



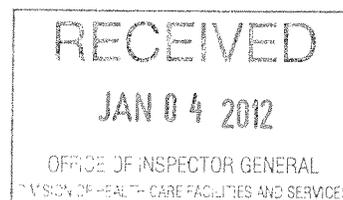
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/14/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185335 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>12/01/2011 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1120 CRISTLAND ROAD<br>LOUISVILLE, KY 40214 |
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| F 274              | <p>Continued From page 1</p> <p>Record review of the Significant Change in Status Assessment policy, dated October 2011, revealed a significant change was a decline or improvement in a residents status that: will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, was not "self-limiting". Impacts more than one area of the resident's health status and requires interdisciplinary review and/or revision of the care plan. A decline in two or more of the following: 1. Resident decision making changes. 2. Any decline in an ADL physical functioning area where a resident is newly coded as extensive assistance, total dependence or activity did not occur since last assessment. 3. Residents incontinence pattern changes or there was placement of an indwelling catheter. 4. Emergence of unplanned weight loss problem ( five (5)% change in thirty (30) days or ten (10) % change in one hundred and eighty (180) days). 5. Overall deterioration of resident's condition.</p> <p>Record review of Resident #4's Minimum Data Set (MDS), revealed the facility completed an admission assessment on 06/20/11 and a Quarterly assessment on 11/21/11. Comparatively Resident #4 showed a significant decline in cognition from moderately impaired to unable to assess due to mental status changes. The facility assessed a decline in ambulation from limited assist to it did not occur, transfer and hygiene from limited assist to total dependance and the resident went from not using a catheter to use of a catheter for voiding. In addition, the resident now required the nutrition supplement via the use of a tube feeding.</p> | F 274         | <p>Continued from Page 1</p> <p>wound and changes in residents status etc.) and weekly in At Risk Meeting to determine the need for a significant change with updated care planning. Any residents identified with a need for a significant change assessment will have a significant change assessment and an updated care plan with the interdisciplinary team. The Minimum Data Set Coordinator will also complete new assessments while comparing to the prior assessment to identify changes that would warrant a significant change. The Interdisciplinary team was in-serviced on 12-20-11 by Consultant Nurse on regulatory guidelines related Significant Change MDS.</p> <p><b>Monitoring of Corrective Action :</b></p> <p>Director of Nursing will audit a 10% resident sample monthly to identify residents who need a significant change assessment and updated care plan for the next 6 months and then for an additional two quarters to identify residents who need a significant change assessment and ensure care plans are updated. Concerns will be addressed immediately.</p> <p>Findings of the above audits regarding Significant Changes will be reviewed in Quality Assurance Meeting monthly for 6 months and then quarterly time two for recommendations and further follow up as indicated.</p> | 12/29/11             |



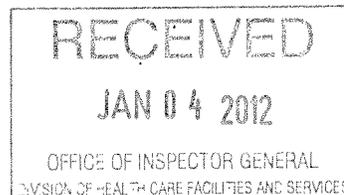
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| F 274              | <p>Continued From page 2</p> <p>Record review of the Progress Notes, dated 11/02/2011, revealed Resident #4 showed a decline and failure to thrive for several months. Several family meetings had been held and as of the last family meeting, the plan was for comfort care. Resident #4 was documented as end-stage Dementia for the feeding tube by the physician.</p> <p>Record Review of the Social Services Progress Notes, revealed Resident #4 was unable to complete a BIMS and PHQ9 on 11/15/11. The resident had short term and long term memory impairments and the resident's decision making was severely impaired. Staff chooses resident's clothing, bathing time and meal preferences daily and anticipates the resident's wants and needs. The Social Services Progress Note further stated, the resident appeared down/depressed, had little energy, moved and spoke slower and was easily annoyed. Resident #4 was on palliative care.</p> <p>Observations made of Resident #4, on 11/29/11 at 11:12 AM, 12:00 PM, 12:30 PM, 2:45 PM, 3:17 PM, 5:00 PM, and on 11/30/11 at 9:05 AM, and 10:55 AM revealed Resident #4 in his/her room lying in the bed.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 11/29/11 at 11:20 AM, revealed there had been a decline in Resident #4's activity of daily living (ADL) since admission. CNA #3 further stated, Resident #4 was much weaker and wanted to lie in bed more.</p> <p>Interview with Minimum Data Set (MDS) Coordinator, on 12/01/11 at 5:15 PM, revealed she did not have an answer as to why a</p> | F 274         |   |                      |



