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

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JUN 30 2011
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

PRINTED: 06/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185196		C 06/15/2011

NAME OF PROVIDER OR SUPPLIER
KINDRED NURSING AND REHABILITATION-BASHFORD

STREET ADDRESS, CITY, STATE, ZIP CODE
3535 BARDSTOWN ROAD
LOUISVILLE, KY 40218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated survey was initiated on 06/14/11 and concluded on 06/15/11 to investigate KY16456. The complaint was substantiated and deficiencies were cited.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, resident record review, and resident incident reports it was determined the facility failed to ensure services provided were completed in accordance with the care pan for two (2) of three (3) sampled residents (#2 and #3). Resident #2's care plan directed staff to use a tab alarm when the resident was in a wheelchair and a sensor pad and floor mat when the resident was in bed. The resident sustained two (2) falls, one (1) requiring an emergency room visit, related to failure of the facility to ensure the safety devices were functional. Resident #3's care plan directed staff to use a sensor alarm when the resident was in bed. The resident sustained a fall requiring hospitalization related to the facility's failure to ensure the safety device was functional. The findings include: Observation of Resident #2 on 06/14/11 at 1:00pm and 2:00pm revealed the resident's	F 282	**F 282** CNA # 1 has been counseled and provided a copy of the facility's policy on following CNA assignment sheets. Employee was reminded, "CNA assignment sheets are to be used with every shift worked due to the information being updated so frequently. Additionally, CNA is to sign and turn into RN at the end of shift for RN Unit Manager Review. Observation of resident #2's wheelchair on 6/14/2011 revealed Maintenance removing anti-tippers as they were and properly assembling to the front of Resident # 2's wheelchair. In-servicing is currently being conducted for all-staff to ensure they are aware of the proper placement of anti-tippers. Facility wide assessment of wheelchairs was audited on 6/27/2011 to ensure all wheelchairs had anti-tippers placed correctly on wheelchairs. Director of Rehabilitation and Executive Director have validated placement. Facility wide audit of all CNA Assignment Sheets was matched with	7/23/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

X Administrator X 6/30/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	Continued From page 1 wheelchair was equipped with anti-tippers on the rear and was in the room where the resident was asleep in bed, a sensor pad was in place on the bed and turned on, and fall mats were on both sides of the bed. Review of Resident #2's medical record revealed the physician ordered anti-tippers to the front of the wheelchair, not the rear, on 06/08/11. The Certified Nurse Aide (CNA) Assignment Sheet only offered the information that the wheelchair was to have 'anti-tippers'. In addition, the physician ordered mats on the floor, a tab alarm on the wheelchair, and a sensor pad on the low bed. The facility completed a significant change Minimum Data Set (MDS) assessment of the resident on 04/29/11 which revealed the resident was unable to bear weight to ambulate and required extensive assistance of one with transfers. The resident was cognitively impaired. The care plan dated 01/15/11 revealed the resident had impaired mobility and cognition and required a tab alarm to the wheelchair, a sensor pad on a low bed, anti-tipping devices on the front of the wheelchair and fall mats on both sides of the bed for safety. The wheelchair was to be removed from the room, not present, when the resident was in bed. Interview with Licensed Practical Nurse (LPN)#1, on 06/14/11 at 2:00pm, revealed alarms were on the resident's care plan and the alarms were monitored by the CNAs and supervised by the nurses. She could not explain why the resident had the wheelchair in the room while asleep or why the anti-tippers were attached to the wrong part of the wheelchair.	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* care plans to ensure 100% accuracy in addition to ensuring those interventions were in place as care planned and functioning as they should be on 6/14/2011. A facility wide in-service was conducted, by the Staff Development Coordinator (SDC), on 6/21/11, 6/22/2011, 6/23/2011, for all employees, with emphasis on Falls, Fall Documentation, Use of CNA Assignment Sheets, and Fall Prevention. A competency was completed for all direct care staff using a "Fall Room" where a mannequin was set up in a room with several things wrong. Staff was to identify all the things that could have led to Root Cause of fall. This was submitted to SDC for competency check-off. All new hires will receive training during orientation related to Falls, Fall Documentation, Use of CNA Assignment Sheets, and Fall Prevention. The facility does not employ agency personnel. If the facility should employ agency personnel in the future, this		

