

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

PRINTED: 06/24/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185268</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/10/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229</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 000	INITIAL COMMENTS  An abbreviated survey was initiated on 06/09/11 and concluded on 06/10/11 investigating KY #16530. The Division of Health Care substantiated the allegation with deficiencies cited at a S/S of a "G". The facility had opportunity to correct.  In addition, KY #16450 was investigated during this survey and found to be substantiated; however, no regulatory deficiencies were issued. The facility was out of compliance at the time of the occurrence (05/13/11) with substantial compliance achieved on 05/27/11. No new non-compliance was found during the abbreviated survey concluded on 06/10/11.	F 000	<p><b>Plan of Correction</b> Preparation and Execution of this response and plan of correction does not constitute an 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. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.</p>		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation of the facility's video taping, interview, review of facility policy, incident report, and the clinical record it was determined the facility failed to provide appropriate assistive devices to prevent accidents for one (1) of three (3) sampled residents. Resident #1, who had a history of a CVA (stroke) and left sided hemiparesis, utilized a leg/foot rest on the	F 323			

**RECEIVED**  
**JUL 19 2011**  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Beverly M. Edwards* TITLE: *Administrator* (X6) DATE: *7/5/11*

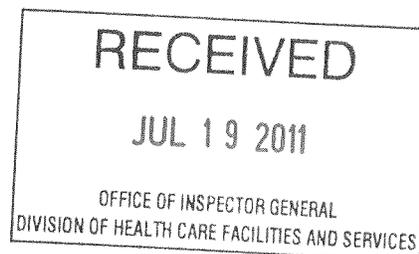
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

*B/B*

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

PRINTED: 06/24/2011  
FORM APPROVED  
OMB NO. 0938-0391

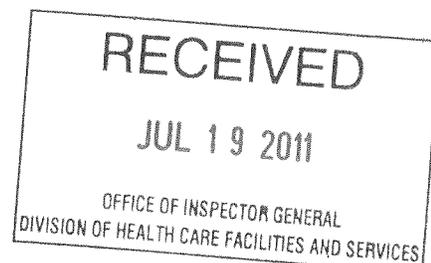
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/10/2011
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 GOOD SAMARITAN WAY LOUISVILLE, KY 40229		
(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 1 wheelchair for all transports. On 06/03/11, facility staff failed to apply this device to the resident's wheelchair. During a transport, the resident's left foot touched the floor, and the foot and leg bent backward under the wheelchair. On 06/04/11, after family reported Resident #1 was complaining of pain, the nurse assessed the resident and identified the left leg exhibited plus 3 non-pitting edema, was tender to touch, and the left ankle was not in alignment with the upper portion of the lower leg. Resident #1 was transferred to the hospital and diagnosed with a fracture to the left tibia and fibula (lower leg bones) which required hospitalization.  The findings include:  Review of the facility's policy for fallen or injured residents, revised April 2011, revealed the policy focused on falls with injuries rather than other incidents of injury.  Review of Resident #1's clinical record revealed the resident was admitted to the nursing facility on 05/27/07 with diagnoses of a Cerebral Vascular Accident (stroke), left-sided Hemiplegia, muscle weakness, and Hypertension. Review of the most current MDS (Minimum Data Set) assessment completed on 05/18/11 revealed the facility had assessed the resident to be non-ambulatory with total assistance from staff for locomotion on and off the unit. The facility assessed the resident to have no deficit in memory recall with the resident able to recall all three words with no cues required. Review of the care plan dated 05/25/11 revealed alteration in self care related to CVA, left hemiparesis, weakness, and independently perform own ADLs	F 323	F323 1. The charge nurse will assess resident #1 daily when she is out of bed to ensure the adaptive equipment is in place. Resident #1's adaptive equipment will be listed on the Treatment Record for the charge nurse to assess then initial each shift to confirm that the equipment is present. 2. The DON or Unit Manager will audit <u>all</u> residents to determine if they have or require adaptive equipment. The DON or Unit Manager will ensure that all adaptive equipment is included in care plan approaches and listed on each resident's Treatment Record to ensure the charge nurse checks each resident each shift then initials that the equipment is present. 3. The DON and/or Staff Development Coordinator will in-service <u>all</u> Department Directors on the importance of being observant of lower extremities prior to pushing a resident's wheelchair. The DON, Staff Development Coordinator or Department Director will in-service <u>all</u> staff on the importance of being observant of lower extremities prior to pushing a resident's wheelchair. The DON, Staff Development Coordinator and/or Unit Manager will in-service all nursing staff (CNAs, CMTs, LPNs, RNs) on the importance of knowing and monitoring resident's ordered adaptive equipment.		



