

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

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OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

PRINTED: 11/28/2012  
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>11/09/2012</b>
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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>
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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	<b>INITIAL COMMENTS</b>  A standard health survey was initiated on 11/07/12 and concluded on 11/09/12 with a Life Safety Code survey completed on 11/09/12. The highest scope and severity was an E. The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	<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.	
F 250 SS=D	<b>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</b>  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  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 provide medically-related social services to one (1) of seventeen (17) sampled residents (Resident #4). The facility failed to address Resident #4's behaviors and refusals to eat.  The findings include:  Review of the facility's policy regarding Minimum Data Set (MDS), dated 12/2010, revealed each discipline will be responsible for completing its section of the MDS and Care Area Assessment (CAA)  Review of the clinical record for Resident #4, revealed the facility admitted the resident with diagnoses of Hypertension, Depression and	F 250	<b>F250</b> 1. On 11/9/12 SS Director or Social Worker requested that MD from Parkview (Psyche Services) review Res #4 related to her behaviors and refusal to eat. On 11/9/12 MD from Parkview ordered Remeron for resident for mood and appetite stimulation. On 11/13/12 Res #4 attending physician asked that the NAS order be discontinued and gave an order to draw Res #4 prealbumin levels. The results of Res #4's prealbumin levels were within normal range. Res #4 was also reviewed again by NP from Parkview on 11/16/12 and placed on Geodon for psychosis. Assigned license nurse notified family of changes on 11/9/12, 11/13/12, and 11/16/12 respectively. Res #4's family was in agreement with changes noted above.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *[Signature]* (X6) DATE: *X 12/13/12*

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.

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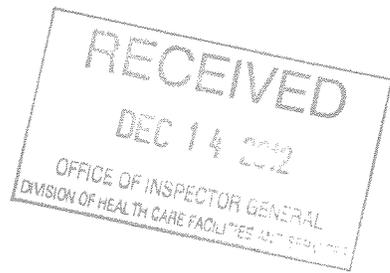
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F 250	<p>Continued From page 1</p> <p>Dementia. Nursing notes from 08/14/12, revealed the resident complained of food and fluids tasting bitter, refused the food and talked about the devil. On 09/06/12, it was noted that the resident had a significant weight loss and a significant change MDS assessment was completed. A review of the CAAs for cognition and antipsychotic medications revealed the resident's cognition, behaviors, and refusal to eat were not addressed. Review of the social services notes revealed no documentation in the resident's clinical record since 09/06/12 when an entry was made to note the care plan had been reviewed and revised.</p> <p>Review of the weight log for Resident #4, revealed the resident weighed 192.4 on 10/17/12, 176.4 on 10/24/12 and 165.0 on 10/31/12.</p> <p>Review of the comprehensive care plan for Resident #4, revealed a problem with the resident yelling out and being resistive to care. The resident's refusal to eat, complaints of food and fluids being bitter and seeing the devil were not addressed. In addition, no documentation was provided to show the facility consulted with the family regarding medical interventions for the significant weight loss discovered on 09/06/12 or for another significant weight loss of twenty-seven pounds between 10/17/12 and 10/30/12.</p> <p>Interview with the Social Services Director (SSD), on 11/09/12 at 10:30 AM, revealed she was aware Resident #4 had experienced a significant weight loss and had behaviors of refusing to eat and seeing the devil. She stated she was not instructed to notify the family regarding the second weight loss. She stated she was not</p>	F 250	<p>F250</p> <p>In addition to the corrective measures above, as outlined in the <i>Policy and Procedure for Monitoring Residents for impaired Nutrition and Nutritional Risk</i>, resident #4 was comprehensively assessed on 11/13/12 during a QA meeting by the Care plan and NAR Team which includes, DON, SS Director, Dietary Director, Unit Managers, MDS Coordinators and HIM Director. The care plan and NAR teams identified and addressed resident #4's behaviors and dietary intake with a goal in mind to curtail any further preventable, significant weight losses with resident #4.</p> <p>On 11/29/12 the RD completed the Mini Nutrition form for Res #4. On 12/6/12 Social Services Director updated Res #4's care plan as appropriate and contacted Parkview Services via telephone to relay an update on Res#4 on 12/7/12. The medication changes noted above is working well to date as Res #4's appetite has improved as evidenced by a 5lb weight gain.</p> <p>2. To ensure that all residents receive the same comprehensive assessment, MDS nurses completed a full chart audit of all residents beginning on November 13, 2012, with a completion date of November 19, 2012. All residents were assessed following policy and procedure and a Nutrition Risk Notification form (GSS #196) was used to identify any areas assessed that could potentiate a resident being nutritionally at risk. Areas that were assessed include but are not limited to all resident diagnosis that places them at risk for weight loss.</p>	
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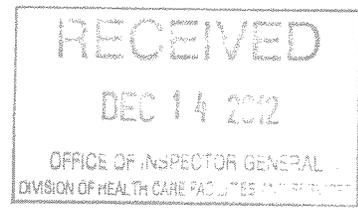
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F 250	Continued From page 2 aware of what the family wanted to do if weight loss continued.  Interview with the Administrator, on 11/09/12 at 4:00 PM, revealed she had no knowledge that the facility failed to provide medically-related social services.	F 250	3. A QA committee meeting was held on 11/13/12. It detailed a reconfiguration of the center's current approach to identifying and serving those residents deemed to be Nutritionally at Risk and served as a basic overhaul to the way that the center identifies, assesses, and communicates our residents at risk nutritionally throughout the interdisciplinary team. The new configurations - which implemented weekly NAR meetings, rather than monthly - focused on assuring that communication across disciplines (from nursing/MDS, to dietary, to social services, to families, to physician, etc.) becomes efficient and most of all effective for all residents.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Contenance; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care	F 272	During this meeting, all members of the Care Plan Team, MDS Coordinators and NAR Team were in-serviced by the DON on Nutrition at Risk Committee, Interventions for Nutritional Risk of Residents, Weight and Height, Weight Monitoring, Elimination as well as policy and procedure for Monitoring Residents for Impaired Nutrition and Nutritional Risk. The team decided that the NAR weekly updates associated with a 3% gain/loss will be brought to the attention of Social Services and the Interdisciplinary Team participating at the weekly Care Plan Meeting by the Director of Dietary. Input from these meetings will be addressed and written up in the current care plan for the resident by Social Services Director or Social Worker. Any NAR reviews that note immediate changes in Mood and/or Behaviors affecting the resident will be relayed to the Social Service Director/team by the Unit Manager of the area in which the resident resides for immediate review to address those changes that require immediate attention.	