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F 282	Continued From page 2 Interview with the Unit Manager, on 06/15/11 at 3:00pm, revealed the residents' care plans were to be followed and the nurses were supervising the CNAs to ensure safety devices were used according to the care plan. She stated she did not go behind the nurses to ensure they did their job. She stated she talked to specific staff regarding the resident care planned safety devices. She stated she was responsible for updating the CNA Assignment Sheets. Interview with CNA #1, on 06/14/11 at 2:00pm, revealed her CNA Assignment Sheet documented anti-tippers however, she was not aware they were attached to the wrong part of the wheelchair. She stated she used the CNA Assignment Sheet to provide care to Resident #2 and was not aware the wheelchair was to be removed from the room when the resident was in bed. She stated the CNA Assignment Sheet did include information on removing the resident's wheelchair while the resident was in bed after reviewing the assignment sheet again. Interview with the Administrator, on 06/15/11 at 8:30am, revealed a group of managers made rounds once a week to ensure safety devices followed the care plan. He stated rounds had not occurred since Resident #2's anti-tipper devices were added to the wheelchair on 06/08/11 and so the mistake had not been discovered.	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* education will be included in agency orientation. The facility will offer a facility wide mandatory training on a yearly basis, and as needed, with emphasis on Falls, Fall Documentation, Use of CNA Assignment Sheets, and Fall Prevention. Rounds will continue to be completed daily by Unit Managers/Weekend Supervisor to ensure CNA Assignment Sheets are being followed, and mobility devices are properly equipped with any additional equipment. Observations of the IDT members will be reported daily (Monday through Friday) during morning Stand-Up meeting, and tracked and trended monthly during Performance Improvement Committee (PIC) meeting for the next three months and thereafter as needed.	
F 323 SS=E	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	F 323	**F 323** Thorough investigations of both Resident # 2's and Resident # 3's falls were completed. Thorough investigations to determine	7/23/2011

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F 323	Continued From page 3 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on resident record review, review of the facility's Resident Event Report Worksheet, facility policies on Condition Change of a Resident (Revised 10/31/06), Routine Toileting (Revised 10/31/09) and Accidents and Supervision to Prevent Accidents (Revised 04/28/11), Discharge Summary from Norton Suburban Hospital, observation and interview, it was determined the facility failed to complete thorough investigations for two (2) of three (3) sampled residents. Resident #2 did not have a thorough investigation completed after sustaining a fall which subsequently led to an Emergency Room visit. Resident #3 did not have a thorough investigation completed after sustaining a fall, which led to hospitalization. The findings include: The facility policy on Accidents and Supervision to Prevent Accidents (Revised 04/28/11), under the section "Falls" stated the facility evaluates the causal factors leading to a patient fall to help support relevant and consistent interventions to try to prevent future occurrences. However, the facility failed to investigate the fall of Resident #3, which stopped the facility from determining the causal factors which led to the fall. The facility policy on Condition Change of a Resident (Revised 10/31/06) states to "Complete	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Root Cause of all falls for the last 30 days were completed. A thorough investigation to determine the Root Cause of all falls resulting in a transfer to the hospital since February 1, 2011. Facility wide audit of all CNA Assignment Sheets was matched with care plans to ensure 100% accuracy in addition to ensuring those interventions were in place as care planned and functioning as they should be. A facility wide audit was performed by the Unit Managers to ensure all Care plans corresponded with the Nursing Assistant Assignment sheets. The Nursing Department performed a facility wide audit to assess the Fall Risk Scores of all residents. Residents scoring greater than 13 were assessed to ensure appropriate interventions were in place and that interventions were on care plan along with all Nursing Assistant Assignment sheets. A new Fall Audit Tool has been initiated for completion during Morning Stand-Up Meeting requiring questions pertinent to investigative protocol to include questions prompting Root Cause	

