the resident's room. The report further stated the beautician notified the aide of the resident's and the nurse that the resident had been returned. The nurse went to the linen closet and then a visitor yelled out the resident had fallen. The resident was found on the floor in front of the wheelchair with the left side of his/her face to the ground and a large amount of blood pooled to the resident's forehead. The resident was sent to the emergency room and was admitted to the hospital for a large Subdural Hematoma (under</p>	F 280	<p>Residents sustaining falls will be reassessed, care plans will be reviewed and revised with new interventions as applicable. The chart will be brought to the next clinical meeting for review and ascertain appropriate interventions are in place. Falls will be reviewed weekly at the Risk meeting for root cause analysis, and to assess the effectiveness of current intervention(s) to reduce risk of injury or further falls.</p> <p>An in-service education was completed on 3-19-2015 by Corporate Nurse for the Interdisciplinary team; Director of Nursing, Social Services, MDS Coordinators, SDC, RD, Quality of Life Director, ADONs, Wound Nurse and Restorative Nurse regarding comprehensive care planning, appropriate development, immediate plans of care, and updating of care plans for all residents.</p> <p>Licensed Nursing Staff were in-serviced by the Director of Nursing/ Assistant Directors of Nursing / SDC regarding appropriate development and updating of care plans (immediate and comprehensive) for all residents by 4-1-2015. Any licensed nursing staff that has not been in-serviced by 4-1-15 will be removed from schedule until they have completed the in-service.</p>	



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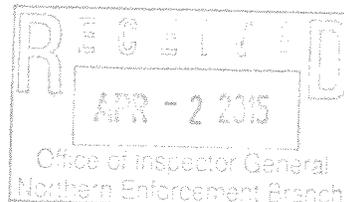
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F 280	<p>Continued From page 14 the skin bruise).</p> <p>Continued review of the Comprehensive Care Plan for Resident #10 revealed the care plan remained the same after the facility readmitted the resident to the facility on 01/28/15 after the hospitalization for the fall. There was no evidence that new interventions were put in place to prevent future falls when the resident returned from the hospital.</p> <p>Interview with the Assistant Director Nursing (ADON)/West Wing Charge Nurse, on 02/27/15 at 4:30 PM, revealed she was uncertain why Resident #10's comprehensive care plan was not updated after the facility readmitted the resident after the fall. The ADON stated new admissions and re-admissions are discussed at the morning meetings and a nurse or one of the MDS Coordinators would update the care plans after the information was shared in the morning meeting. The ADON was uncertain why the care plan was not updated.</p> <p>Interview with MDS Coordinator/RN #3 revealed someone from Nursing should have updated Resident #10's care plan when the resident was re-admitted to the facility. RN #3 stated it was not her responsibility to update a resident's care plan when the facility first brought a resident into the facility.</p> <p>Interview with MDS Coordinator/RN #4, on 02/27/15 at 5:10 PM, revealed she did not remember it being brought up in morning meeting the facility had re-admitted Resident #10. RN #4 stated other interventions absolutely should have been added to the resident's care plan to prevent further injury from falls. RN #4 stated she did not</p>	F 280	<p>All CNAs and Unit Managers/ADONs will be in-serviced by the SDC on updating and following CNA Care records by 4 -1-15. Any ADON or CNA staff that has not been in-serviced by 4-1-15 will not work until they have completed the in-service.</p> <p>SDC will educate new hired CNA and licensed nursing stakeholders on these matters during the orientation process.</p> <p>The DON and ADONs will complete an audit of 10% of new comprehensive care plans monthly to ensure appropriate development, and the updates reflect the resident's current needs. Nurse Consultant will audit 10% of care plans during three times a year visits. MDS Coordinators will audit all immediate plans of care on new/readmits Monday through Friday (excluding holidays.)</p> <p>Findings of the audits regarding appropriate development and updating of care plans will be reviewed in the QAPI meeting monthly for 6 months for recommendations and further follow up as indicated until sustainability is achieved.</p>	
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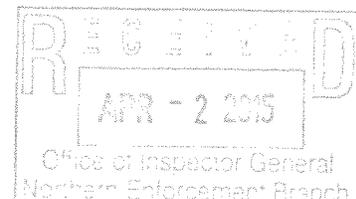
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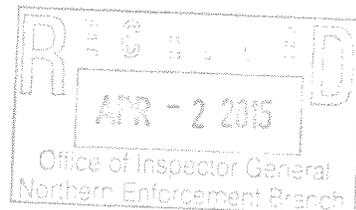
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F 280	<p>Continued From page 15</p> <p>think the resident needed further interventions added to the care plan because the resident was not making eye contact, moving side to side, and had not walked prior to admission, when she assessed the resident on 02/19/15. RN #4 commented one thing she would have added was an alarm.</p> <p>Interview with the Director of Nursing (DON), on 02/27/15 at 5:20 PM, revealed Resident #10's comprehensive care plan should have been updated when the facility re-admitted the resident to the facility on 01/28/15 and on 02/13/15. The DON was uncertain why the comprehensive care plan was not updated on 01/28/15 and commented there should have been more interventions in place to prevent jury from possible future falls.</p> <p>Interview with the Administrator, on 02/27/15 at 5:40 PM, revealed whenever the facility re-admits a resident the facility should always review the resident's comprehensive care plan and should make changes and revisions to the care plan if needed. The Administrator was uncertain why this was not done on Resident #10's comprehensive falls care plan and commented she obviously needed to do some reviewing and more training.</p> <p>3. Review of the clinical record for Resident #17, revealed the facility admitted Resident #17, on 06/24/13, with diagnoses of Senile Dementia, History of Falls, Difficulty Walking, and Muscle Weakness. The facility completed an annual Minimum Data Set (MDS) assessment for the resident on 06/07/14, which revealed the resident had severely impaired decision making abilities, required extensive assistance with transfers, had</p>	F 280		



