

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

PRINTED: 05/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/19/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  HIGHLANDS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205
---	--

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS  An abbreviated standard survey was conducted 04/18/12 through 04/19/12, investigating KY 18165 was substantiated with regulatory violation and deficiency cited.	F 000	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  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.  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.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy it was determined the facility failed to evaluate and revise the care plan for three (3) of the four (4) sampled residents (Resident #1, #2 and #3) and three unsampled Residents as the residents' status changed.	F 280	1. <u>Resident #1's</u> fall care plan was reviewed and updated on 5/9/12 by the Interdisciplinary Team, (for all future references related to the interdisciplinary team, or the IDT, this team consists of at least three of the following team members, Licensed Nurses, Unit Managers, Therapy, Activities, Certified Nursing Assistant, Director of Nursing, Assistant Director of Nursing, Dietary Manager, RAI Coordinator and Administrator). The updates included addressing the discontinued PRN Ativan, Landing Strips, and 6:00am schedule for rising. <u>Resident #</u>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karely Hamilton TITLE: Administrator (X6) DATE: 5-17-12

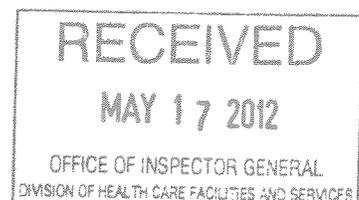
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

RECEIVED  
MAY 17 2012  
If continuation sheet Page 4 of 11  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 05/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

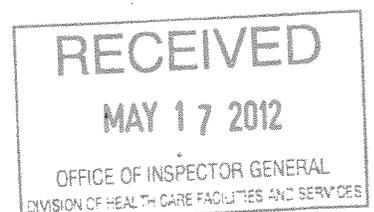
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/19/2012
NAME OF PROVIDER OR SUPPLIER  HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205	
(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 280	Continued From page 1  The findings include:  Review of the facility's policy regarding Assessment/Care Plans, undated, regarding Risk Management/Quality Assessment and Assurance, revealed residents' plans of care are assessed, reviewed and revised upon admission, quarterly, with any significant change and as needed. The policy further stated the plan of care would be reviewed and revised at the time of the significant change.  1. Review of the clinical record revealed the facility admitted Resident #1 on 03/24/09 with diagnoses of Congested Heart Failure, Hypertension, Alzheimer Disease and Depression. Review of the Unusual Occurrence Reports revealed Resident #1 sustained a fall on 03/18/12, 03/30/12 and 04/06/12. Review of Resident #1 Comprehensive Care Plan for Falls, last reviewed on 02/09/12, revealed no review or revision of Resident #1 falls. The falls comprehensive care plan had no evidence of revision to reflect interventions for the landing strips noted on the Medication Administration Record (MAR) dated 02/06/12. Further review of the Interdisciplinary Care Plan and Evaluation dated 03/19/12 revealed no evidence of interventions related to the fall sustained on 03/19/12. Review of the Short Term Care Plan Problem originated on 03/19/12 revealed no evidence of interventions related to Resident #1's 03/18/12 fall. The comprehensive care plan further did not reflect the resident as being on the 6:00 AM get up list. Further review of Resident #1's comprehensive nursing care plan for Anxiety, revised 05/25/12, revealed no documentation of	F 280	2's fall care plan was reviewed and updated by IDT on 5/9/12. The updates included adding the non-skid strips to the care plan. Resident #3's fall care plan was added immediately during the survey and was reviewed again by the IDT team on 5/9/12.  2. All residents who have experienced a fall incident in the past 60 days were identified by the IDT team. On 5/8 and 5/9 the IDT team audited these records for accuracy. The audit consisted of comparing the care plan interventions with orders as well as the interdisciplinary team's recommendations. All residents identified with any inconsistency in fall intervention care plans, were reviewed and any inconsistencies were clarified and updated on the resident's plan of care. Furthermore, the IDT team noted and corrected any other care plan discrepancy identified during this review process.  3. The policy and procedure for the care planning process was reviewed by the Director of Nursing on 4/30/12 and no changes or revisions were	