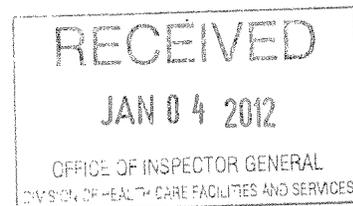
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| F 274              | Continued From page 3<br>significant change was not completed on the MDS; however, there should have been a significant change completed for Resident #4.   | F 274         |   |                      |
| F 280<br>SS=F      | <p>Interview with the Director of Nursing (DON), on 12/01/11 at 5:45 PM, revealed there should have been a significant change documented because of Resident #4's comfort care status.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</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:<br/>Based on interview, record review and facility policy review it was determined the facility failed to develop, review and/or revise the</p> | F 280         | <p><b>F 280</b><br/><b>Measures or Systems changes to prevent reoccurrence</b></p> <p><b>Corrective Action for Residents Affected:</b></p> <ol style="list-style-type: none"> <li>1. Resident # 10 Care plan was reviewed and updated by the Director of Nursing / Minimum Data Set Coordinator/Interdisciplinary team to clinically correspond to the residents care needs related to Incontinent . Completed on 12-22-11.</li> <li>2. Resident # 17 – no longer resides in the facility</li> <li>3. Resident # 1 Care plan was reviewed and updated by the Director of Nursing, Minimum Data Set Coordinator/Interdisciplinary team to clinical correspond to the resident care needs related to Transfers/Ambulation. Completed on 12-22-11</li> <li>4. Resident #5 - Care plan was reviewed updated by the Director of Nursing/ Minimum Data Set Coordinator/ Interdisciplinary team to clinical corresponds to the resident needs related</li> </ol> |                      |



