

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

PRINTED: 05/17/2011
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185335 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/06/2011 |
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| NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE 1120 CRISTLAND ROAD LOUISVILLE, KY 40214 |
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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 000 | INITIAL COMMENTS | F 000 | | |
| F 463 SS=D | <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide one resident (#1) of four sampled residents the means to communicate with the nurses' station. The facility removed Resident #1's call light in July 2010 and was to provide a hand bell. Observation upon tour of the facility on 05/05/11 revealed no hand bell present.</p> <p>The findings include: Observation of Resident #1 on 05/05/11 at 1:15pm revealed the resident lying in bed with eyes closed. Observation revealed the call light had been removed from the wall and a plug placed into the socket to silence the call light system. Continued observation revealed Resident #1's roommate had a call light with a cord attached to the resident's bed. No other means of communication was found. In addition, the</p> | F 463 | <ol style="list-style-type: none"> 1. Resident #1's call light cord was replaced the Maintenance on 5-6-11. Nursing staff conducted rounds every two hours to ensure resident's needs were appropriately met. Based on resident's history and continued behavioral concerns, a push button, wireless call system has been ordered for Resident #1. 2. The called light cord has not been removed from any other resident's room and therefore no other resident's have the potential to be affected by the alleged deficient practice. Rounds were completed by nursing administration on 5-6-11 to assure that call lights were present and in reach. No concerns were identified. | 5-9-11 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Charles A. Meyer* TITLE: *Admission* (X6) DATE: *5-23-11*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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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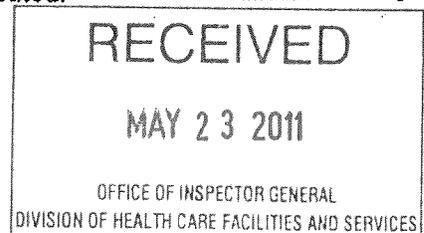
MAY 23 2011

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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| F 463 | Continued From page 1 resident's room was located at the end of the hall approximately 100-150 feet from the nurses' station. Interview with Resident #1 on 05/05/11 at 1:15pm revealed the staff had removed the call light several months ago and the resident would have to "hollow" for staff whenever the resident needed anything. Interview with the Director of Nursing (DON) on 05/05/11 at 1:45pm revealed the resident's call light system was removed July 2010 when the resident placed the call light cord around her/his neck. The DON stated the resident was upset because the physician had ordered to limit snacks and the resident wanted crunchy cheese snacks. The DON stated the resident was suppose to have a hand bell to use whenever the resident wanted or needed any services. However, observation revealed no hand bell was available upon tour. After awhile, staff found the hand bell in the bottom drawer of the resident's chest. The DON indicated the resident would throw the bell at staff and probably placed the bell in the bottom drawer. She stated staff are suppose to check on the resident during rounds. Record review revealed Resident #1 has resided at the nursing facility since June 2003. The resident has diagnoses of Paranoid Schizophrenia, Chronic Depression, and Diabetes. The resident is under the care of a psychiatrist with inpatient admission to a psychiatric hospital March 3-14, 2011 for paranoia and aggressive with another resident. On 07/31/10 at 3:00pm nurses' noted documented the resident was found in room with a phone cord | F 463 | 3. In-service was completed for resident #1 by the Director of Nursing on 5-6-2011 regarding the appropriate use of the call light. In-service was completed for staff regarding insuring call lights were in reach for residents at all time. Also discussed was the requirement to answer call lights or other forms of call communication in a timely manner. Rounds will be completed by the unit managers daily and by the charge nurse on the weekends to insure call lights are in reach for residents. Social Services Director will interview 5 residents per week to insure call lights are answered in a timely manner times four weeks. 4. Findings of the above stated audits will be reviewed in the Quality Assurance Meeting for three months for recommendations and further follow up as indicated. | |



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| F 463 | <p>Continued From page 2</p> <p>wrapped around the resident's neck. The psychiatrist was called with orders to monitor only. The psychiatrist stated the resident had a history of similar behaviors with various threats to harm self; however, plans are "unrealistic". The call light cord was removed at that time.</p> <p>Observation in Resident #1's room on 05/06/11 at 1:50pm revealed the hand bell was rung at 1:50pm. The door to the resident's room was closed. No staff responded to the hand bell. The hand bell was rung again at 2:00pm and still no response. At 2:05pm, CNA#1 entered the resident's room with the roommate. When asked if she was responding to the hand bell, she replied, "No." The CNA stated she was transporting the resident's roommate to be placed in bed and did not hear the hand bell.</p> <p>Interview with the DON on 05/06/11 at 3:00pm revealed Resident #1's assigned CNA told her she did not want to disturb the resident because she knew the surveyor was in the room talking to the resident. However, when the DON was asked if a call light was activated, was the expectation for staff to answer? The answer was, "Yes." Therefore, staff did not response to the only method Resident #1 had to communicate needs.</p> <p>Review of the most recent MDS (Minimum data set) assessment completed on 03/28/11 revealed Resident #1's cognition was intact. The facility assessed the resident to require extensive assist with bed mobility, transfers, ambulation, and toileting needs.</p> | F 463 | | | |