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F 280	<p>Continued From page 16</p> <p>poor balance which stabilized with staff assistance. The facility completed a Falls Risk Evaluation on 06/06/14 indicated the resident was at high risk for falls.</p> <p>Review of Resident #17's Comprehensive Care Plan, dated 06/08/13 with a re-evaluation date of 04/06/15, revealed a care plan was developed for the resident being at risk for falls with a goal for the resident not to sustain a fall related injury. The interventions included: report a fall to the physician; observe for medication side effects that could cause gait disturbance; provide and monitor adaptive devices; appropriate footwear; and keep room free of clutter and spills.</p> <p>Review of a Fall Investigation report, dated 06/11/14, revealed Resident #17 fell on 06/11/14 at 4:45 PM. The resident was sitting in his/her wheel chair in the dining room for activities. The resident's family told the resident they were leaving and after they exited the dining room, the resident attempted to stand and fell to the floor. The Activities Director heard an alarm go off and responded to find the resident on the floor on his/her right side. The resident complained of right hip pain and he/she was sent to the emergency room for an evaluation. The emergency room found no injuries.</p> <p>Further review of the clinical record for Resident #17, revealed the nurse's notes dated 06/12/14, 06/13/14, 06/15/14, and 06/25/15 contained documentation that the resident continued to complain of pain to the right hip. An x-ray of the right hip was ordered on 06/25/15 and completed on the same date at the facility. The x-ray showed an acute right femoral neck fracture. The facility sent Resident #17 to the emergency room</p>	F 280		