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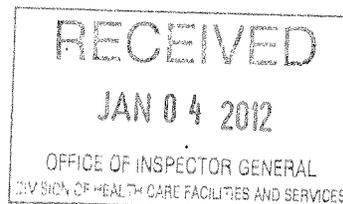
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| F 280 | <p>Continued From page 4</p> <p>comprehensive plan of care for seven (7) of seventeen (17) sampled residents. The facility failed to complete accurate and/or update comprehensive plans of care for Residents #1, 2, 4, 5, 9, 10 and 11.</p> <p>The findings include:</p> <p>Review of the facility's policy on Care Planning revealed the plan of care should be individualized, based on the diagnosis, resident assessment and personal goals of the resident and his/her family.</p> <p>Review of the facility's Care Plan policy revealed the Interdisciplinary Care Plan is reviewed; revised and updated quarterly and more frequently if warranted by a change in the resident's condition.</p> <p>Interview with the Director of Nursing (DON), on 12/01/11 at 5:20 PM, revealed the MDS staff was responsible for updating plans of care.</p> <p>Interview with the MDS Coordinator, on 12/01/11 at 5:15 PM, revealed MDS staff were responsible to update the careplans.</p> <p>1. Record review for Resident #10 revealed the facility admitted the resident on 03/17/11 with the diagnoses of Osteoarthritis, Closed fracture of neck of femur, Muscle Weakness, Lymphedema and Morbid Obesity. Review of the Minimum Data Set (MDS) dated 11/13/11 revealed the facility assessed Resident #10 as frequently incontinent of both bowel and bladder. Review of the comprehensive plan of care revealed there was no care plan to address the needs of</p> | F 280 | <p>Continued from Page 4</p> <p>to Communication and assistive devices. Completed on 12-22-11</p> <p>5. Resident #9 Care plan was reviewed and updated by the Director of Nursing / Minimum Data Set Coordinator/ Interdisciplinary team to clinically correspond to the resident care needs related to Bowel and Bladder, including renal failure. Completed on 12-22-11.</p> <p>6. Resident #2 care plan was reviewed updated by the Director of Nursing/ Minimum Data Set Coordinator/ Interdisciplinary team to clinical correspond to the resident needs related to 1. PICC Line was D/C - care plan updated, 12-1-11 2). Staples - D/C 12-1-11, care plan updated, 12-1-11.</p> <p>7. Resident # 4 Care plan was reviewed and updated by the Director of Nursing/Minimum Data Set Coordinator/Interdisciplinary team to clinical correspond to the resident care needs related to Comfort Care, 12-15-11.</p> <p>8. Resident # 11 - no longer resident in the facility</p> <p><b>Identification of Resident with Potential to be Affected:</b></p> <p>All Residents could potentially be impacted. Care plans will be reviewed by 1-7-12 by the Director of Nursing/</p> |  |
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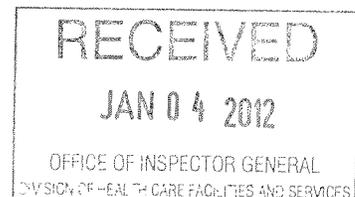
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| F 280              | <p>Continued From page 5</p> <p>Resident #10's incontinence of bowel or bladder.</p> <p>2. Record review for Resident #17 revealed the facility re-admitted the resident on 08/11/11 with the diagnoses of Urinary Tract Infection (UTI), Morbid Obesity and Diabetes. Review of the MDS dated 08/25/11 revealed the following areas triggered and would be addressed on the care plan; Activities of Daily Living, Visual, Urinary incontinence, Psychosocial, Falls, Nutrition, Dehydration, Dental, Pressure, Psychotropic Drug Use, and Pain. The facility was unable to produce a comprehensive care plan to address the needs of this resident in any of the areas that triggered.</p> <p>3. Record review of Resident #1's medical record revealed, the facility admitted the resident on 02/25/10 with medical diagnoses of Hypertension, Renal Disease, Osteoarthritis, and Dehydration. Review of the Quarterly Minimum Data Set, dated 10/24/11, the facility assessed the resident as extensive assist with transfers and ambulation as not occurring. Neither the transfer or ambulation needs were reflected in the comprehensive care plan.</p> <p>4. Record review of the medical record of Resident # 5 revealed, the facility admitted the resident on 12/17/10 with medical diagnoses of Brain cancer, Urinary Tract Infection, Dementia, Hypertension, Gastrostomy-tube, Diabetes Mellitus, Seizures, and Oral Trush. The facility re-admitted the resident after a hospital stay on 11/28/11. The CAA's identified communication as a care plan need. The resident was non-verbal and the care plan intervention was to ask yes/no questions. There were no interventions for an</p> | F 280         | <p>Continued from Page 5</p> <p>Minimum Data Set Coordinator/Unit Manager, Inter-disciplinary team to ensure appropriate identification and individualized care planning is completed upon admission and revised as changes in residents status requires.</p> <p><b>Measures or Systems changes to prevent reoccurrence:</b></p> <p>The interdisciplinary Team, (the Director of Nursing/ Minimum Data Set Coordinator/Unit Manager/Interdisciplinary team) will discuss/review daily during the Clinical Meeting any changes to the residents care needs will be reviewed and discussed daily in clinical meeting. Care plans will also be reviewed in this meeting to ensure that the care plan has been updated by the Minimum Data Set nurse and corresponds to the residents' needs. Residents care needs who are returning to the facility from an acute care setting will be reviewed and discussed in clinical (a daily Meeting with the IDT to discuss physician orders, labs results, falls, wounds etc.) and their care plans updated accordingly by the Interdisciplinary team. In-service education was completed on 12/20/11 by Corporate Nurse for the Interdisciplinary team regarding appropriate development and updating of care plans for all residents.</p> <p>Licenses Nursing Staff will be in-serviced by the Director of Nursing and the Staff Development Coordinator by 12-24-11</p> |                      |



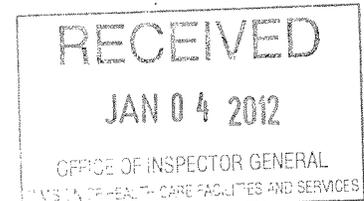
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| F 280              | <p>Continued From page 6</p> <p>assistive device to enhance the resident's ability to communicate needs to the staff.</p> <p>5. Record review of the medical record of Resident #9 revealed the facility admitted the resident on 07/21/10 with medical diagnoses of a Pacemaker, Abdominal Pain, Diabetes Mellitus, Renal insufficiency, and Coronary Artery Disease. Review of the care plan revealed the resident was care planned for Renal failure and was to be assessed for the complications of renal dialysis; however the resident was not receiving dialysis.</p> <p>Interview, on 12/01/11 at 2:00 PM, with the Director of nursing revealed the facility has had a concern with care plans and MDS assessments. She stated the care plan of Resident #9 should have been revised to address the current and actual needs of the resident.</p> <p>6. Review of the medical record for Resident #2 revealed the facility admitted the resident on 11/03/11 with diagnoses of Right (rt) Fracture Neck Femur, Urinary Tract Infection, Right Upper Extremity (RUE) PICC Line and Clostridium Difficile. Review of the plan of care for Resident #2 revealed there was no updated care plan regarding the discontinuation of the (RUE)PICC line or the removal of staples from right hip.</p> <p>Record review of the Physician's Orders dated 11/19/11 revealed; the PICC Line was to be discontinued. Review of the twenty-four (24) hour report/change of condition report revealed Resident #2's PICC Line was discontinued on 11/19/11. Review of the IV Therapy Care Plan on 11/30/11 revealed Resident #2 was currently utilizing a (RUE)PICC line.</p> | F 280         | <p>Continued from Page 6</p> <p>regarding appropriate development and updating of care plans for all residents.</p> <p><b>Monitoring of Corrective Action :</b></p> <p>The Director of Nursing and Minimum Data Set Coordinator will complete an audit of 10% of care plans weekly to ensure appropriate development and updating reflect the residents current needs.</p> <p>Findings of the audits regarding appropriate development and updating of care plans will be reviewed in the Quality Assurance meeting monthly for 6 months and then quarterly time two for recommendations and further follow up as indicated.</p> | 1-7-12               |