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F 323	Continued From page 4 documentation on Resident Event Report Worksheet", which the facility only partially completed for the fall on Resident #3. The facility policy on Routine Toileting (Revised 10/31/09) fails to address, when taking a resident to the bathroom, if the assistant is to remain near the resident if a high risk for falls exist, or to leave the resident unattended. Resident #3 was admitted to the facility on 07/10/09, with diagnoses of Dementia with Behavioral Disturbance, Type II Diabetes Mellitus, Esophageal Reflux, History of Falls and Hypothyroidism. On the quarterly Minimum Data Set (MDS) assessment dated 02/17/11 the facility assessed the resident for transferring and walking in his/her room as requiring the physical assist of one (1) person. The Brief Interview for Mental Status (BIMS) score for the resident was eleven (11), which assessed the resident as being moderately impaired. On the Falls Risk Assessment for Resident #3 dated 10/12/10, the facility assessed the resident to have a summary score of fourteen (14). The range yields any number fourteen (14) or higher was a high risk for falls. The Falls Risk Assessment score for 11/19/10 was sixteen (16) and the score for 05/08/11 was nineteen (19). Interview, on 06/15/11 at 1:13pm, with Resident #3 revealed he/she had fallen in his/her room while attempting to walk back and forth from the bathroom. He/she stated "I have the scars to show it". There are marks on his/her body due to falls that have occurred when he/she "tried it on my own" to get to and from the bathroom.	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Analyses with investigative summary. The Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator began immediate Nursing department direct care staff in-servicing on Falls, Fall Documentation, Use of CNA Assignment Sheets, and Fall Prevention. A competency was completed for all direct care staff using a "Fall Room" where a mannequin was set up in a room with several things wrong. Staff was to identify all the things that could have led to Root Cause of fall. 100% completion of Facility Fall Packet was required to be completed as demonstrations of how all Fall Packets are to be completed. All direct care employees continued to be in serviced prior to assuming care of residents in the facility. No nursing department direct care employee was allowed to work until he/she had been in serviced. A list of all residents at High Risk for falls was provided to RCS Coordinator to add to CNA Flow Sheets stating that Fall Risk residents are to remain supervised during toileting to ensure safety.	

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F 323	Continued From page 5 Resident #3 turned onto his/her right side to expose a slight discoloration to his/her left hip. The facility's Resident Event Report Worksheet completed on 05/03/11 at 11:30pm by Licensed Practical Nurse (LPN) #4 revealed Resident #3 fell while in his/her room returning to bed from the bathroom. The location of the resident prior to the fall is noted as the bathroom. The activity of the resident at the time of the fall is noted as unassisted ambulation. Injuries noted include a change of "LOC", level of consciousness, pupils unequal and pain in the left hip. The Certified Nursing Assistant Fall Review page is left blank with no entries. The Post Fall Evaluation page is also left blank with no entries. Interview, on 06/14/11 at 5:00pm, with the Administrator revealed no investigative report existed for Resident #3 because he/she did not go to the hospital: however, Resident #3 was transferred to the hospital by ambulance at 7:40am the following morning. Interview, on 06/14/11 at 4:30pm, with LPN #6 revealed she was told in report, which takes place at the beginning of the shift, on the morning of 05/04/11, that Resident #3 had fallen during the night. She stated she immediately went to the room of Resident #3 and did an assessment. She stated she noticed a "gross abnormality to the left hip" and that the resident could only verbalize "I don't know" when asked questions, and by the time the ambulance arrived, the resident was non-verbal. Record Review of the Discharge Summary from Norton Suburban Hospital revealed following the	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The facility does not employ agency personnel. If the facility should employ agency personnel in the future, this education will be included in agency orientation. The Unit Managers/designee will assess for 30 days performing random audits on 2 residents per shift per day to ensure the Nursing assistant assignment sheet was being followed, and the correct intervention was in place as care planned and functioning as intended. Observations of the IDT members will be reported daily (Monday through Friday) during morning Stand-Up meeting, and tracked and trended monthly during Performance Improvement Committee (PIC) meeting for the next three months and thereafter as needed.	Enter D Completed 3/1/2011