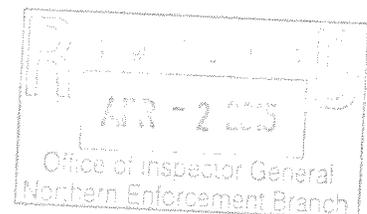
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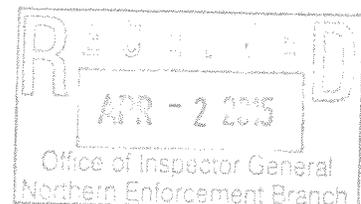
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F 280	Continued From page 17 for evaluation and treatment.  Continued review of the Comprehensive Care Plan for Resident #17, revealed the care plan interventions remained the same after the fall on 06/25/15. There was no evidence that new interventions were put into place to prevent future falls when the resident returned from the hospital.  Interview, on 02/26/15 at 5:00 PM, with the West Wing Assistant Director of Nursing (ADON) revealed care plans were not updated by the staff nurses on the units. She reported care plans were updated during the daily morning clinical meetings that were attended by the Director of Nursing (DON), the ADON's, and the Minimum Data Set (MDS) Coordinators. Further interview with the ADON on 02/27/15 at 10:15 AM, revealed after Resident #17's fall, the family was instructed to let staff know when they were leaving the facility. The ADON further stated the intervention should have been placed on the resident's comprehensive care plan.  Interview, on 02/27/15 at 4:55 PM, with the DON revealed after Resident #17's fall, the family members were instructed to notify staff when they were leaving the facility. The DON further stated the resident's wheel chair alarm was changed from a sensor alarm to a clip alarm. The DON did not know what prevented the interventions from being added to the resident's comprehensive care plan.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.	F 281		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185335</b>	(X2) MULTIPLE CONSTRUCTION... A. BUILDING _____  B. WING _____		(X3) DATE SURVEY... COMPLETED  <b>02/27/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1120 CRISTLAND ROAD LOUISVILLE, KY 40214</b>		
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F 281	Continued From page 18  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedures it was determined the facility failed to ensure staff did not pre-set medications before administration for two (2) twenty (20) sampled residents (Residents #5 and #16) and for three (3) of four (4) unsampled residents (Unsampled Residents A, B, and C). Medications were observed prepared and sitting inside two (2) of five (5) medication carts on the East and West wings.  The findings include:  Review of the facility's policy and procedure regarding Medication Administration-Preparation of Drugs and Biologicals, dated December 2010, revealed medications would not be set up prior to administration.  Observation of the West Hall Medication Cart #1, on 02/27/15 at 9:12 AM, revealed a medication cup intended for Unsampled Resident A with twelve (12) loose pills and a cup intended for Resident #16 with six (6) loose pills sitting in a locked drawer.  Interview with Licensed Practical Nurse (LPN) #5, on 02/27/15 at 9:17 AM, revealed the medications in the medication cups on the West Hall medication cart belonged to Unsampled Resident A and Resident #16. The LPN further stated that both residents were at breakfast at the time the medication was prepared and the residents stated they would like their medications administered after breakfast. She stated that per	F 281	F 281  LPN#5 immediately discarded res # 16 and Res A prepared medication in appropriate container. ADON at West Unit supervised nurse during preparation and dispensing to the above stated residents on 2/27/15. LPN#5 received verbal counseling and in-service training on medication administration Policy and Procedures on 2-27-15 by SDC. LPN#5 was assigned medication administration learning modules, and these were completed on 3-16-15. LPN#5 will be observed weekly during medication administration for the next four weeks, then monthly for 5 months by SDC/ ADONs/DON. Any deficient practices will be immediately addressed during this time. LPN#1 immediately discarded res# 5, B, C and D prepared medication in appropriate container. ADON at East Unit supervised nurse during preparation and dispensing to the above stated residents on 2/27/15. LPN#1 received written counseling and in-service training on medication administration on 2-27-15 by SDC. LPN #1 was assigned medication administration learning modules, and these were completed on 3-16-15. LPN#1 will be observed weekly during medication administration for the next four weeks, then monthly for 5 months by SDC/ ADONs. Any deficient practices will be immediately addressed during this time.	4-2-15	



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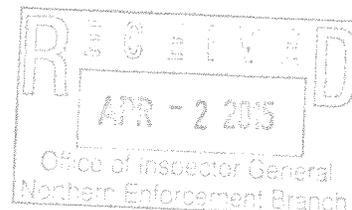
NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE

1120 CRISTLAND ROAD  
LOUISVILLE, KY 40214

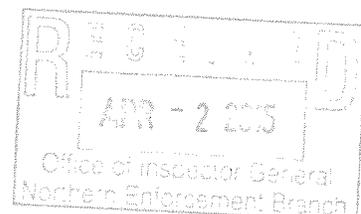
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F 281	<p>Continued From page 19</p> <p>the facility's policy and procedures the prepared medication should have been immediately discarded in the sharps container and should not have been placed back in the medication drawer as this could cause medication errors.</p> <p>Observation of the East Hall Medication Cart #2, on 02/27/15 at 9:32 AM, revealed a medication cup for Unsampled Resident B containing seven (7) loose pills; a medication cup for Unsampled Resident C containing eleven (11) loose pills; a medication cup for Unsampled Resident D containing six (6) loose pills; and a medication cup with 7 crushed pills for Resident #5 sitting in a locked drawer of the medication cart. Additional observation revealed a cup of dark liquid with a crushed substance and not identified as to who it belonged to.</p> <p>Interview with LPN #1, on 02/27/15 at 9:51 AM, revealed she had prepared medications in advanced because the state was in the building and she wanted to get her medication pass completed. She further stated the medications in the medication cups on the East Hall medication cart belonged to Resident #5 and Unsampled Residents B, C and D.</p> <p>Interview with the Director of Nursing, on 02/27/15 at 3:10 PM, revealed she would expect the nurses to follow the five (5) rights of medication administration and would expect the nurses to check with the resident before preparing their medications. In addition, medications not administered after they were prepared should immediately be disposed of in a sharps container. She stated it was never acceptable to prepare medications in advanced as that practice could contribute to medication</p>	F 281	<p>All Residents have the potential to be affected by this practice.</p> <p>Pharmacy consultant provided medication administration training to nurses and CMT's on 3/27/15. Additional training was provided by pharmacy consultant to facility trainers, SDCs and ADONs on 3/27/15.</p> <p>All licensed nurses and CMTs will be provided in-service training on medication administration by 4-1-15 by SDC, DON, ADONs or pharmacy consultant.</p> <p>All licensed nurses and CMTs will be observed during medication administration by DON, ADON or SDC by 4-1-15. Any deficient practices will be immediately addressed during this time. Stakeholders that have not received training will be removed from the schedule until completion.</p> <p>DON,ADONs, or SDC will observe 10% of nurses and CMTs medication administration monthly for the next six months, then quarterly.</p> <p>All new hire licensed staff and CMTs will be observed by SDC or ADON's during medication administration monthly for the first three months.</p> <p>Any deficient practices will be reviewed at the QAPI committee monthly for six months for recommendations and further follow up as indicated.</p>	