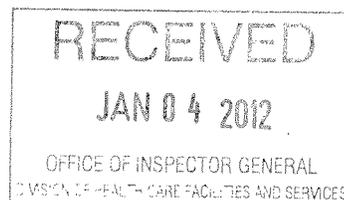
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| F 280              | <p>Continued From page 7</p> <p>Review of the Nurse's Notes dated 11/14/11 revealed staples were removed, monitoring and treatment to right hip was discontinued. Review of the Impaired Skin Integrity Care Plan on 11/30/11 revealed Resident #2 as having seven (7) staples in right hip.</p> <p>Interview with LPN #4, on 12/01/11 at 3:00 PM, at the East Nursing Station revealed the nursing care plans are kept in the Minimum Data Set (MDS) office. She further stated updating the nursing care plan was the responsibility of MDS Coordinator. The floor nurses are not to update the nursing care plan but only document changes on the twenty-four hour(24) report sheet. She further stated by not having an accurate nursing care plan the residents care could be compromised.</p> <p>Interview with LPN #5, on 12/01/11 at 3:10 PM, at the East Unit Hallway revealed the MDS was responsible for updating the nursing care plan and the nursing care plans are kept in the MDS office. The Director of Nursing ensures the accuracy of the nursing care plan based on the 24 hour report. She also stated by not having and accurate up to date nursing care plan a resident could receive incorrect care.</p> <p>Interview with the Unit Manager LPN #6, on 12/01/11 in front of the East Nurses Desk at 3:40 PM, revealed the nurses are responsible for updating the care plan and logging changes on the 24 hour report. The 24 hour report was what was used by the MDS staff to update plans of care. Resident #2's IV and Skin plan of care had not been updated.</p> | F 280         |   |                      |



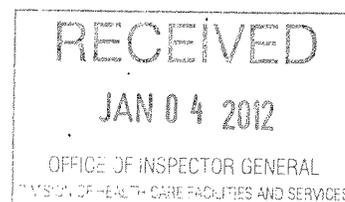
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| F 280              | <p>Continued From page 8</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, on 12/01/11 at 4:50 PM, revealed staff failed to update Resident #2's plan of care. She stated floor staff do not up date the plan of care. The facility's system was not effective for updating the plan of care.</p> <p>Interview with the Director of Nursing (DON), on 12/01/11 at 5:20 PM, revealed the plan of care for Resident #2 should have been updated to reflect the removal of the PICC line and the right hip staples. However, the facility's current system was not working for updating nursing care plans.</p> <p>7. Record Review of Resident #4's record revealed the facility admitted the resident with Severe Dementia, Dysphagia in which a g-tube needed to be placed, Chronic Lymphocytic Leukemia, Renal Failure and Muscle Weakness. Record review of Resident #4's care plan revealed Resident #4 was not careplanned for comfort care.</p> <p>Record review of Progress Notes, dated 11/02/11, revealed during a meeting with the family, the plan was for Resident #4 to be on comfort care.</p> <p>Interview with the Director of Nursing (DON), on 12/01/11 at 5:45 PM, revealed Comfort Care should have been careplanned for Resident #4. Some nurses know to update the careplans and some nurses do not. She stated the current process was not working.</p> <p>Interview with LPN #6, on 12/01/11 at 4:05 PM, revealed nurses do not update the care plans, the</p> | F 280         |   |                      |