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

PRINTED: 06/24/2011  
FORM APPROVED  
OMB NO. 0938-0391

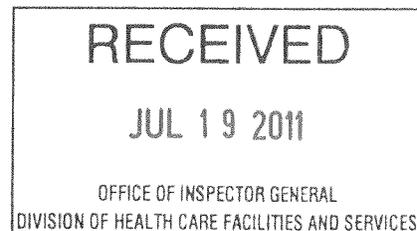
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/10/2011
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 2 (activities of daily living). The care plan stated the resident required total assist from staff for wheelchair mobility.</p> <p>Review of a facility's incident detail report, completed on 06/04/11, revealed Resident #1 had an injury of unknown source. The report revealed the resident's left ankle/lower leg was swollen and the ankle "looked dislocated". The report revealed the resident complained of pain and the daughter had reported the leg/foot rest had not been applied for "a great deal of the day" on 06/03/11.</p> <p>Review of the clinical record revealed a nurses' note dated 06/04/11 at 6:15pm where Resident #1's daughter approached the nurse and reported the resident's left foot was "dragging along the ground at times". The daughter informed the nurse that the leg/foot rest had not been attached to the resident's wheelchair for a portion of time on 06/03/11. The daughter stated the resident spent the "entire night of 06/03/11 in pain to the left leg". Upon assessment of the resident's left foot the nurse documented the left leg exhibited plus 3 non-pitting edema, tender to touch, and the left ankle was not in alignment with the upper portion of the lower leg. The physician was notified and the resident was transferred to the emergency room. At 9:00pm, the hospital's emergency room notified the facility the resident was being admitted to the hospital for fracture of the left tibia and fibula.</p> <p>Observation of Resident #1, on 06/09/11 at 8:45am, revealed the resident lying in bed with eyes closed. An immobilizer was applied to the resident's left leg from the knee to the toes. Interview with the resident at the time of the</p>	F 323	<p>4. The Restorative Nurse and/or restorative aide will monitor adaptive equipment placement each morning for <u>all</u> residents. The DON and/or Unit Manager will conduct a random audit regarding placement of adaptive equipment during facility rounds 3 days each week for 3 months. Results of the audits will be documented and reported to the QA Committee for further recommendations.</p> <p>The Plan of Correction will be completed by July 22, 2011.</p>	



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

PRINTED: 06/24/2011  
FORM APPROVED  
OMB NO. 0938-0391

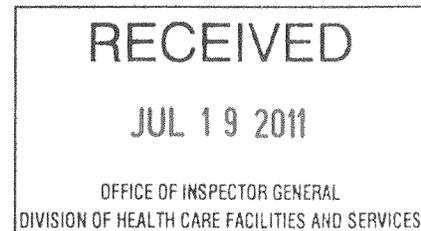
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/10/2011
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 323	<p>Continued From page 3</p> <p>observation revealed the left leg was injured when a lady was pushing the resident's wheelchair and "all at once my leg felt hurt". "The lady stopped and asked if I was hurt and even though my leg was hurting, I told her I would be okay." The resident stated the nurse did not assess the injured leg, only the person pushing the wheelchair. "My daughter came in to visit the next day and saw my foot, she wanted medical care".</p> <p>Interview, on 06/10/11 at 5:15pm, with the nurse who assessed Resident #1 on 06/04/11 revealed the daughter reported the resident's leg was swollen and out of alignment. Upon assessment the nurse found the resident's left foot to be very edematous and was turned inward. She stated the resident did not complain of any pain at that time. The nurse stated she received no report of any incident regarding the residents during shift change report.</p> <p>Interview with Resident's #1's daughter, on 06/09/11 at 11:30am, revealed the daughter visits the resident daily. She revealed the resident was suppose to have a leg/foot rest applied to the left side of the wheelchair since the stroke because of the left sided paralysis and the resident could not propel the wheelchair with the left leg, and this was in place long before this incident. The daughter stated she came to the facility on 06/03/11 at approximately 10:00am and the resident was in an activity. When the daughter went into the activity to see the resident, she noticed the leg/foot rest was not applied to the resident's wheelchair and she requested the staff to apply. The daughter stated the resident complained of pain while the staff was placing the</p>	F 323	