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F 323	Continued From page 6 four (4) day hospital stay, Resident #3 was discharged on 05/08/11. The discharge diagnoses were, listed as number one (1), history of fall and, number two (2), Left Hip Hematoma that was stable. A review of the Care Plan for Resident #3 revealed a "Problem" dated 11/24/10 as Resident needs assist of staff with toileting, and an approach as Transfer assist of one. The problem identified as "Potential for injury secondary to falls" dated 10/28/10 includes the approach "Assist resident with all transfers". Following the fall Resident #3 experienced on 05/03/11, the Care Plan updates did not change under the problem of toileting and the update for "Fall Risk" problem on the care plan did not address assisting the resident to the bathroom or assisting with transfers in toileting, only "Toilet resident per schedule and request". Interview, on 06/15/11 at 11:00am, with LPN #3 revealed she is on the committee that reviews all falls. She revealed, as a team, they identify the problem and come up with interventions. It was stated, all falls are investigated, however, there was only an empty page for the Fall Report on Resident #3. She did not know if any intervention had been put in place following the fall of Resident #3. Interviews, on 06/15/11 with Certified Nursing Assistants (CNA) #4 at 3:45pm, #6 at 2:00pm, #7 at 2:35pm and #8 at 1:50pm and Licensed Practical Nurses (LPN) #5 at 2:05pm and #6 at 2:20pm and the Assistant Director of Nursing (ADON) at 10:30am, revealed when the Care Plan states a resident is toileted with the assist of	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 323	Continued From page 7 one, it would require the CNA or other staff member to assist the resident to the bathroom and remain either with the resident or right outside the bathroom door, and to then assist the resident out of the bathroom. Interview, on 06/15/11 at 10:30am, with the ADON revealed falls are to be investigated to determine how the fall occurred and if interventions need to be implemented. Interview, on 06/15/11 at 4:40pm, with the Administrator revealed an investigation did not occur for Resident #3 related to the documented fall of 05/03/11. The Resident Event Report Worksheet, there was no name listed under witness, however, it was noted the fall was witnessed. It was unknown who was assisting the resident to the bathroom at the time of the fall. No CNA or any other staff members were interviewed by the facility. It was unknown if his/her call light was on for assistance or if the bed alarm was in working order. It was unknown if a resolution was achieved in the discussion by the team that reviewed falls. Review of the facility Accident and Supervision policy, dated 04/28/11, revealed the facility was to provide an environment free from accidents over which the facility had control and supervised assistive devices to prevent avoidable accidents.	F 323		

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F 323	Continued From page 8 In addition, the facility was to provide appropriate assistive devices to reduce/ prevent accidents, educate staff on using devices correctly, investigate accidents and develope a plan of action to prevent the accident from recurring. Observation of Resident #2, on 06/14/11 at 1:00pm and 2:00pm, revealed the resident was asleep in a low bed with a sensor alarm on the bed. The resident's wheelchair was present in the room and was equipped with anti-tippers on the rear, a sensor pad was in place on the bed and turned on, and fall mats were on both sides of the bed. Review of Resident #2's medical record revealed the physician ordered anti-tippers to the front of the wheelchair on 06/08/11. The Certified Nurse Aide (CNA) assignment sheet only offered the information that the wheelchair was to have 'anti-tippers'. In addition, the physician ordered floor mats, a tab alarm on the wheelchair, and a sensor pad on the low bed. The facility completed a significant change Minimum Data Set (MDS) assessment of the resident on 04/29/11 which revealed the resident was unable to bear weight to ambulate and required extensive assistance with transfers. The resident was cognitively impaired. The care plan dated 01/15/11 revealed the resident had impaired mobility and cognition and required a tab alarm to the wheelchair, a sensor pad on a low bed, and fall mats for safety. The care plan was updated on an unknown date to include mats on both sides of the bed. The resident's wheelchair was not to be left in the room when the resident was in bed. Interview with CNA #1, on 06/14/11 at 2:00pm,	F 323		