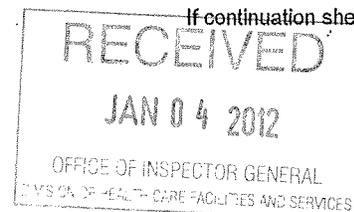
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| F 280              | <p>Continued From page 9<br/>MDS Coordinator updates the careplans.</p> <p>Continued interview with the MDS Coordinator, on 12/01/11 at 5:15 PM, revealed the careplans had not been addressed because she had been trying to catch the facility up on the annual and quarterly assessments that were not completed timely. She adds updates to the careplan when the nurse manager in morning meeting reads off the orders.</p> <p>She further explained if the nurse was to write healed on a treatment, she would not see it because it was not an order, thus the care plan would not be updated. The Unit Managers were not checking behind the MDS Coordinators to make sure the care plans were updated. The MDS Coordinator further stated the total care plan process was not appropriate because it was all up to the MDS staff to get the care plans completed. The MDS Coordinator stated the managers should have more responsibility. The Care plans were placed in the MDS office and were not out in the clinical area for the nurses to assess, because the staff was losing the care plans.</p> <p>Continued interview with the Director of Nursing (DON), on 12/01/11 at 5:45 PM, revealed the care plans were kept in the MDS office because care plans were coming up missing and not being updated. The DON stated the care plans got worse again. She started noticing the dietary care plans were not being updated or initiated. She was also concerned with the nursing care plans and MDS staff was forced to follow up more and the MDS Coordinator oversaw the clinical meetings. The DON stated in March she fired ten</p> | F 280         |   |                      |



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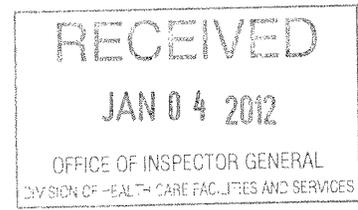
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| F 280         | Continued From page 10<br>(10) to eleven (11) nurses and she could not manage it all. The computer generated care plans from the MDS; however, the MDS Coordinator did not like the care plans as outlined. Some nurses know to update the care plan and some nurses do not. The DON stated she was aware the process for the MDS staff to just look at orders to updated the care plan was not working. The DON stated the MDS department and the Administrator were ultimately responsible to make sure the care plans were completed.<br><br>Interview with the Administrator, on 12/01/11 at 5:35 PM, revealed they were looking at Activity of Daily Living documentation, timely MDS assessments and timely submissions. They found the Directors were not updating appropriately. The responsibility of the care plans was shifted to the Administrator. | F 280 |  |  |
| F 309<br>SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of the Physician Orders At-A-Glance Policy and the Hydration Policy, it was determined   | F 309 | <b>F309</b><br><br><b>Corrective Action for Residents Affected:</b><br><br>1.) Resident # 4 had an assessment completed (12-2-11) by the Unit Manager regarding hydration per G-tube and water PO. Speech Therapy – screened (12-9-11), Dietician – consulted (12-7-110. Care plan with family (12-15-11). Physician Order received (12-1-11) “Discontinue Free Water Order. Clarified Flush GT per order and Continue with Sips of H2O with Nurses only per resident’s request. The State Registered Certified Nursing Record was clarified with Sips of Water with Nurse only per residents request. |  |



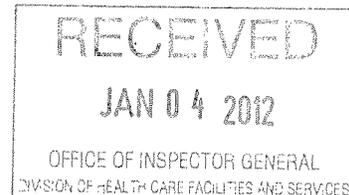
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| F 309              | <p>Continued From page 11</p> <p>the facility failed to follow MD orders for one (1) of seventeen (17) residents, Resident #4 as it related to the Free Water order.</p> <p>The findings include:</p> <p>Record review of the Physician Orders At-A-Glance Policy, no date provided, revealed #1 stated Physician/Medical Practitioner order given (via telephone; directly written in chart; verbal; faxed), the nurse receiving the order determines if the order is formulary compliant and clarifies variance with Medical Practitioner.</p> <p>Record review of the Hydration Policy dated 12/2010, revealed it is the intent of this facility that residents receive sufficient amounts of fluid to maintain proper hydration.</p> <p>Record Review of Resident #4's record revealed, the facility re-admitted the resident on 08/23/11 with Severe Dementia and Dysphagia in which a G-tube needed to be placed. The speech therapist notes, dated 08/24/11, revealed Resident #4 was on palliative care and had increased confusion. Patient was screened on thin liquids. Resident #4 refused mechanical soft diet. MD [approved] returning resident to mechanical soft, thin liquids for pleasure and peg tube feedings for nutrition. No speech therapy recommendations at this time.</p> <p>Observation of Resident #4's bedside table, on 11/29/11 at 11:12 AM, 12:00 PM, 12:30 PM, 2:45 PM, 3:17 PM, 5:00 PM and on 11/30/11 at 9:05 AM and 10:55 AM, revealed no water at bedside.</p> <p>Interview with Resident #4, on 11/30/11 at 9:05</p> | F 309         | <p>Continued from Page 11</p> <p><b>Identification of Residents with potential to be affected:</b></p> <p>Any resident receiving an order for "Free Water" could be impacted.</p> <p>All medical records were audited on 12-2-11 by the Director of Nursing, Minimum Data Set Coordinator, Assistant Director of Nursing to ensure the accuracy of all physician/ nurse practitioner orders related to "Free Water"</p> <p><b>Systematic changes to prevent recurrence of the deficient practice.</b></p> <p>All physician/nurse practitioner orders will be discussed daily in the clinical meeting (a daily meeting with the IDT to discuss physician/nurse practitioner orders) and we find any order for "free water" a clarification order will be obtained from the ordering physician/nurse practitioner.</p> <p>Education for Nurse Practitioner to write the order to state P.O. instead of "Free Water" was completed on 12-2-11 By the Director of Nursing.</p> <p>Education for Dietician and Dietary Manager regarding By Mouth/ Oral intake instead of "Free Water" was completed on 12-2-11 by the Director of Nursing</p> <p>In-service to staff to clarify any NPO orders and "Free Water " orders was completed on 12-2-11 by the Director of Nursing.</p> |                      |