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F 281	Continued From page 20 errors.	F 281	F 315	4-2-15
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure one (1) of twenty (20) sampled residents (Resident #6) urinary drainage bag was maintained at a level lower than the bladder to prevent urinary tract infections.  The findings include:  Review of the facility's policy regarding Catheters-Closed System, dated December 2010, revealed rule #1 the staff was not to raise the drainage bag above the level of the bladder and rule #2 was keep the drainage bag off the floor, never allow the drainage bag to touch the floor and change the tubing immediately if contaminated.  Review of the clinical record for Resident #6, revealed the facility admitted the resident on	F 315 Resident # 6, leg bag immediately changed to Foley catheter bag. CNA and therapist that were assigned to Resident were educated immediately by the ADON to notify the nurse upon resident's return to unit in order to implement appropriate catheter bag and placement prior to lying down on 2-27-15. Education provided related to leg bag applications. Both C.N.A care plan and the Comprehensive plans of care were updated to reflect education on 2-27-15 by ADON.  All residents with Foley catheters have the potential to be affected and have been assessed.  All residents with Foley catheters will be assessed by DON/ADONs to determine if leg bags are applicable for resident's individual needs and these residents' plans of care will updated to reflect notification to the nurse prior to lying down by 4-1-15.  Education will be provided by SDC or ADON's to nursing staff and therapy department related to Catheters closed indwelling systems and leg bags positioning by 4-1-2015.  All new hire will be provided education on closed catheter systems and reviewed during annual skills competencies by SDC or ADON's.		