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

PRINTED: 05/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

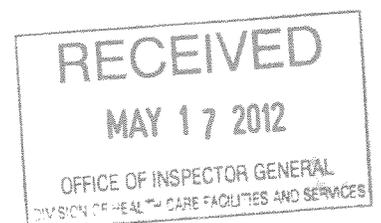
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/19/2012
NAME OF PROVIDER OR SUPPLIER  HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205	
(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 280	<p>Continued From page 2</p> <p>the physician's order, dated 03/21/12, to discontinue the as needed medication Ativan.</p> <p>2. Review of the clinical record for Resident #2 revealed, the facility admitted the resident on 08/20/11 with diagnoses of Pneumonia, Hypertension, Congestive Heart Failure and Diabetes. Review of the Unusual Occurrence Report, dated 04/18/12, revealed Resident #2 sustained a fall in the resident's bathroom. Review of the nurses notes, dated 04/18/12 addendum revealed non skid strips to be applied to the bathroom floor as an intervention to prevent falls. Continued review revealed an undated comprehensive care plan for Falls, with an initiated date of 09/20/11 and a revised target date 06/26/12, revealed no evidence of non-skid strips to the floor as an intervention.</p> <p>3. Review of the clinical record for Resident #3 revealed the facility admitted the resident on 02/10/11 with diagnoses of Dementia, Alzheimer's, Depression, and Cancer. Review of the Unusual Occurrence Report, dated 01/09/12, revealed Resident #3 sustained a fall. Review of the Admission Care Area Assessment Summary revealed #11 Falls as a triggered care area and was to be addressed in the care plan. Further review of the comprehensive care plan revealed no care plan was developed with interventions for the 01/09/12 fall.</p> <p>Interview with Licensed Practical Nurse (LPN #1), on 04/19/12 at 2:50 PM, revealed the nursing care plan was updated every morning by the Interdisciplinary Team (IDT). She further stated the IDT reviewed and updated the care plan from the twenty-four (24) report log, recent physician</p>	F 280	<p>required. Education was provided to licensed and certified nursing staff regarding the care plan process. This education was provided by the Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator. The education was initiated on 4/21/12 and consists of updating the care plan with changes of condition, as well as following the care plan interventions. The Director of Nursing provided additional education to the interdisciplinary team and to the MDS team on 5/9/12. This education addressed care planning changes in condition, orders, and safety interventions regarding falls.</p> <p>Unit managers (licensed nurses) are responsible for validation of all care plan updates following any unusual occurrence including falls. The IDT team will review all care plan updates within 72 hours of any event including falls.</p> <p>4. The Director of Nursing (DON), and the Assistant Director of Nursing (ADON), will audit 100% of fall care plans every week for 4</p>	



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

PRINTED: 05/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

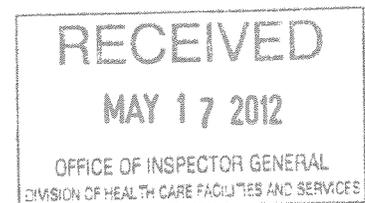
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/19/2012
NAME OF PROVIDER OR SUPPLIER  HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205		
(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 280	Continued From page 3 orders or any changes in the resident's condition. She continued to state if the plan of care was incorrect the resident would not receive appropriate care.  Interview, on 04/19/12 at 4:50 PM, with LPN #3 Unit Manager of the Memory Unit revealed everyone was responsible to update the care plan. She stated the IDT meets daily during the week, reviews all previous orders and the 24 hour log report to accurately update the residents' plan of care. She stated by not having an accurate, up to date, care plan placed the residents' care at risk.  Interview, on 04/19/12 at 5:15 PM, with the Minimum Data Set (MDS) Coordinator revealed direct care staff and the IDT are responsible to update and revise the care plan. He reviewed the care plans daily during the IDT meeting for updates and revisions, and during the quarterly and annual assessments.	F 280	weeks for any resident that has a fall. This audit will consist of reviewing IDT notes and recommendations, the fall care plan, and physician orders for consistency of the resident's care plan. After the initial 4 week audit, the DON and/or ADON will audit 10 resident care plans per month for accuracy for another 5 months to determine if resident care plans are appropriate. The results of these audits will be submitted to the Quality Assessment and Assurance Committee. (For future reference the QA&A Committee consists of the following staff members, The Director of Nursing, The Medical director and one or more of the following Administrator, Social Services, Therapy, Human Resources, Health Information Specialist, Activities, Unit Managers, Dietary, certified nursing staff, licensed nursing staff and MDS coordinator). Unit managers (licensed nurses) are responsible for validation of all care plan updates following any unusual occurrence including falls. The IDT team will review all care plan updates within 72		
F 323 SS=D	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, interview, record review	F 323			