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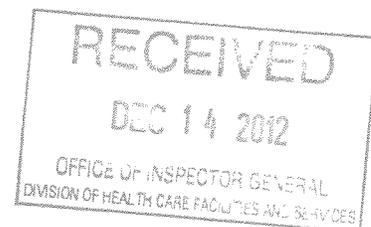
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F 272	<p>Continued From page 3 areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to make a comprehensive assessment of one (1) of seventeen (17) sampled residents (Resident #4) nutritional needs. The facility failed to identify and address the resident's behaviors and complaints of food tasting bitter in the Nutritional Care Area Assessment (CAA).</p> <p>The findings include:</p> <p>Review of the facility's policy on MDS 3.0 Minimum Data Set (MDS), dated 12/2010, revealed the interdisciplinary team member will review the listed risk factors, complications and confounding problems which may impact the resident for a specific triggered CAA. Risk factors that do not come from an MDS question require analysis. The staff member will describe, in narrative form, the relationship between the risk factors/complications and confounding problems and the triggered CAA.</p> <p>Review of the clinical record for Resident #4, revealed the facility admitted the resident with diagnoses of Venous Insufficiency, Dementia and</p>	F 272	<p>F250 GSS Skilled Rehab Consultant will provide education to all Social Workers on Understanding your role in Medical Social Work by 12/21/12. All facility Social Workers will be required to take a written post-test with a passing score of 80 or above to ensure that they understand how to provide medically related social services to residents. The Social Services Director or Staff Development Coordinator will educate all staff to report changes in mood/behaviors of residents to their Charge Nurse and Social Services immediately so that medically-related changes that require attention may be given immediate attention. Based on care plan reviews and staff reports, the appropriate resources (i.e. pain management consultants, Park View Psychiatric Services, Family Meetings, Physician's assistance, etc.) will be contacted by Social Services/Assigned License Nurse for further review and collaboration to meet current resident's needs.</p> <p>4. The Administrator, DON or Unit Managers will audit the provision of medical social services for all residents referred to Nutrition at Risk with significant weight loss of a 3% gain/loss to determine if their care plan has been updated and to ensure that their family has been notified weekly x 6, then bi weekly x 10 and quarterly thereafter to ensure that effective interventions are in place and are currently working for the affected resident. The results of this audit will be reported to the QA committee monthly x 6 months for further review or recommendations. If additional audits are recommended by the QA committee, they will continue to be reviewed monthly until the QA committee agrees that compliance has been established and will be maintained.</p> <p>5. All Corrective measures will be completed by 12/22/12.</p>	
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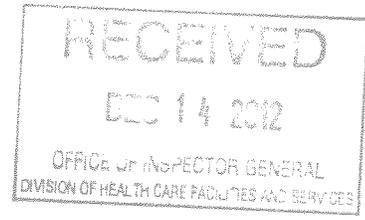
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F 272	<p>Continued From page 4</p> <p>Depression. Nursing notes from 08/14/12, revealed the resident started complaining of food tasting bitter and was telling staff it was poisoned. In addition, the resident was verbalizing concerns regarding the devil. On 09/06/12, it was discovered the resident had lost 7.5 percent of their body weight. The facility completed a significant change MDS assessment on 09/06/12 which revealed the resident had a significant weight loss of 7.5 percent. The resident required extensive assistance with eating. Review of the CAA for nutrition, revealed these risk factors were not addressed.</p> <p>Review of the facility weight log for Resident #4, revealed the resident had a weight of 189.2 on 10/03/12, 192.4 on 10/17/12, 176.4 on 10/24/12 and 165.0 on 10/31/12. The resident's weight was verified in the presence of a surveyor on 11/08/12 as 164 pounds.</p> <p>Interview with LPN #1, on 11/08/12 at 9:00 AM, revealed Resident #4 refused food frequently and would not drink supplements offered twice a day. She stated the resident said the food and fluids tasted bitter.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 11/08/12 at 2:30 PM, revealed Resident #4 was not eating well. He stated the resident continued to complain of food and fluids tasting bitter and would frequently refuse meals. He stated this was a pattern the resident had for a couple of months.</p> <p>Interview with CNA #2, on 11/08/12 at 10:00 AM, revealed Resident #4 started complaining of food being bitter in August 2012. She stated the</p>	F 272	<p>F272</p> <p>1. As outlined in the <i>Policy and Procedure for Monitoring Residents for impaired Nutrition and Nutritional Risk</i>, resident #4 was comprehensively assessed on 11/13/12 during a QA meeting by the Care plan and NAR Team which includes, DON, SS Director, Dietary Director, Unit Managers, MDS Coordinators and HIM Director. The care plan and NAR teams identified and addressed resident #4's behaviors and dietary intake with a goal in mind to curtail any further preventable, significant weight losses with resident #4. A form entitled <i>Nutrition Risk Notification</i> (GSS #196) was utilized to ensure that an effective assessment was completed and that interdisciplinary communication was effective. Using this new form, the NAR Team determined that resident #4 will be addressed during newly implemented weekly NAR committee meetings related to significant weight loss, an abnormal lab, a Braden Scale score of 14, as well as a recent urinary tract infection until otherwise noted by NAR team. Carbon copies of this newly implemented form were given to the Dietary Director, Registered Dietician, Unit Managers, MDS nurses, and the Health Information Management department. On 11/29/12 the RD completed the Mini Nutrition form for Res #4. While the weekly NAR meetings began on 11/29/12, corrective measures to include new orders from the physician and family notification occurred on 11/9/12, 11/13/12 and 11/16/12 respectively for Res #4. On 11/9/12 MD from Parkview (Psyche Services ordered Remeron for mood and appetite stimulation.</p>	
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F 272

Continued From page 5  
resident also talked about being poisoned and had seen the devil. She stated the resident ate poorly most of the time.  
  