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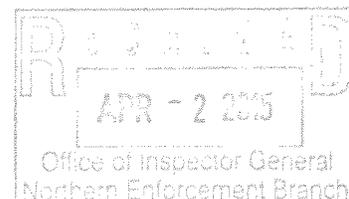
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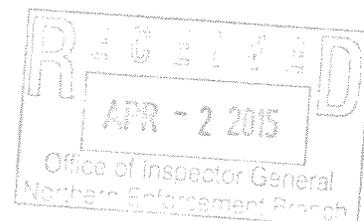
F 315	<p>Continued From page 21</p> <p>02/14/15 with diagnoses of Weakness, Poor Balance, and Urinary Retention and physician's order for an indwelling catheter.</p> <p>Observation of Resident #6, on 02/24/15 at 11:10 AM, revealed the resident was laying on the bed, eyes closed and had an indwelling catheter attached to a drainage bag.</p> <p>Observation of Resident #6, on 02/27/15 at 11:30 AM, 1:20 PM and 3:40 PM, revealed the absence of a drainage bag as previously noted. The resident was in a supine position with the head of the bed down.</p> <p>Interview with Resident #6, on 02/27/15 at 3:40 PM, revealed the resident stated a catheter was still attached to the left leg.</p> <p>Interview with CNA #5, on 02/27/15 at 3:50 PM, revealed Resident #6 was up in a chair prior to lunch. She stated the drainage bag was replaced with a leg bag for dignity while the resident was up. She pulled aside the cover and a leg bag was noted attached to the top of the resident's left thigh. The leg bag was noted to be above the level of the bladder. The CNA stated the leg bag was up too high and should have been attached to the side of the thigh. She stated she was trained to place the bag lower than the bladder.</p> <p>Interview with LPN #2, on 02/27/15 at 3:55 PM, revealed the resident was placed on a leg bag while up in a chair earlier in the day. She stated staff put the resident to bed and forgot to remove the leg bag and replace it with the drainage bag. She stated staff were trained not to use a leg bag if the resident was in bed. She stated the back flow of urine could cause a urinary tract infection.</p>	F 315	<p>F 315</p> <p>ADON or SDC will audit 10% of residents with catheters weekly for a month, and then monthly for the next six months.</p> <p>All audits will be reviewed by the DON/ADONs or SDC to ensure appropriate completion and follow-up.</p> <p>DON/ADON will audit 10% of new hired stakeholders and annual competencies for compliance.</p> <p>Findings of the above stated audits will be reviewed by the QAPI committee monthly for three months for recommendations and further follow-up as indicated.</p>	
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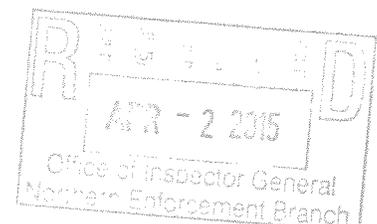
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F 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure it was free of medication error rates of five (5) percent or greater. Medication pass observations conducted on 02/25/15 resulted in the assessment of two (2) medication errors out of twenty-nine (29) opportunities, reflecting a medication error rate of 6%. Licensed Practical Nurse (LPN) #7 administered a dose of insulin to Resident #13 which was ordered with meals two (2) hours after the scheduled meal time and intended to administer the wrong medication to Resident #16.</p> <p>The findings include:</p> <p>Review of a facility's policy and procedure regarding Medication Administration-Administering Medications, dated December 2010, revealed medications are administered only as ordered by the physician. The facility staff would review the five (5) rights of medication administration during preparation and administration which included the right medication, right dosage, right resident, right time and right route.</p> <p>1. Observation of a medication administration pass with LPN #7, on 02/25/15 at 9:10 AM, revealed Omeprazole (a medication used to</p>	F 332	<p>Res #16 After Nurse #7 was stopped from giving Resident the wrong medication, the medication in error was discarded. Resident was then, given correct medication and dosage during medication pass with no adverse findings.</p> <p>On 2-25-2015, Res#13 blood glucose level was taken at 11:30am and was within normal findings. Insulin administration at noon prior to lunch was observed by ADON and DON on 2-25-15. Resident consumed 100% of meal without signs and symptoms of hypo/hyperglycemia. Physician notified and informed would see patient during 2-27-15 rounds. Physician visit with resident on 2-27-15 with no adverse findings.</p> <p>LPN#7 was in-serviced and provided training on medication administration on 2-27-15 by SDC. LPN #7 was assigned medication administration learning modules that were completed on 3-16-15. LPN #7 will be observed weekly during medication administration for the next four weeks, then monthly for 5 months by SDC/ADONs. Any deficient practices will be immediately addressed and resolved. LPN#7 was assigned diabetic management learning modules for completion by 4-1-15.</p> <p>All Diabetic residents receiving fast acting insulin such as Novolog with meals can be affected by this practice.</p>	4-2-15



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F 332	<p>Continued From page 23</p> <p>reduce acid produced by the stomach) was prepared for Resident #16. Review of the Medication Administration Record (MAR) for Resident #16, revealed Plavix (medication used to prevent blood clots) should have been administered. Continued observation revealed LPN #7 entered Resident #16's room and stated here is your morning medication. LPN #7 was stopped before the wrong medication was administered.</p> <p>Review of Resident #16's physician's orders, dated 02/01/15-02/28/15, and the Medication Administration Record for February 2015, revealed an order for Plavix 75 milligrams (mg) daily.</p> <p>2. Observation of the medication administration pass with LPN #7, on 02/25/15 at 9:52 AM, revealed the LPN administered 3 Units of Novolog (Insulin ) to Resident #13, approximately two (2) hours after the breakfast meal was consumed.</p> <p>Review of the MAR and Physician's orders dated February 2015, revealed Novolog (rapid-acting human insulin used to lower blood glucose), three (3) units subcutaneous (beneath the skin), three (3) times a day with meals.</p> <p>Interview with LPN #7, on 02/25/15 at 3:50 PM, revealed she normally waits until after the resident eats before she administers the medications that are ordered with meals. She stated she liked to make sure the resident had eaten when the orders state take with meals.</p> <p>Interview with the Director of Nursing (DON), on 02/27/15 at 3:00 PM, revealed nurses were</p>	F 332	<p>F 332</p> <p>The Physicians orders, MARS, and blood sugar tests recording will be audited by 4-1-15 for administration timeframe compliance. Any resident noted with consistent abnormal readings will be recommended for physician review</p> <p>All licensed nurses will successfully complete learning modules on diabetic management by 4-1-15 by SDC/ DON. All licensed nurses and CMTs will be provided an in-service training on the 5 rights of medication administration by 4-1-15 by SDC.</p> <p>All licensed floor and CMT stakeholders will complete medication pass observation with DON, ADONs or SDC by 4-1-15. Any deficient practices will be immediately addressed during this time.</p> <p>All licensed nurses that have not been trained, will be off the schedule until completion.</p> <p>All new hired licensed nurses will receive diabetic management medications education, and will be observed during a medication pass monthly for the first three months by SDC or ADONs.</p>	