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

PRINTED: 05/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

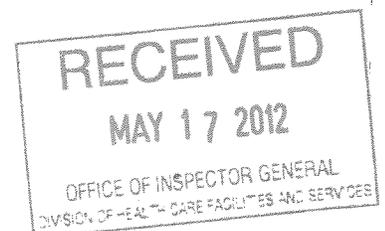
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/19/2012
NAME OF PROVIDER OR SUPPLIER  HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205		
(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 and review of the facility's policy, it was determined the facility failed to provide adequate supervision to prevent accidents for two (2) of four (4) sampled residents. (Resident #1 and #4). The facility failed to ensure Resident #1's self releasing seatbelt was fastened and operational and Resident #4's tab alarm was present and activated.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Accidents and Incidents: Report, Investigation and Follow-up Policy, undated, pages 62-33 of 300 titled Risk Management/Quality Assessment and Assurance, revealed an accident, was an actual or potential undesirable outcome, which may include a fall.</p> <p>Review of the Secure Universal Alarm, revision date 12/02/09, instruction #8 revealed for resident's safety, the alarm did not have an "On/Off" switch. Staff members do not need to remember to turn the alarm on as the alarm has an auto reset feature.</p> <p>Review of the clinical record revealed the facility admitted Resident #4 on 12/07/09 with diagnoses of Hypertension, Alzheimer's Disease, Personal Falls and Depression. Review of the physician's order, dated 04/12/12, revealed to discontinue sensor pad to bed, hipsters, leaving overhead light on at all times and geri sleeves. Review of the nursing care plan #13, undated, revealed the tab alarm to the wheelchair dated 03/29/11 had not been discontinued.</p> <p>Continuous observation while sitting in the</p>	F 323	<p>hours of any unusual occurrence, including falls. The IDT team will report any care plan inconsistencies or concerns immediately to the QA&amp;A Committee. The QA&amp;A Committee will determine if additional education or auditing is required.</p> <p>5. The facility alleges compliance on 5/14/2012.</p> <p>F 323</p> <p>1. Resident #1 and resident #4 were reviewed by the interdisciplinary team on 5/9/12 regarding the appropriateness of their safety interventions and to determine if any revisions were necessary. Following the event in which resident #1's seat belt did not alarm, the nurse and nursing assistant on duty were in-serviced regarding their responsibilities for monitoring alarms and safety equipment throughout their shifts. (Note in-services can also be</p>		



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

PRINTED: 05/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/19/2012
NAME OF PROVIDER OR SUPPLIER  HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205		
(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>hallway, on 04/19/12 from 8:30 AM to 9:55 AM, revealed residents up and about and staff interacting. Two staff members with badges stating hall monitor were on each end of the hallway. An unsampled resident with a tab alarm in place made attempts to move and would set the alarm off. Staff have responded to the alarm. This surveyor did not have direct visual of the alcove; however, heard a loud thump and moved to the alcove area.</p> <p>Observation, on 04/19/12 at 9:55 AM, in the 1C alcove area, revealed Resident #4 lying on the floor with the right side of the face closest to the floor. The Social Service Director knelt to the right side of the Resident #4. LPN #1 then LPN #3 (Unit Manager) arrived at Resident #4's side. The Regional Support person arrived at the alcove area and immediately started to assess Resident #4. Observation of Resident # 4's wheelchair (w/c) revealed a black Velcro holder and inside was a white hard shell box. No pin/cord or clip, was noted. Continued observation, at 10:15 AM revealed LPN #1, LPN #3 and CNA #1 lift Resident #4 to the w/c.</p> <p>Observation, on 04/19/12 at 10:45 AM, in Resident #4's room revealed LPN #1 in an attempt to test the alarm inserted a metal pin into the universal alarm on the back of Resident #4's w/c. LPN #1 removed the metal pin from the universal alarm and the alarm sounded.</p> <p>Observation, on 04/19/12 at 10:50 AM, in Resident #4's room revealed CNA #1 also attempted to test the alarm by inserting a metal pin into the universal alarm on the back of Resident #4's w/c. CNA #1 removed the metal pin from the</p>	F 323	<p>considered level one disciplinary actions). Immediately following the event with resident #4 the tab alarm was removed and a sensor pad was placed on the residents chair by the unit manager. The nurse aide responsible for resident #1 was educated regarding safety equipment by the unit manager (verbal discussion).</p> <p>2. All residents who were identified as having a fall incident in the previous 60 days were identified by the ADON. (There were no other events noted during this review in which safety devices were not used correctly.) All residents with a fall in the past 60 days were identified and reviewed by the IDT team for appropriateness of fall interventions on 5/8 and 5/9. During this review the residents care plans, nurse aide assignment sheets, and safety logs were updated by the interdisciplinary team to reflect safety interventions as needed.</p> <p>To clarify <i>safety logs</i> are logs which identify all safety equipment in use by the building.</p>		