Interview with the Unit Manager, on 11/09/12 at 10:30 AM, revealed the MDS CAAs did not reflect Resident #4's concerns regarding bitter tasting food and fluids.

F 272

On 11/13/12 Res #4's attending physician asked that the NAS order be discontinued and gave an order to draw Res #4's prealbumin levels. The results of Res#4's prealbumin levels were within normal range.

F 280  
SS=D

483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

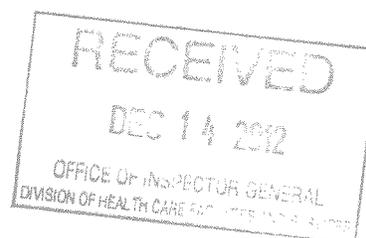
F 280

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.

On 11/16/12 Res #4 was reviewed again by NP from Parkview and placed on Geodon for psychosis. On 11/29/12, Res #4's care plan was updated by the assigned license nurse to include potential for nutrition at risk related to dementia and reduced PO in-take with a goal of no further significant weight loss. On 12/6/12 Res #4's care plan was also updated as appropriate and SS Director relayed an update to Parkview on 12/7/12. To date, Res #4's nutritional status has improved as evidence by her 5lb weight gain. The pharmacy consultant will be utilized to ensure that potentialities regarding medication contraindications and adverse reactions are empirically researched to ensure that they do not cause nutritionally at risk behaviors by 12/21/12.

2. To ensure that all residents receive the same comprehensive assessment, MDS nurses completed a full chart audit of all residents beginning on November 13, 2012, with a completion date of November 19, 2012. All residents were assessed following policy and procedure and A Nutrition Risk Notification form (GSS #196) was used to identify any areas assessed that could potentiate a resident being nutritionally at risk. All residents who were identified as nutritionally at risk will be weighed weekly and monitored for a ±3% weight gain or loss; all residents were discussed during the newly implemented weekly NAR committee meetings; all residents not discussed in weekly NAR committee meetings will be weighed monthly with regard to ±3% weight gain or loss, and will be upheld to ensure that in the event that there is a change, that resident will be included in NAR discussions.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review and facility