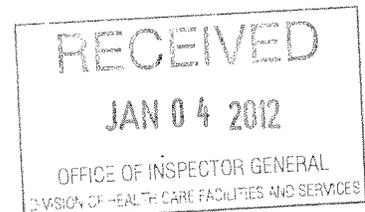
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| F 309              | <p>Continued From page 12<br/>AM, revealed he/she was thirsty.</p> <p>Record review of progress notes, dated 09/26/11, revealed the resident complained of wanting water, questionable electrolyte imbalance. Additional progress note, dated 10/3/11, revealed an electrolyte imbalance- 9/27 BUN 50, resident now on free H2O (water) flushes. A progress note, dated 10/13/11, stated complaints of being "thirsty". Record review of MD orders revealed, on 10/21/11, Resident #4 was to receive an increase in Free H2O (water) of 250 cc every four (4) hours. Physician Progress notes, dated 11/02/11, revealed HEENTconsult: Resident #4 had crusting around his/her mouth and the oral mucosa was dry.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 11/30/11 at 9:10 AM, revealed she had to go check the chart to make sure Resident #4 could receive water.</p> <p>Record review of the Medication Administration Record (MAR) for the month of 11/11, revealed an order to flush g-tube with 250 cc every 4 hours. The MAR also revealed an order for [resident] may have 250 cc of H2O po every four (4) hours. Documentation revealed one signature on the order that stated may have 250 cc of H2O po every four (4) hours. Record review of the Daily Consumption Record revealed nothing by mouth (NPO) twenty-one (21) of the thirty (30) days allocated.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 11/29/11 at 11:00 AM, revealed she was not aware Resident #4 could receive fluids and in report she learned Resident #4 was NPO.</p> | F 309         | <p><b>Monitor to ensure continued compliance.</b> The Assistant Director of Nursing and Minimum Data Set Coordinator will complete an audit of 10% of comprehensive assessments and plans of care as well as physician/nurse practitioner orders to ensure appropriate level of hydration is being achieved. Results of the audits will be forwarded to the Director of Nursing for reviewed and to insure appropriated completion and follow up. Findings of the above audits will be forwarded by the Director of Nursing to the Quality Assurance Committee monthly for 3 months for recommendations and further follow up as indicated.</p> | 1-7-12               |



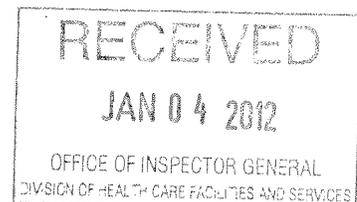
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| F 309              | <p>Continued From page 13</p> <p>Interview with CNA #2, on 11/29/11 at 11:10 AM, revealed Resident #4 was NPO and that she had never set water at Resident #4's bedside. CNA #2 stated she lets the nurse know if Resident #4 is thirsty, but she did not remember if the nurse ever gave Resident #4 anything to drink.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 11/29/11 at 11:12 AM, revealed Resident #4 could not have water at bedside; although record review had revealed there was no order the resident could not receive water at the bedside or that the resident needed to be monitored. LPN #5 further stated if Resident #4's BUN was elevated and the resident was not receiving water as ordered, dehydration could occur. Interview with LPN #5, on 11/30/11 at 4:35 PM, revealed free water meant the resident could have water by mouth and she had been giving Resident #5 water by mouth for the past month.</p> <p>Interview with LPN #7, on 11/30/11 at 4:42 PM, revealed free water ment the resident could drink by mouth.</p> <p>Interview with Advanced Practical Registered Nurse (APRN) #2, on 11/30/11 at 4:15 PM, revealed free water meant per G-tube administration. Interview with APRN #1, on 11/30/11 at 4:15 PM revealed she agreed that free water meant per G-tube.</p> <p>Interview with the Director of Nursing (DON), on 12/1/11 at 2:25 PM, revealed she did not want Resident #4 to drink without the nurses present, this was why the aids were not to give Resident #4 water. The DON further stated, she did not</p> | F 309         |   |                      |