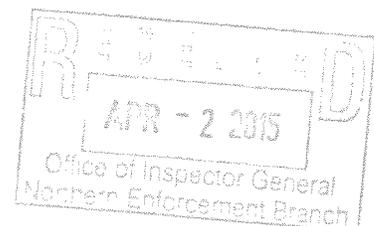
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F 332	Continued From page 24 trained to follow the physician's orders. She further stated that Novolog should be given within 30 minutes before a meal so that when the medication peaks the resident will not "bottom out" or become hypoglycemic (low blood sugar).  Interview with Resident #13's physician, on 02/27/15 at 2:50 PM, revealed it was not ideal to administer a fast acting insulin such as Novolog after meals which could result not only in poor glucose control, but also hypoglycemia. He further stated it was his expectation for the facility staff to follow his orders.	F 332	F 332  Medication administration competencies will be completed during new hire orientation and annually by DON, ADONs, or SDC.  DON, ADONs and SDC will observe 10% of Residents medication administration monthly for the next six months, then quarterly. DON will review 10% of new hired licensed stakeholders and annual medication administration competencies for compliance.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedures, it was determined the facility failed to ensure that residents were free from significant medication errors for one (1) of twenty (20) sampled residents (Resident #13). Licensed Practical Nurse (LPN) #7 administered a dose of insulin which was ordered with meals two (2) hours after the scheduled meal time.  The findings include:  Review of the facility's policy and procedure regarding Medication	F 333	All findings of the above stated observations will be reviewed at the QAPI committee monthly for six months for recommendations and further follow-up as indicated.  F 333  On 2-25-2015, Res#13 blood glucose level was taken at 11:30am and was within normal findings. Insulin administration at noon prior to lunch was observed by ADON and DON on 2-25-15. Resident consumed 100% of meal without signs and symptoms of hypo/hyperglycemia. Physician notified on 2-25-15 and he indicated he would see patient during rounds on 2-27-15. Physician visit with resident on 2-27-15 with no adverse findings.	4-2-15



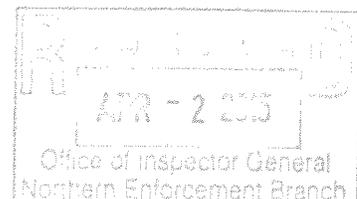
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F 333	<p>Continued From page 25</p> <p>Administration-Administering Medications, dated December 2010, revealed medications were to be administered only as ordered by the physician.</p> <p>Review of the facility's guidelines from Medication-Pass on Insulin Administration, last revised October 2010, revealed the type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's orders.</p> <p>Review of the clinical record for Resident #13 revealed the facility admitted the resident on 10/28/14 with a diagnosis of Diabetes Mellitus.</p> <p>Review of the physician's orders, dated February 2015, revealed orders for Novolog (rapid-acting human insulin used to lower blood glucose), three (3) units subcutaneous (beneath the skin), three (3) times a day with meals.</p> <p>Observation during a medication pass, with on 02/25/15 at 9:52 AM, revealed LPN #7 administered three (3) units of Novolg to Resident #13.</p> <p>Interview with LPN #7, on 02/25/15 at 3:50 PM, revealed she normally waited until after the resident ate before she administered the medications that were ordered with meals. She stated she liked to make sure the resident had eaten.</p> <p>Interview with the Director of Nursing (DON), on 02/27/15 at 3:00 PM, revealed it was her expectation for nurses to follow the physician's orders. She further stated that Novolog should</p>	F 333	<p>F 333</p> <p>LPN#7 was assigned diabetic management learning modules for completion by 4-1-15, SDC will ascertain completion. LPN#7 was in-serviced and provided training on medication administration on 2-27-15 by SDC. LPN #7 was assigned medication administration learning modules that were completed on 3-16-15. LPN #7 will be observed weekly during medication administration for the next four weeks, then monthly for 5 months by SDC/ ADONs. Any deficient practices will be immediately addressed and resolved.</p> <p>All Diabetic residents receiving fast acting insulin such as Novolog with meals may be affected by this practice. Physicians' orders, MARS, and blood sugar tests recording will be audited by 4-1-15 for timeframe compliance. Any resident noted with consistent abnormal readings will be recommended for physician review.</p> <p>All licensed stakeholders will be provided learning modules on diabetic management by 4-1-15 by SDC/ DON.</p> <p>Licensed nurses will review the medication record during each medication pass.</p>	



F 333  
Page 26 (A)

All nurses and CMT stakeholders will complete medication pass observation with DON, ADON's or SDC by 4-1-15. Any deficient practices will be immediately addressed during this time.