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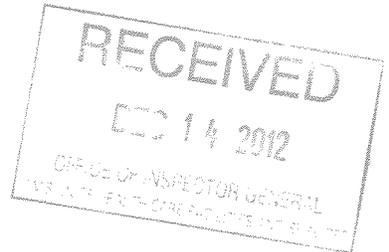
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F 280	<p>Continued From page 6</p> <p>policy review, it was determined the facility failed to review and revise the comprehensive care plan for one (1) of seventeen (17) sampled residents (Resident #4) with weight losses. Resident #4 experienced weight losses on 09/06/12, 10/24/12 and 10/31/12.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care Plans, dated 01/2009, revealed a qualified team of persons will review care plans at least quarterly and when there is a significant change in the resident's condition. The care plan will be modified to reflect the care currently required/provided for the resident.</p> <p>Review of the clinical record for Resident #4, revealed the facility admitted the resident with diagnoses of Depression, Dementia and Hypertension. The facility completed an annual Minimum Data Set (MDS) assessment on 06/08/12 which revealed the resident had a cognitive impairment, required extensive assistance with care needs except for eating which the resident was able to do independently after tray set-up. The resident weighed 202 pounds. The care plan indicated the resident was to receive a diet as ordered by the physician, weigh as ordered, and record intake.</p> <p>On 09/06/12, the facility discovered the resident's weight was down to 185 pounds. Review of the resident's 09/06/12 care plan revealed it was reviewed and revised to add supplemental feedings on 09/06/12. On 10/17/12, the resident's weight had increased to 192.4; however, the resident's weight dropped to 176.4</p>	F 280	<p>F272</p> <p>The pharmacy consultant will be utilized to ensure that potentialities regarding medication contraindications and adverse reactions are empirically researched to ensure that they do not cause nutritionally at risk behaviors.</p> <p>3. A QA committee meeting was held on 11/13/12. It detailed a reconfiguration of the center's current approach to identifying and serving those residents deemed to be Nutritionally at Risk and served as a basic overhaul to the way that the center identifies, assesses, and communicates our residents at risk nutritionally throughout the interdisciplinary team. The new configurations - which implemented weekly NAR meetings, rather than monthly - focused on assuring that communication across disciplines (from nursing/MDS, to dietary, to social services, to families, to physician, etc.) becomes efficient and most of all effective for all residents. During this meeting, all members of the Care Plan Team, MDS Coordinators and NAR Team were in-serviced by the DON on Nutrition at Risk Committee, Interventions for Nutritional Risk of Residents, Weight and Height, Weight Monitoring, Elimination as well as policy and procedure for Monitoring Residents for Impaired Nutrition and Nutritional Risk They were also informed by the DON that the NAR meetings will now be held weekly beginning November 29, 2012, as opposed to monthly. The GSS Skilled Rehab Consultant will educate the care plan team on the completion of CAAs during annual/significant change MDS by 12/21/12. All residents deemed to be nutritionally at risk will be weighed weekly until it is assured evidently that said resident is no longer nutritionally at risk, i.e. by either stabilization of weight, through physician consultation that weight changes are unavoidable, or by way of family/resident individual choice.</p>	
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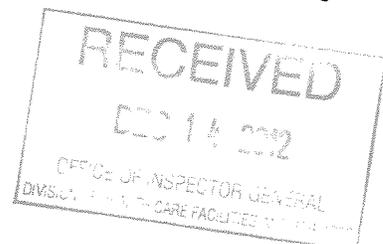
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185268</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/09/2012</b>
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NAME 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>
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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 280	<p>Continued From page 7</p> <p>on 10/24/12 and to 165.0 on 10/31/12. Review of the care plan revealed no documentation was provided to show the facility addressed the additional weight losses.</p> <p>Interview with Unit Manager #2, on 11/09/12 at 10:30 AM, revealed she was aware the resident had lost weight several times, however, she had not reviewed the care plan. She stated the restorative nurse tracked monthly weights and notified the Unit Manager if the resident lost 5 percent of their weight. The nutritional risk committee then monitored these residents and other residents at their discretion. The care plan was revised according to physician orders. She stated the physician was notified on 10/24/12; however, weight loss was not addressed with the physician. She had no comment on how the facility monitored the effectiveness of care plan interventions.</p> <p>Interview with the Director of Nursing, on 11/09/12 at 10:30 AM, revealed Resident #4 did have continuing weight loss; however, the monthly meeting of the nutritional risk committee was not due until next week. She stated the care plan would be revised at that time to have staff feed the resident. She indicated there were no interventions available to address the resident's complaints of bitter tasting food and fluids or the resident's frequent refusal to eat.</p> <p>Interview with the Administrator, on 11/09/12 at 5:00 PM, revealed Resident #4's care plan should have been revised and a protocol was needed to monitor residents' weights.</p>	F 280	<p>F272</p> <p>All weekly and monthly weights will be held to the new standard of deviation of <math>\pm 3\%</math> weight gain or loss. Form GSS #196 titled <i>Nutrition Risk Notification</i> will be used to communicate throughout the interdisciplinary team to ensure that care plans are updated immediately, accurately, and effectively.</p> <p>The pharmacy consultant will be utilized to ensure that potentialities regarding medication contraindications and adverse reaction are empirically researched to ensure that they do not cause nutritionally at risk behaviors. All care plans of those residents at risk nutritionally will be reviewed weekly during NAR committee meetings by the DON to assess for accuracy and effectiveness. The Staff Dev. Coordinator will in-service the weight monitoring CNA or licensed nurse 1 x month x 6 months regarding the importance of obtaining weekly weights at same time and in the same manner every week.</p> <p>The DNS will create a procedure for <i>Obtaining Accurate Weekly Weights</i> by December 10, 2012 to be referenced by the weight monitoring CNA or licensed nurse that outlines use of weights scales throughout the facility, how to identify possible causes of weight discrepancy, as well as when to alert the Unit Manager. The Unit Managers and all nurses will be in-serviced by Staff Development Coordinator on <i>Weight and Height</i> procedure, <i>Obtaining Accurate Weekly Weights</i> procedure, and how to complete the form GSS #196, titled <i>Nutrition Risk Notification</i> by December 21, 2012.</p> <p>4. The MDS Nurse or HIM Director will audit the completion of weekly weights weekly x 3 months then monthly thereafter to ensure that the weights are accurate and are free from discrepancy.</p>	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		