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

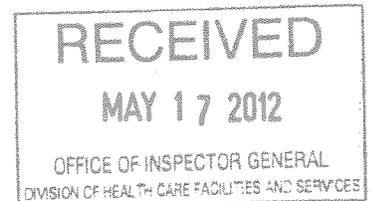
PRINTED: 05/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/19/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  HIGHLANDS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205
---	--

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

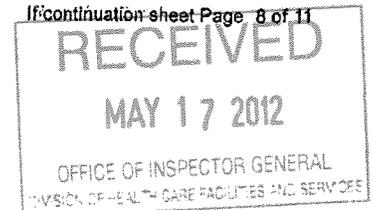
F 323	<p>Continued From page 6 universal alarm and the alarm sounded.</p> <p>Observation, on 04/19/12 at 10:55 AM, in Resident #4's room revealed LPN #3 inserted a metal pin into the universal alarm on the back of Resident #4's w/c. LPN #3 removed the metal pin from the universal alarm and the alarm sounded.</p> <p>Interview, on 04/19/12 at 10:15 AM, with the Regional Specialist beside Resident #4's w/c revealed the black Velcro holder with a white hard shell box was the tab alarm. The Regional Specialist revealed she heard a thump sound from inside 1C chart room, upon entering the alcove area she observed Resident #4 on the floor. She stated she removed the pin/cord and clip from the back of the resident and gave it to LPN #3. She also stated the tab alarm did not sound.</p> <p>Interview, on 04/19/12 at 10:55 AM, with LPN #3 in Resident #4's room revealed she heard a thump from the hallway. Immediately went to the alcove area, and observed Resident #4 on the floor. No pin/cord or clip was observed, nor did the alarm sound. She stated the Regional Specialist did not give her a pin/cord or clip. The purpose of the tab alarm was a safety measure to decrease the potential for falls.</p> <p>Interview, on 04/19/12 at 10:45 AM, with LPN #1 in Resident #4's room revealed she heard a thump and immediately exited the medication room door which was adjacent to the alcove area. She stated seeing Resident #4 on the floor in front of the w/c. She further stated neither the pin/cord or clip were present, nor did the tab</p>	F 323	<p>The IDT team identified all residents with safety equipment and reviewed each resident to determine if appropriate devices and supervision were in place on 5/8 and 5/9/12.</p> <p>3. The Accident and Incident policy was reviewed by the Administrator and Director of Nursing on 5/7/12. No changes or revisions were required. Education was provided to licensed and certified nursing staff regarding falls prevention, supervision and safety equipment. This education was provided by the Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator. The education was initiated on 4/21/12 and consisted of falls defined, importance of fall interventions in decreasing incidence of falls, frequent alarm checks (and other fall interventions) for function and placement, securing the alarm boxes to a stable surface, increased supervision, and updating the care plan to reflect fall interventions.</p> <p>Licensed nursing staff are responsible for validating that all</p>	
-------	---	-------	---	--



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

PRINTED: 05/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/19/2012
NAME OF PROVIDER OR SUPPLIER  HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205	
(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 7 alarm sound. However, she stated the importance of the tab alarm was to notify staff of the residents' unsafe movements.  Review of the clinical record revealed the facility admitted Resident #1 on 03/24/09 with diagnoses of Congested Heart Failure, Hypertension, Alzheimer Disease and Depression. Review of the Unusual Occurrence Report, dated 03/18/12, revealed the resident sustained a fall located in the 1C alcove area while in a w/c. The Medication Administration Record dated 03/01/12 through 03/31/12 revealed Resident #4 had a self releasing alarming click belt, which was to be checked every hour and released every two (2) hours. The Unusual Occurrence Report, dated 03/18/12, revealed the self release click belt was not fastened nor did it alarm. Resident #1 was transported to the Emergency Room (ER) per physician's order. Continued review of the nursing note revealed Resident #1 returned to the facility on 03/18/12 with a Right Mid Forehead Hematoma. Review of the Unusual Occurrence Report, dated 03/30/12, revealed the resident sustained an additional fall at which time the alarm sounded and the nurse found the resident lying in his/her room against the door beside the dresser. Continued review of the Fall Investigation revealed the preventative care plan intervention was to add Resident #4 to the six (6) AM get up list. Review of the Unusual Occurrence Report, dated 04/06/12, revealed the resident sustained a fall, the CNA responded and found the resident in a squatting position holding on to the w/c. The hospital CT Scan, dated 04/06/12, revealed a focal area Encephalomalacia (hematoma). Resident #1 was transferred back to the facility on 04/06/12.	F 323	safety equipment is in place during their shift. Licensed nursing staff will be required to document q shift validation that all safety alarms are functional and in place.  4. The IDT team will be responsible for reviewing all falls and found on floor events within 72 hours of each occurrence. The IDT team will report any events that reflect any concerns with improper use of equipment and/or lack of supervision to the Administrator and/or DON immediately. The Administrator and/or DON will determine the appropriate action required specific to the event.  Licensed nursing staff will be required to complete additional safety alarm audits to determine if alarms are in place and functioning appropriately. These audits will be completed q shift for three months and will include validation of safety alarm placement and supervision of the devices to make sure they are functional. A minimum of 10 alarms will be validated each shift. The results of these audits	