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F 323	Continued From page 9 revealed her assignment sheet documented anti-tippers; however, she was not aware they were attached to the wrong part of the wheelchair. She stated she used the resident assignment sheet to provide care to Resident #2 and was not aware the wheelchair was to be removed from the room when the resident was in bed. She stated the assignment sheet did include information on removing the resident's wheelchair while the resident was in bed after reviewing the assignment sheet again. Interview with Licensed Practical Nurse (LPN)#1, on 06/14/11 at 2:00pm, revealed she had monitored the anti-tippers, however, she was not aware the anti-tippers were attached to the wrong part of the wheelchair. She stated the resident tried to stand unassisted and had fallen forward on several occasions so the physician ordered the front anti-tippers. She indicated she did supervise the CNAs to ensure residents were safe and using assistive devices. She could not explain why the resident had the wheelchair in the room while asleep or why the anti-tippers were attached to the wrong part of the wheelchair. Review of Resident #2's medical record and incident reports dated 05/06/11 and 06/02/11 revealed the resident fell on each of these dates. On 05/06/11 during the time of shift change from first to second shift, the resident rolled out of a low bed, landed on the floor and sustained a closed head injury. The resident had a sensor alarm on the bed at the time of the fall; however the sensor was not operational as the batteries were missing. In addition, the resident was to have a mat on the right side of the bed on the floor; however the mat was placed on the left side	F 323		

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185196		C 06/15/2011

NAME OF PROVIDER OR SUPPLIER
KINDRED NURSING AND REHABILITATION-BASHFORD

STREET ADDRESS, CITY, STATE, ZIP CODE
3535 BARDSTOWN ROAD
LOUISVILLE, KY 40218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10 of the bed. The resident was treated and released from a local emergency room with instructions for staff to monitor the resident for 24 hours for complications. Interview with CNA #2, on 06/15/11 at 3:00pm, revealed he provided care for Resident #2 on 05/06/11 during the first shift and everything was in place when he left at 3:00pm. He indicated the sensor pad was on the bed and functioning properly and floor mat was on the right side of the bed. He stated he was well aware of the resident's care requirements from the assignment sheet and could not account for what happened. He stated he had received training on fall prevention. Interview with CNA #9, on 06/15/11 at 5:10pm, revealed she found Resident #2 on the floor while making rounds at shift change around 3:00pm on 05/06/11. She stated she completed part of the incident report regarding the safety equipment status at the time of the fall. She stated the sensor alarm batteries were missing so the alarm did not sound and the resident did not have a mat on the right side of the bed where falls usually occurred. She stated the CNAs and Nurses were responsible to monitor safety alarms and devices every shift to ensure they were in good working order. Review of the medical record and incident report for Resident #2's fall on 06/02/11 revealed the resident stood up from the wheelchair in the hallway and fell. The CNA reported the tab alarm attached to the resident was in the off position. Interview with the Administrator, on 06/14/11 at	F 323		

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

PRINTED: 06/22/2011
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185196		C 06/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-BASHFORD	3535 BARDSTOWN ROAD LOUISVILLE, KY 40218

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F 323	Continued From page 11 3:00pm, revealed falls were reviewed and investigated during morning meetings at the facility. He stated Resident #2 fell while trying to reach a motorcycle and again when standing up alone from a seated position. He indicated he did not know why the resident would stand alone. He stated the incident reports contained part of the information regarding investigations into causative factors and were located in the medical record progress notes. He stated a fall log was maintained for each resident and included name, time, date, and description of the event. The records for Resident #2 revealed information regarding what happened; however, no information regarding causative factors was provided.	F 323		

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