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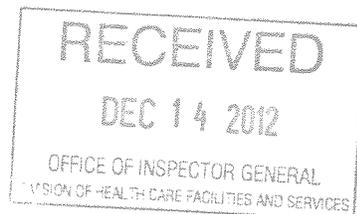
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F 325	<p>Continued From page 8</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review and review of the facility's policy, it was determined the facility failed to maintain acceptable parameters for weight on one (1) of seventeen (17) sampled residents (Resident #4). Resident #4's weight dropped from 202 pounds on 06/08/12 to 165 pounds on 10/31/12.</p> <p>The findings include:</p> <p>Review of the facility's policy for Weight Monitoring, dated 02/2005, revealed the facility was to ensure residents maintained acceptable parameters of nutritional status regarding weight.</p> <p>Review of the facility's policy on Weight and Height, dated 09/2010, revealed the facility completed monthly weights and may be obtained during the first week of the month. Residents with nutritional risk would be weighed weekly. Residents with a weight varying more or less than three pounds would have the weight verified and</p>	F 325	<p>F272</p> <p>The DON, Staff Dev. Coordinator or Unit Manager will audit the completion of Mini Nutrition Assessments and/or CAAs weekly x 6, biweekly x 10, then quarterly thereafter. The DON or Unit Manager will report the results of the audits to the QA committee monthly x 6 months for further recommendations. If additional audits are recommended by the QA committee, they will continue to be reviewed monthly until the QA committee agrees that compliance has been established and will be maintained. Failure to accurately complete the mini nutrition assessment and/or CAAs by licensed nurse may result in corrective action.</p> <p>5. All Corrective measures will be completed by 12/22/12.</p> <p>F280</p> <p>As outlined in the <i>Policy and Procedure for Monitoring Residents for impaired Nutrition and Nutritional Risk</i>, resident #4 was comprehensively assessed on 11/13/12 during a QA meeting by the Care plan and NAR Team which includes, DON, SS Director, Dietary Director, Unit Managers, MDS Coordinators and HIM Director. The care plan and NAR teams identified and addressed resident #4's behaviors and dietary intake with a goal in mind to curtail any further preventable, significant weight losses with resident #4. A form entitled <i>Nutrition Risk Notification</i> (GSS #196) was utilized to ensure that an effective assessment was completed and that interdisciplinary communication was effective. Using this new form, the NAR Team determined that resident #4 will be addressed during newly implemented weekly NAR committee meetings related to significant weight loss, an abnormal lab, a Braden Scale score of 14, as well as a recent urinary tract infection until otherwise noted by NAR team.</p>	
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F 325	<p>Continued From page 9</p> <p>the weight would be reported to the licensed nurse. The licensed nurse would notify the Dietary Supervisor if the weight loss was significant (five percent in 30 days, 7.5 percent in 90 days, and ten percent in 180 days). The licensed nurse would report any significant weight losses to the physician.</p> <p>The facility did not provided a policy for the Nutritional at Risk Committee.</p> <p>Interview with the Director of Nursing (DON), on 11/09/12 at 10:30 AM, revealed the facility did have a committee to address residents with weight problems, usually significant weight losses.</p> <p>Observation of Resident #4, on 11/08/12 at 8:10 AM, revealed the resident was in bed with eyes closed and a breakfast tray in front of him/her. The food on the tray was uneaten. Staff entered the room and removed the tray and documented the resident ate 25 percent of the meal.</p> <p>Observation of Resident #4, on 11/08/12 at 12:10 PM, revealed the resident up in a chair in the common area. A staff member was attempting to feed the resident; however, the resident refused to eat related to the food tasting bitter.</p> <p>Review of the clinical record for Resident #4, revealed the facility admitted the resident with diagnoses of Depression, Dementia and Hypertension. The facility completed an annual Minimum Data Set (MDS) assessment on 06/08/12 which revealed the resident was cognitively impaired, was independent with eating</p>	F 325	<p>F280</p> <p>Carbon copies of this newly implemented form were given to the Dietary Director, Registered Dietician, Unit Managers, MDS nurses, and the Health Information Management department. On 11/29/12 the RD completed the Mini Nutrition form for Res #4. While the weekly NAR meetings began on 11/29/12, corrective measures to include new orders from the physician and family notification occurred on 11/9/12, 11/13/12 and 11/16/12 respectively for Res #4. On 11/9/12 MD from Parkview (Psyche Services ordered Remeron for mood and appetite stimulation.</p> <p>On 11/13/12 Res #4's attending physician asked that the NAS order be discontinued and gave an order to draw Res #4's prealbumin levels. The results of Res#4's prealbumin levels were within normal range. On 11/16/12 Res #4 was reviewed again by NP from Parkview and placed on Geodon for psychosis. On 11/29/12, Res #4's care plan was updated by the assigned license nurse to include potential for nutrition at risk related to dementia and reduced PO in-take with a goal of no further significant weight loss. On 12/6/12 Res #4's care plan was also updated as appropriate and SS Director relayed an update to Parkview on 12/7/12. To date, Res #4's nutritional status has improved as evidence by her 5lb weight gain.</p> <p>The pharmacy consultant will be utilized to ensure that potentialities regarding medication contraindications and adverse reactions are empirically researched to ensure that they do not cause nutritionally at risk behaviors by 12/21/12.</p>		



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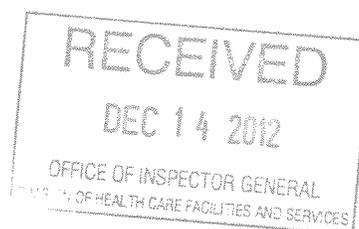
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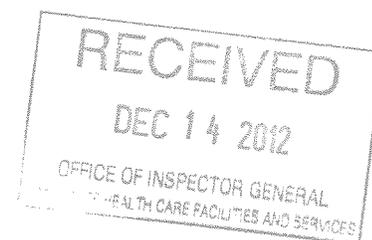
F 325	<p>Continued From page 10 after tray set-up, and weighed 202 pounds. The care plan goal was for the resident not to have any weight gains by providing the correct diet and monitoring weight monthly.</p> <p>Review of the nursing notes, revealed Resident #4 started complaining of food and fluids tasting bitter on 08/14/12. In addition, the resident was refusing meals, talked about poison in the food and seeing the devil. The weight log revealed the resident's weight dropped from 202 pounds to 185 pounds. The facility completed a significant change MDS assessment on 09/06/12 which revealed the resident now required staff total assistance to eat. The physician ordered a supplement for the resident and the intervention was added to the care plan.</p> <p>The facility next weighed the resident on 10/03/12 and the resident's weight log revealed a gain to 189.2 pounds. On 10/17/12, the resident weighed 192.4 pounds, however, on 10/24/12, the resident weighed 176.4 pounds and had lost 16 pounds in one week. The physician was contacted by fax on 10/24/12; however, the resident's new weight loss was not addressed. Review of the care plan revealed no documentation of new interventions provided by the facility.</p> <p>On 10/31/12, the resident's weight log revealed the resident weighed 165 pounds, an 11 pound weight loss in one week. The facility did not provide any documentation to show the physician and family were notified or that the resident's care plan was reviewed and revised.</p> <p>On 11/08/12 at 2:30 PM, the resident was</p>	F 325	<p>F280</p> <p>2. To ensure that all residents receive the same comprehensive assessment, MDS nurses completed a full chart audit of all residents beginning on November 13, 2012, with a completion date of November 19, 2012. All residents were assessed following policy and procedure and form GSS #196 was used to identify any areas assessed that could potentiate a resident being nutritionally at risk. All residents who were identified as nutritionally at risk will be weighed weekly and monitored for a ±3% weight gain or loss; all residents were discussed during the newly implemented weekly NAR committee meetings; all residents not discussed in weekly NAR committee meetings will be weighed monthly with regard to ±3% weight gain or loss, and will be upheld to ensure that in the event that there is a change, that resident will be included in NAR discussions. The pharmacy consultant will be utilized to ensure that potentialities regarding medication contraindications and adverse reactions are empirically researched to ensure that they do not cause nutritionally at risk behaviors.</p> <p>3. A QA committee meeting was held on 11/13/12. It detailed a reconfiguration of the center's current approach to identifying and serving those residents deemed to be Nutritionally at Risk and served as a basic overhaul to the way that the center identifies, assesses, and communicates our residents at risk nutritionally throughout the interdisciplinary team. The new configurations - which implemented weekly NAR meetings, rather than monthly - focused on assuring that communication across disciplines (from nursing/MDS, to dietary, to social services, to families, to physician, etc.) becomes efficient and most of all effective for all residents.</p>	
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F 325	<p>Continued From page 11 weighed by staff at 164 pounds and this weight was verified by a surveyor.</p> <p>Review of Resident #4's intake log, revealed the resident consumed zero percent of breakfast and lunch on 11/02/12. The resident consumed 75 percent of dinner and zero percent at breakfast and lunch on 11/03/12. The resident consumed 25 percent of breakfast and 25 percent of lunch on 11/04/12. On 11/05/12, the resident refused breakfast and ate 25 percent of dinner. On 11/06/12 the resident refused breakfast and lunch and ate 75 percent of dinner. On 11/07/12, the resident ate 25 percent of breakfast, refused lunch and ate 75 percent of dinner. On 11/08/12, the resident ate 25 percent of breakfast, refused lunch and ate 25 percent of dinner.</p> <p>Interviews with Certified Nurse Aides (CNA) #1 and #2, on 11/08/12 at 10:30 AM, revealed Resident #4 refused meals frequently. They stated the resident started complaining about food tasting bitter several months ago and continued to complain.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 11/08/12 at 10:00 AM, revealed Resident #4 was frequently refusing meals for over a month. She stated the resident said the food was bitter and talked about the devil and poison. She stated the resident also refused the supplements ordered by the physician. She indicated she was unable to locate documentation that the physician had been notified of the resident's continued refusal to eat. She revealed staff did not always notify the nurse if a resident did not eat, especially if the resident was known not to eat well.</p>	F 325	<p>F280</p> <p>During this meeting, all members of the Care Plan Team, MDS Coordinators and NAR Team were in-serviced by the DON on Nutrition at Risk Committee, Interventions for Nutritional Risk of Residents, Weight and Height, Weight Monitoring, Elimination as well as policy and procedure for Monitoring Residents for Impaired Nutrition and Nutritional Risk. They were also informed by the DON that the NAR meetings will now be held weekly beginning November 29, 2012, as opposed to monthly. The GSS Skilled Rehab Consultant will educate the care plan team on care planning policy and procedure by 12/21/12. All residents deemed to be nutritionally at risk will be weighed weekly until it is assured evidently that said resident is no longer nutritionally at risk, i.e. by either stabilization of weight, through physician consultation that weight changes are unavoidable, or by way of family/resident individual choice. All weekly and monthly weights will be held to the new standard of deviation of <math>\pm 3\%</math> weight gain or loss. Form GSS #196 titled <i>Nutrition Risk Notification</i> will be used to communicate throughout the interdisciplinary team to ensure that care plans are updated immediately, accurately, and effectively. The pharmacy consultant will be utilized to ensure that potentialities regarding medication contraindications and adverse reaction are empirically researched to ensure that they do not cause nutritionally at risk behaviors. All care plans of those residents at risk nutritionally will be reviewed weekly during NAR committee meetings by the DON to assess for accuracy and effectiveness.</p>		