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

PRINTED: 06/24/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/10/2011
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 4</p> <p>left leg upon the leg rest but she thought it was "normal aches and pains". The daughter came back to the facility the morning of 06/04/11 and checked the resident's legs for edema, which according to the daughter she did regularly. She stated the left foot didn't look right but the resident was not complaining of pain at that time. The daughter came back to the facility that evening (06/04/11) and found the resident's left ankle/foot swollen and the ankle was not in alignment with the rest of the leg. The daughter informed the nurse who then called the physician. The daughter voiced concern that the resident had been transferred by a mechanical lift where the resident would have to bear weight on the left leg after the incident and may have caused further harm. The daughter stated the resident's injury could have been prevented if the staff had only applied the leg/foot rest and she was upset that she had to be the one who discovered the injury.</p> <p>Interview with the Director of Nursing (DON), on 06/09/11 at 10:30am, revealed the facility became aware of the injury of unknown source on 06/04/11 when the daughter reported the changes to the resident's left leg. During the investigation, it was found the resident's leg/foot rest had not been applied on the morning of 06/03/11. The activity assistant told the activity director that there had been an incident on 06/03/11 where the resident's left foot had caught on the floor and bent backward under the wheelchair. The DON stated upon interview with the activity assistant, it was found the resident's left foot probably was injured when the left foot was bent backward.</p> <p>On 06/09/11 at 9:45am, an interview with the</p>	F 323			



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

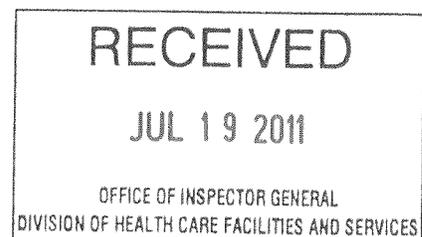
PRINTED: 06/24/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/10/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

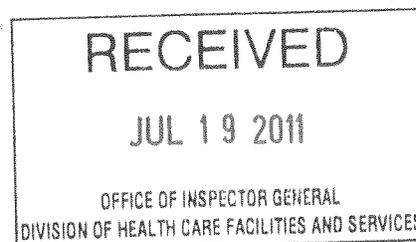
F 323	<p>Continued From page 5</p> <p>activity assistant revealed she went into the resident's room on 06/03/11 before 10:00am to take the resident to an activity. The resident was already sitting up in the wheelchair. She stated she did not look at the wheelchair to see if the leg/foot rest was applied. When she was pushing the wheelchair across the first dining room, the resident yelled, "Oh!" She stated she stopped and the resident said something like my foot is stuck or ouch my foot hurts. When she pulled the wheelchair back, the resident's foot was bent under the wheelchair. The activity assistant stated she apologized to the resident and asked if the resident was okay. She stated the resident indicated the foot was okay and they proceeded on toward the activity. She stated the resident was in the activity without any signs of pain. She stated the daughter came to the door and asked if she could take the resident. The daughter was upset the leg/foot rest was not on the resident's wheelchair and requested staff to apply the leg/foot rest. The activity assistant stated she didn't realize the leg/foot rest was suppose to be on the resident' wheelchair. She acknowledged she had not asked about the leg/foot rest and did not report the incident to anyone. She stated she thought the resident was fine and didn't realize the resident was really hurt.</p> <p>On 06/10/11 at 8:50am, a review of the facility's security video tape (with the administrator and DON) for the morning of 06/03/11 revealed the resident propelled the wheelchair from the resident's room at 4:45am, down the hallway (D-wing) and into the sitting area outside the C/D dining room. The resident was observed to move the wheelchair with the right foot and right hand. The leg/foot rest was not applied and the</p>	F 323		
-------	---	-------	--	--