All licensed staff and CMTs that have not been trained, will be taken off the schedule until completion.

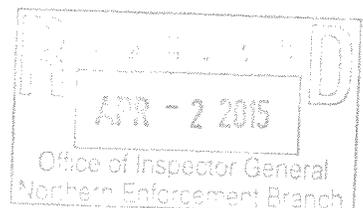
All new hired licensed stakeholders will receive diabetic management medications education, and will be observed during a medication pass monthly for the first three months by SDC or ADON's.

Diabetic education competencies during new hire orientation and annually will be completed by DON, ADON's or SDC.

DON, ADON or SDC will observe 10% of Diabetic Residents medication administration monthly for the next six months then quarterly.

DON will review 10% of new hired licensed stakeholders and annual Diabetic management competencies for compliance.

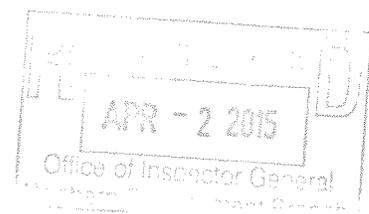
All findings of the above stated observations will be reviewed by the QAPI committee monthly for six months for recommendations and further follow-up as indicated.



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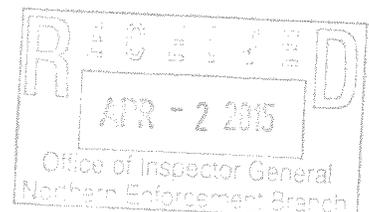
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185335</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/27/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1120 CRISTLAND ROAD LOUISVILLE, KY 40214</b>	
(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 333	Continued From page 26 be given within 30 minutes before a meal so that when the medication peaks the resident would not bottom out or become hypoglycemic (low blood sugar).  Interview with Resident #13's physician, on 02/27/15 at 2:50 PM, revealed it was not ideal to administer a fast acting insulin such as Novolog after meals which could result not only in poor glucose control, but also hypoglycemia. He further stated it was his expectation for the facility staff to follow his orders.	F 333		
F 441 SS=D	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  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	F 441	F 441  Resident #5 Oxygen tubing and mask were discarded and replaced on 2-24-15 by the ADON. Resident has been discharged to the hospital on 3-09-15. Resident #6 closed catheter tubing and drainage bag were changed on 2-25-15 by the ADON. The current dignity bag was replaced with a different style allowing a greater clearance from the bag to the floor.  All residents with indwelling catheters and oxygen tubing have the potential to be affected.  All residents with Foley catheters bags were assessed by ADON's on 2/25/15 for appropriate distance from the floor. The C.N.A. care records were updated on 2/25/15 by the and ADON's.	4-2-15



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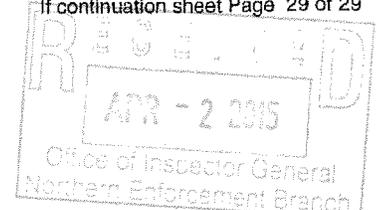
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F 441	<p>Continued From page 27</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens 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, and record review, it was determined the facility failed to ensure infection control practices were followed by staff to ensure resident equipment did not make contact with the floor for two (2) of twenty (20) sampled residents (Residents #5 and #6). The staff failed to ensure Resident #5's oxygen tubing and mask for the tracheotomy was not touching the floor and failed to ensure Resident #6's catheter tubing and drainage bag did not touch the floor.</p> <p>The findings include:</p> <p>Review of the Infection Control Policies provided by the facility, revealed no policy to address nursing equipment. However, review of the Catheter-Closed System policy, dated December 2010, revealed the drainage bag was to be kept off the floor and never allowed to touch the floor. The tubing and drainage bag was to be changed</p>	F 441	<p>F 441</p> <p>Residents requiring respiratory supplies were assessed by the ADON's on 2-25-15 to ensure proper equipment storage. The ADONs ascertained that tubing was not located on floor, or other areas deemed noncompliant with infection control practices.</p> <p>Nursing staff in-serviced on proper placement of Foley catheter drainage bags when residents are in bed and sitting in wheel chair by SDC/ADON's 2/25/15 through 4/1/15.</p> <p>Nursing staff were in-serviced on proper storage and cleaning of respiratory supplies by Respiratory Therapist or SDC on 2-27-15 through 4/1/15.</p> <p>Housekeeping staff will be in-serviced 2/27-4/1/15 by SDC or ADONs to notify nursing or respiratory personnel of equipment on the floor or not properly stored.</p> <p>All new hire stakeholders will be provided with education on Infection control practices, nursing equipment storage by SDC or ADON.</p> <p>Competencies on Infection control will be conducted by SDC or ADONs upon new hire orientation and annually for all stakeholders.</p>	