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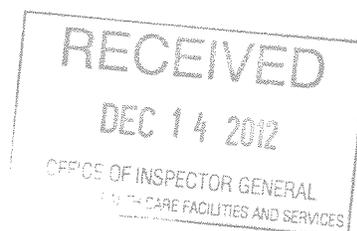
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F 325	<p>Continued From page 12</p> <p>Interview with the Unit Manager, on 11/09/12 at 10:45 AM, revealed a meeting was held with the family and care plan team after the significant weight loss on 09/06/12.</p> <p>Interview with the Director of Nursing, on 11/09/12 at 10:00 AM, revealed the facility weighed Resident #4 on 09/06/12 and discovered the resident had lost from 198.2 pounds to 183.6, a significant (5 percent in 30 days or 10 percent in 180 days) amount of weight. She stated residents losing a significant amount of weight were referred to the Nutritional at Risk (NAR) which met on 09/17/12 to discuss the resident's weight loss. She stated the resident's physician had already ordered a supplement and weekly weights for four weeks and no other action was taken. She indicated the facility weighed the resident on 10/03/12 at 189.2, on 10/17/12 at 192.4 and on 10/24/12 the resident weighed 176.4. She stated the physician was not notified for the second significant weight loss. She stated the resident's complaints regarding the bitter taste of food were not investigated nor were the resident's medications reviewed for a possible cause of the bitter taste. She indicated no action was taken. On 10/31/12, the facility weighed the resident at 165.0 pounds and she revealed no action was taken until 11/08/12 when nursing staff were instructed to feed the resident. She stated the resident was eating poorly and refusing to accept the supplements. After reviewing the resident's care plan, she stated the physician should have been notified after each weight loss and because the care plan interventions did not work for the resident. She stated the facility should have been more aggressive in preventing</p>	F 325	<p>F280</p> <p>The Staff Dev. Coordinator will in-service the weight monitoring CNA or licensed nurse 1 x month x 6 months regarding the importance of obtaining weekly weights at same time and in the same manner every week.</p> <p>The DNS will create a procedure for <i>Obtaining Accurate Weekly Weights</i> by December 10, 2012 to be referenced by the weight monitoring CNA or licensed nurse that outlines use of weights scales throughout the facility, how to identify possible causes of weight discrepancy, as well as when to alert the Unit Manager. The Unit Managers and all nurses will be in-serviced by Staff Development Coordinator on <i>Weight and Height</i> procedure, <i>Obtaining Accurate Weekly Weights</i> procedure, and how to complete the form GSS #196, titled <i>Nutrition Risk Notification</i> by December 21, 2012.</p> <p>4. The HIM Director or MDS Nurse will audit the completion of weekly weights weekly x 3 months then monthly thereafter to ensure that the weights are accurate and are free from discrepancy. The SS Director, DON or Unit Managers will complete a random audit of resident's care plans that are nutritionally at risk for a change in condition weekly x 6, biweekly x 10 then quarterly thereafter to ensure that they are up to date, accurate and effective. The Staff Dev. Coordinator and the Unit Managers will report the results of the audits to the QA committee monthly x 6 months for further review and recommendations. If additional audits are recommended by the QA committee, they will continue to be reviewed monthly until the QA committee agrees that compliance has been established and will be maintained.</p>	
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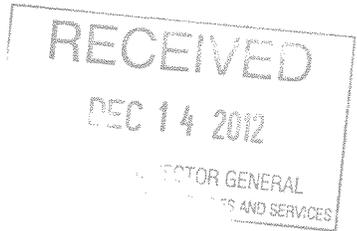
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F 325	Continued From page 13 further weight loss and she was not sure how the care plan team evaluated the effectiveness of the care plan goals. She stated the resident was at risk for skin breakdown related to the weight loss.	F 325	F280 Failure to accurately take weekly weights and to update the care plan by the weight monitoring CNA and licensed nurse respectively may result in corrective action.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens	F 441	5. All Corrective measures will be completed by 12/22/12.  F325 1. As outlined in the <i>Policy and Procedure for Monitoring Residents for impaired Nutrition and Nutritional Risk</i> , resident #4 was comprehensively assessed on 11/13/12 during a QA meeting by the Care plan and NAR Team which includes, DON, SS Director, Dietary Director, Unit Managers, MDS Coordinators and HIM Director. The care plan and NAR teams identified and addressed resident #4's behaviors and dietary intake with a goal in mind to curtail any further preventable, significant weight losses with resident #4. A form entitled <i>Nutrition Risk Notification</i> (GSS #196) was utilized to ensure that an effective assessment was completed and that interdisciplinary communication was effective. Using this new form, the NAR Team determined that resident #4 will be addressed during newly implemented weekly NAR committee meetings related to significant weight loss, an abnormal lab, a Braden Scale score of 14, as well as a recent urinary tract infection until otherwise noted by NAR team. Carbon copies of this newly implemented form were given to the Dietary Director, Registered Dietician, Unit Managers, MDS nurses, and the Health Information Management department.	