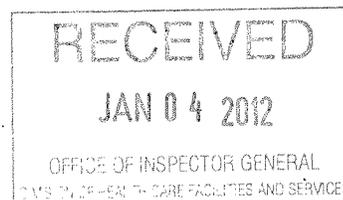
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| F 309              | <p>Continued From page 14<br/>know where the NPO order came from.</p> <p>Interview with the Speech Therapist, on 12/01/11 at 2:39 PM, revealed the practitioner should of clarified if she wanted the water to be administered by mouth (PO) or per g-tube. Free water means it would be administered per G-tube. You would think from a nursing stand point they would know what free water meant.</p> <p>483.75(o)(1) QAA<br/>COMMITTEE-MEMBERS/MEET<br/>QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> | F 309         | <p><b>F520</b></p> <p><b>Corrective Action for Residents Affected:</b><br/>The process for managing the Care plans process for Resident # 1,2,4,5,9,10,11,17 was presented by the Administrator to the Quality Assurance Committee on 12-22-11 for recommendations and continued follow up.</p> <p><b>All residents could be potentially impacted:</b><br/>The Process for managing Care plans was presented by the Administrator to the Quality Assurance Committee on 12-22-11 for recommendations and continued follow up.</p> <p><b>Measures or systems changes to prevent re-occurrence:</b><br/>The Administrator, Director of Nursing, Social Services, Minimum Data Set Coordinator , Plant Operations Director, Staff Development Coordinator, Dietary Manager, Quality of Life Director, Rehab Medical Director, Rehab Therapy Manager,</p> |                      |
| F 520<br>SS=F      |  | F 520         |   |                      |



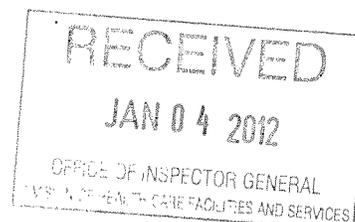
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| F 520              | <p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on interview and Plan of Correction review for the last survey, dated 11/30/10 through 12/02/10, it was determined even though the facility was cited last year, the facility continued to fail to maintain a quality assurance plan of action for care plans which would have identified their system did not ensure the back log of MDS assessments to be completed would not prevent the revision of current careplans for seven (7) out of seventeen (17) resident care plans.</p> <p>The findings include:</p> <p>Record review of the Plan of Correction (POC) dated 12/02/10, revealed staff would be in-serviced by the Director of Nursing (DON) regarding development and updating of care plan. Care plans would be reviewed and revised daily in the Clinical Meeting by the Interdisciplinary team for residents who have changes in their orders that would require a change in their plan of care. The Unit Manager will be responsible for ensuring appropriate changes for the residents on their assigned units. The DON and MDS Coordinator will complete an audit of 10% of care plans weekly to ensure appropriate development and updating to reflect the residents current needs. Development and updating care plans will be reviewed in the Quality Assurance Meeting monthly for six (6) months for recommendations and further follow-up as indicated.</p> <p>Interview with the East Wing Unit Manager, on 12/01/11 at 4:05 PM, revealed she did not update care plans. MDS was responsible to update the care plan every morning in morning meeting.</p> | F 520         | <p>Continued from Page 15</p> <p>Chaplain, Human Resources Director, Medical Director, Medical Records Director members received in-service education provided by the Corporate Nurse on 12-22-11 regarding the requirement of Quality Assurance process and the roles of each Quality Assurance Committee member. Facility staff received in-service education provided by Staff Development Coordinator and Administrator 12-23-11 regarding the Quality Assurance process with identified concerns. The Administrator initiated a process to introduce, develop and implement plans for identified concerns on 12/22/11 with Quality Assurance Committee. The Quality assurance process will foster interdisciplinary communication which will encourage facility- wide involvement and accountability for the maintenance and oversight of facility systems. Concerns are discussed in the morning meeting. The identified concern is assigned to the appropriate Department Manager. A plan to correct the identified concern is developed by the Department manager, along with other staff as indicated. Audits are completed to evaluate the effectiveness of the plan. Findings are discussed by the Quality Committee for recommendations and further follow up. The Administrator initiated a Quality Assurance meeting on 12-22-11 to review and ensure follow up with the system for management of Care plans have been completed. Audits and plans regarding concerns brought to Quality Assurance by other Department Manager were reviewed by the Committee on 12/22/11 for recommendations.</p> |                      |