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

PRINTED: 06/24/2011  
FORM APPROVED  
OMB NO. 0938-0391

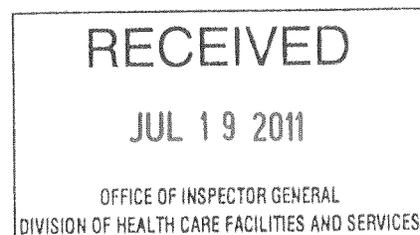
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/10/2011
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 6</p> <p>resident's left foot was observed to be dangling above the floor. At 5:10am, CNA#4 brought another resident to the sitting area and placed the resident beside Resident #1. Throughout the tape, CNA #4 passed Resident #1 several times and did not identify the resident's leg/foot rest was not applied.</p> <p>Continued review of the facility's video tape revealed on 06/03/11 at 7:55am, LPN #3 pushed Resident#1's wheelchair to the dining room and placed the resident under the table. The nurse did not identify the leg/foot rest was not applied. At 8:57am, LPN #4 removed the resident from the dining room and took the resident back to the room. The video taping revealed the leg/foot rest was not applied. At 10:05am, the activity assistant was observed to go into the resident room and came out pushing Resident #1's wheelchair down the hallway. The wheelchair did not have the leg/foot rest applied. The resident's right foot was resting on top of the left foot.</p> <p>Interview with CNA #4, on 06/09/11 at 10:45pm, revealed on the morning of 06/03/11 she was assisting LPN #4 with a straight cath for urinalysis on Resident #1. She stated the resident requested to get up early (4:30am) so she washed and dressed the resident. She left the resident in the wheelchair in the resident's room and didn't know how the resident got to the sitting area. She confirmed she had not applied the leg/foot rest to the resident's wheelchair. When she conducted the last visual check on the resident, she found the resident sitting in the same area as before. She stated she did not think about the leg/foot rest not being applied.</p>	F 323			



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

PRINTED: 06/24/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/10/2011
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 7</p> <p>Interview with CNA #3, on 06/10/11 at 10:35am, revealed Resident #1 was already up in the wheelchair when she arrived for work on 06/03/11. The CNA did not notice the leg/foot rest was not applied. Later that morning, she saw the resident with the daughter and the leg/foot rest was applied at that time. CNA #3 stated when she put the resident back to bed at 2:00pm, the resident's left leg was slightly swollen but nothing was alarming because the resident routinely has some edema in the feet. The resident requested to have the left leg elevated and did whimper a little but did not vocalize any pain.</p> <p>Interview with LPN #4, on 06/10/11 at 10:25am, revealed she had pushed Resident #1 in the wheelchair from the dining room to the resident's room after breakfast on 06/03/11. She stated she placed the resident in the room, turned on the television, and gave the resident the call light. She then left the room without applying the leg/foot rest even though she knew the resident required the use of the leg rest. The nurse stated she had not noticed the leg/foot rest was not applied.</p> <p>Review of the hospital's Orthopedic consultation and Radiology report revealed the resident experienced an acute angulated mildly comminuted and impacted fractures at the distal shafts of the tibia and fibula, approximately 5 centimeters above the Morris (ankle) joint.</p> <p>Interview with Resident #1's physician, on 06/09/11 at 11:15am, revealed the injury was consistent with the type of trauma a resident would experience with the left foot caught behind the wheelchair. The physician added the resident</p>	F 323			



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

PRINTED: 06/24/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/10/2011
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 323	<p>Continued From page 8</p> <p>was non-ambulatory and demineralization of the bones comes with age causing bones to break easily.</p> <p>Continued interview with the DON, on 06/10/11 at 11:00am, revealed the facility did not use paper CNA care plans. The staff used hand held computer devices that had instructions for the CNAs. Review of the hand held device revealed approaches for Resident #1 was non-weight bearing status, immobilizer to left leg, and assure leg/foot placed on wheelchair when resident is up. She revealed those approaches were not in place prior to the incident; however, staff knew the resident required the leg/foot rest when up in the facility. She stated nursing staff involved had been counseled on the failure to apply the leg/foot rest on Resident #1's wheelchair.</p>	F 323		