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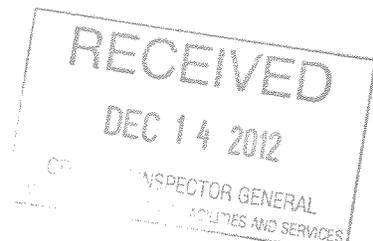
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 441	<p>Continued From page 14</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies, it was determined the facility's staff failed to sanitize their hands before and after gloving and failed to change gloves when moving from a dirty area/task to a clean one during skin assessments and wound care for two (2) of seventeen (17) sampled residents, Residents #2 and #5. In addition, the staff providing residents with hand hygiene in the dining room failed to sanitize their hands after holding soiled sanitizing wipes.</p> <p>The findings include:</p> <p>Review of the facility's Hand Hygiene and Handwashing Policy, revised 07/2012, revealed hands should be washed before having direct contact with residents, after having direct contact with the resident's skin, body fluids, wounds, or broken skin, after touching equipment or furniture near the resident, and after removing gloves. If hands are not visibly soiled or contaminated with blood or body fluids, an alcohol-based hand rub may be used for routinely cleaning hands.</p> <p>Observation, on 11/08/12 at 9:30 AM, revealed the Staff Development Nurse and the Unit Manager (UM) for D Hall failed to wash their hands prior to donning gloves to perform Resident #2's skin assessment. The UM assisted</p>	F 441	<p>F325</p> <p>On 11/29/12 the RD completed the Mini Nutrition form for Res #4. While the weekly NAR meetings began on 11/29/12, corrective measures to include new orders from the physician and family notification occurred on 11/9/12, 11/13/12 and 11/16/12 respectively for Res #4. On 11/9/12 MD from Parkview (Psyche Services ordered Remeron for mood and appetite stimulation. On 11/13/12 Res #4's attending physician asked that the NAS order be discontinued and gave an order to draw Res #4's prealbumin levels. The results of Res#4's prealbumin levels were within normal range. On 11/16/12 Res #4 was reviewed again by NP from Parkview and placed on Geodon for psychosis. On 11/29/12, Res #4's care plan was updated by the assigned license nurse to include potential for nutrition at risk related to dementia and reduced PO intake with a goal of no further significant weight loss. On 12/6/12 Res #4's care plan was also updated as appropriate and SS Director relayed an update to Parkview on 12/7/12. To date, Res #4's nutritional status has improved as evidence by her 5lb weight gain. The pharmacy consultant will be utilized to ensure that potentialities regarding medication contraindications and adverse reactions are empirically researched to ensure that they do not cause nutritionally at risk behaviors by 12/21/12.</p> <p>2. To ensure that all residents receive the same comprehensive assessment, MDS nurses completed a full chart audit of all residents beginning on November 13, 2012, with a completion date of November 19, 2012. All residents were assessed following policy and procedure and form GSS #196 was used to identify any areas assessed that could potentiate a resident being nutritionally at risk.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

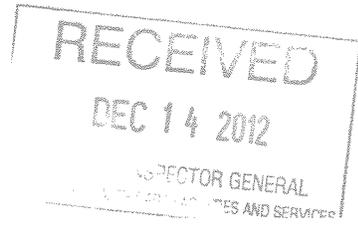
PRINTED: 11/28/2012  
FORM APPROVED  
OMB NO. 0938-0391