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

PRINTED: 05/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/19/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  HIGHLANDS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205
---	--

(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 8</p> <p>Continued review of the Care Plan dated 09/18/10 revealed an intervention, dated 04/06/12, was added to the careplan for staff to request an endocrinologist evaluation, a Hemoglobin A1c and every fifteen (15) minutes checks thru 04/10/12.</p> <p>Phone interview, on 04/19/12 at 7:40 PM, with LPN #4 regarding Resident #1's fall on 03/18/12, revealed she was in the medication room and heard a loud thump in the alcove area. She stated upon entering the alcove area she observed Resident #1 on the floor. She continued to state the self releasing seat belt was unbuckled and did not alarm. Resident #4's self releasing seat belt alarm was not activated. She turned on the seat belt monitor and buckled the seat belt, then released the seat belt and the alarm sounded. She stated RN #1 and Assistant Director of Nursing (ADON) were made aware of the incident. She further stated the purpose of the self releasing seat belt was to warn staff the resident was attempting to get out of the chair.</p> <p>Phone interview, on 04/19/12 at 8:00 PM, with RN #1 regarding Resident #1's fall on 03/18/12, revealed he was aware of Resident #1's fall; however, he was unsure if he had knowledge of the seat belt not being fasten or alarming. He stated he did not investigate the fall of Resident #1 it was completed by LPN #4. He further stated the alarming seat belt was a safety measure to help aid in the prevention of a fall.</p> <p>Interview, on 04/19/12 at 8:30 PM, with the ADON revealed she was unsure if she was notified of Resident #1's fall on 03/18/12. She further stated the procedure for reporting a fall, was to notify the</p>	F 323	<p>will be submitted to the DON and/or ADON for their review. The DON will submit her findings to the Quality Assessment and Assurance committee monthly. The QA&amp;A committee will determine if additional education or audits are required.</p> <p>5. The facility alleges compliance on 5/14/12.</p>	
-------	---	-------	---	--

RECEIVED  
MAY 17 2012  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

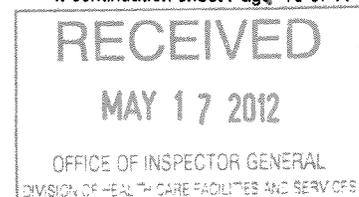
PRINTED: 05/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/19/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>HIGHLANDS NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1706 STEVENS AVENUE LOUISVILLE, KY 40205</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 323	<p>Continued From page 9</p> <p>supervisor, fill out the Unusual Occurrence Report, neuro check sheet, falls investigation report, fall risk assessment form and the therapy screen request. She stated she was responsible for the Risk Management of falls. Resident #1's intervention was to continue every fifteen (15) minute neuro checks. She further stated knowledge of the self releasing seat belt not being fastened and not alarming; however, these factors were not investigated by the Risk Management. She stated the self releasing seat belt was overlooked.</p> <p>Interview, on 04/19/12 at 8:40 PM, with the DON revealed she was ultimately responsible for the Risk Management review but was absent from the facility during the 03/18/12 incident. She further stated their has been no concerns with safety devices. However on 03/21/12, the Supervisors and Unit Managers had re-education staff on falls prevention. The re-education entailed, Falls, Fall Risk Prevention Measures, and Discussed immediate response to call lights and individual responsibilities. She stated everyone was responsible to ensure safety devices are in proper working order. Furthermore, 1C has two (2) hall monitors at all times to observe residents. The Supervisor/Unit Managers are responsible for performing safety checks every shift to ensure that safety devices are in place and functioning on all residents that have been identified at risk for falls. The supervisor/unit managers are to sign off that review was complete and reviewed for problems. The Unit Manager was responsible for updating the Safety Device Monitoring Checklist to ensure the information was correct, and the Charge Nurses are to make changes as needed or</p>	F 323		
-------	--	-------	--	--



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

PRINTED: 05/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/19/2012
NAME OF PROVIDER OR SUPPLIER  HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205		
(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)	(X6) COMPLETION DATE	
F 323	Continued From page 10 indicated by the Inter Disciplinary Team's review.	F 323			