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NAME OF PROVIDER OR SUPPLIER  <b>SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1120 CRISTLAND ROAD LOUISVILLE, KY 40214</b>		
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F 441	<p>Continued From page 28 immediately if contaminated.</p> <p>Observation of Resident #5, on 02/24/15 at 11:10 AM, 11:56 AM and 12:52 PM, revealed the resident's oxygen tubing and mask for the tracheotomy were on the floor.</p> <p>Observation of Resident #6, on 02/24/15 at 11:52 AM, 1:28 PM, 2:45 PM and 3:42 PM and on 02/25/15 at 8:00 AM, and 10:04 AM, revealed the resident's indwelling catheter drainage bag was in direct contact with the floor.</p> <p>Interview with Certified Nurse Aide (CNA) #5, on 02/25/15 at 3:02 PM, revealed Resident #6's catheter bag should not be on the floor. She stated the bed should have been raised enough to prevent the bag from contact with the floor. She stated the floor was not considered clean and an infection could happen. She stated she was trained on catheter bag positioning and infection control.</p> <p>Interview with LPN #2, on 02/25/15 at 3:15 PM, revealed Resident #6's indwelling catheter drainage bag should not be in contact with the floor and that put the resident at risk for infection. She stated she had received training on infection control.</p>	F 441	<p>F 441</p> <p>Respiratory Therapist will audit weekly for 4 weeks, then monthly for five months 100% of residents receiving respiratory supplies and closed catheter systems.</p> <p>10% of all audits monthly will be reviewed by the DON or ADON to ensure appropriate completion and follow-up.</p> <p>DON/ADONs will audit 10% of new hire and annual competencies for compliance.</p> <p>Findings of the above stated audits will be reviewed by the QAPI committee monthly for six months for recommendations and further follow-up as indicated.</p>		



**FIRE SAFETY SURVEY REPORT  
CRUCIAL DATA EXTRACT  
(TO BE USED WITH CMS-2786 FORMS)**

PROVIDER NUMBER <b>K1 185335</b>	FACILITY NAME <b>SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE</b>	SURVEY DATE <b>*K4 02/24/2015</b>
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K6 DATE OF PLAN APPROVAL	K3 : MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS <u>1</u> NUMBER OF THIS BUILDING <u>01</u>	<input checked="" type="checkbox"/> A BUILDING <input type="checkbox"/> B WING <input type="checkbox"/> C FLOOR <input type="checkbox"/> D APARTMENT UNIT
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LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW

ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW

ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

\*K7  12 SELECT NUMBER OF FORM USED FROM ABOVE

*(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)*

K29:  3      K56:  3

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8:  1 PROMPT  
2 SLOW  
3 IMPRACTICAL

---

LARGE

K8:  4 PROMPT  
5 SLOW  
6 IMPRACTICAL

---

APARTMENT HOUSE

K8:  7 PROMPT  
8 SLOW  
9 IMPRACTICAL

---

ENTER E-SCORE HERE

K5:  e.g 2.5

\*K9 : FACILITY MEETS LSC BASED ON: *(Check all that apply)*

A1 <input checked="" type="checkbox"/> (COMP. WITH ALL PROVISIONS)	A2 <input type="checkbox"/> (ACCEPTABLE POC)	A3 <input type="checkbox"/> (WAIVERS)	A4 <input type="checkbox"/> (FSES)	A5 <input type="checkbox"/> (PERFORMANCE BASED DESIGN)
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FACILITY DOES NOT MEET LSC: B. <input type="checkbox"/>	K180: A. <input checked="" type="checkbox"/> FULLY SPRINKLERED (All required areas are sprinklered)	B. <input type="checkbox"/> PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	C. <input type="checkbox"/> NONE (No sprinkler system)
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\*MANDATORY

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1974, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Unprotected</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II generator, installed new in 2009. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey, utilizing the 2786S (Short Form) was conducted on 02/24/15. The facility was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000			

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

TITLE

(X6) DATE

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.