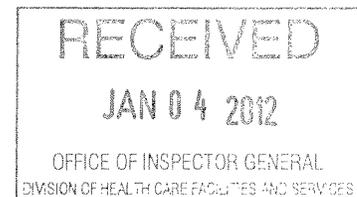
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| F 520              | <p>Continued From page 16</p> <p>Interview with the MDS Coordinator, on 12/01/11 at 5:15 PM, revealed MDS staff were responsible to update the care plans. The MDS Coordinator stated the care plans have not been addressed because the facility was behind in completing the annual and quarterly assessments and she was trying to catch them up. She added updates to the care plan when the nurse manager, in morning meetings, reads off the orders; however, no other updates were provided. She further explained if the nurse was to write healed on a treatment, she would not see it because it was not an order, thus the care plan would not be updated. The Unit Managers were not checking behind the MDS Coordinators to make sure the care plans were updated. The MDS Coordinator further stated the total care plan process was not appropriate because it was all up to the MDS staff to get the care plans completed. The MDS Coordinator stated the managers should have more responsibility and she had not been made aware of the results of the audits the DON was to complete. The Care plans were placed in the MDS office and were not out in the clinical area for the nurses to assess, because the staff was losing the care plans.</p> <p>Interview with the Director of Nursing (DON), on 12/01/11 at 5:45 PM, revealed the care plans were kept in the MDS office because care plans were coming up missing and not being updated. Nurses have access around the clock (24/7) by using a key to get into the MDS room. The purpose of the care plan was to provide a plan of care. The DON stated that the plan was outlined for her to complete checks on the care plans daily, weekly, and monthly. The DON stated the</p> | F 520         | <p>Continued from Page 16</p> <p><b>Monitoring changes/systems to ensure no deficient practice:</b><br/>The Process for managing Care plans will be reviewed by the Quality Assurance Committee weekly for four weeks, and then monthly for recommendations and follow up as indicated.</p> | 12-23-11             |



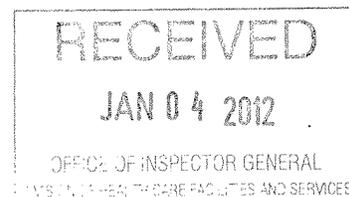
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/14/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185335 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>12/01/2011 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1120 CRISTLAND ROAD<br>LOUISVILLE, KY 40214 |
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|--------------------|---|---------------|---|----------------------|
| F 520              | <p>Continued From page 17</p> <p>care plans got worse again. She started noticing the dietary care plans were not being updated or initiated. She was also concerned with the nursing care plans and MDS staff was forced to follow up more. The DON stated in March she fired ten (10) to eleven (11) nurses and she could not manage it all. The computer generated care plans and the MDS Coordinator did not like the care plans as outlined. The MDS Coordinator oversaw the clinical meetings. Some nurses know to update and some nurses do not know. The DON stated she was aware the process for the MDS staff to just look at orders to updated the care plan was not working. The DON stated the MDS department and the Administrator were ultimately responsible to make sure the care plans were completed.</p> <p>Interview with the Administrator, on 12/01/11 at 5:35 PM, revealed care plans had been addressed the last six (6) weeks as a serious issue. Each department had to draw up a plan of correction in regards to care plans. The new MDS Coordinator has started 10/02/11, she was to publish a monthly letter in regards to care plans. The Administrator stated they were looking at Activity of Daily Living documentation, timely MDS assessments and timely submissions. They found the Directors were not updating appropriately. The DON was relieved of responsibility, and now the Administrator will be responsible.</p> | F 520         |   |                      |



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

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OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185335 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>11/30/2011 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1120 CRISTLAND ROAD<br>LOUISVILLE, KY 40214 |
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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: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (000)</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 standard Life Safety Code survey was conducted on 11/30/11. Signature HealthCARE of South Louisville 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 |  |  |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charles C. Mays TITLE: Administrator (X6) DATE: 12-23-11

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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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