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>11/09/2012</b>
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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>
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F 441	<p>Continued From page 15</p> <p>with turning and repositioning the resident during the skin assessment and wound care. After assessing the resident's head, neck, and chest areas, the Staff Development Nurse opened the resident's brief, touched the peri area and then touched the resident's legs and feet, and unwrapped a gauze dressing from the resident's left foot exposing open areas on the heel and second toe. The nurse failed to remove her gloves, sanitize her hands, and don clean gloves before cleansing the areas with Hibiclens and saline soaked gauze sponges, following with a Betadine solution and saline rinse. A clean dressing was secured with tape. The nurse removed her gloves, put on clean gloves and cleaned stool from the resident's anal area, but did not sanitize her hands between glove changes. Again, the nurse changed gloves but did not sanitize her hands. She performed treatment to an open wound at the sacral area, applied barrier cream around the periphery of the wound, and taped a clean dressing in place. The nurse changed her gloves, cleaned between the resident's labial folds with wet wipes, secured Resident #2's brief, and with the same gloved hands, adjusted the resident's blankets, bed pillow, call button, straightened a cloth coverlet on the bedside table, and then removed her gloves and washed her hands.</p> <p>Interview, on 11/08/12 at 4:00 PM, with the Staff Development Nurse revealed she should have washed her hands before beginning the resident's care and between glove changes during skin assessment and wound care. The Staff Development Nurse stated her most recent hand hygiene in-service occurred in January 2012, and she could not remember when she had last had</p>	F 441	<p>F325</p> <p>All residents who were identified as nutritionally at risk will be weighed weekly and monitored for a ±3% weight gain or loss; all residents were discussed during the newly implemented weekly NAR committee meetings; all residents not discussed in weekly NAR committee meetings will be weighed monthly with regard to ±3% weight gain or loss, and will be upheld to ensure that in the event that there is a change, that resident will be included in NAR discussions. The pharmacy consultant will be utilized to ensure that potentialities regarding medication contraindications and adverse reactions are empirically researched to ensure that they do not cause nutritionally at risk behaviors.</p> <p>3. A QA committee meeting was held on 11/13/12. It detailed a reconfiguration of the center's current approach to identifying and serving those residents deemed to be Nutritionally at Risk and served as a basic overhaul to the way that the center identifies, assesses, and communicates our residents at risk nutritionally throughout the interdisciplinary team. The new configurations - which implemented weekly NAR meetings, rather than monthly - focused on assuring that communication across disciplines (from nursing/MDS, to dietary, to social services, to families, to physician, etc.) becomes efficient and most of all effective for all residents. During this meeting, all members of the Care Plan Team, MDS Coordinators and NAR Team were in-serviced by the DON on Nutrition at Risk Committee, Interventions for Nutritional Risk of Residents, Weight and Height, Weight Monitoring, Elimination as well as policy and procedure for Monitoring Residents for Impaired Nutrition and Nutritional Risk</p>	
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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>
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F 441	<p>Continued From page 16</p> <p>an in-service on dressing changes. She said her hand hygiene/and dressing change technique had not been monitored. The Staff Development Nurse stated the problem with not consistently sanitizing her hands before giving care and between glove changes during wound care would be the spread of infection to Resident #2, other residents, and staff.</p> <p>Interview, on 11/09/12 at 8:10 AM, with the UM for D Hall revealed direct care staff should always sanitize their hands before beginning resident care and before applying clean gloves. The staff development nurse should have changed her gloves when moving from dirty to clean areas of the body, and should have sanitized her hands between glove changes. The UM said she did not monitor her staff's hand hygiene or wound care technique. Hand hygiene, dressing, and glove change in-services occur upon hire and annually for nursing staff. The problem with not consistently observing hand hygiene before, during, and after direct care would be the risk of spreading infection to Resident #2 and other residents in the facility.</p> <p>Interview, on 11/09/12 at 2:55 PM, with the Director of Nursing (DON) revealed she expected the UM's to monitor staff hand hygiene and glove change practices with random spot checks. She relied on the Infection Control and Staff Development nurses to monitor outbreaks of infection through tracking and trending, to increase staff awareness, and prevent complacent behaviors that lead to breaches in infection control.</p>	F 441	<p>F325</p> <p>They were also informed by the DON that the NAR meetings will now be held weekly beginning November 29, 2012, as opposed to monthly. All residents deemed to be nutritionally at risk will be weighed weekly until it is assured evidently that said resident is no longer nutritionally at risk, i.e. by either stabilization of weight, through physician consultation that weight changes are unavoidable, or by way of family/resident individual choice. All weekly and monthly weights will be held to the new standard of deviation of <math>\pm 3\%</math> weight gain or loss. Form GSS #196 titled <i>Nutrition Risk Notification</i> will be used to communicate throughout the interdisciplinary team to ensure that care plans are updated immediately, accurately, and effectively. The pharmacy consultant will be utilized to ensure that potentialities regarding medication contraindications and adverse reaction are empirically researched to ensure that they do not cause nutritionally at risk behaviors. All care plans of those residents at risk nutritionally will be reviewed weekly during NAR committee meetings by the DON to assess for accuracy and effectiveness. The Staff Dev. Coordinator will in-service the weight monitoring CNA or licensed nurse 1 x month x 6 months regarding the importance of obtaining weekly weights at same time and in the same manner every week. The DNS will create a procedure for <i>Obtaining Accurate Weekly Weights</i> by December 10, 2012 to be referenced by the weight monitoring CNA or licensed nurse that outlines use of weights scales throughout the facility, how to identify possible causes of weight discrepancy, as well as when to alert the Unit Manager.</p>	
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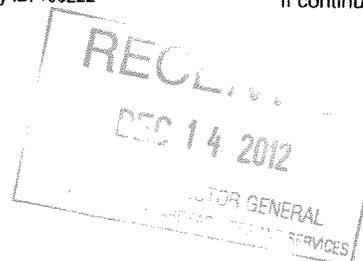
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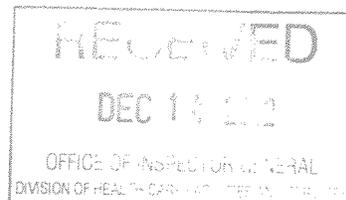
F 441	<p>Continued From page 17</p> <p>Observation of the assistive dining room, on 11/08/12 at 12:30 PM, revealed a staff member cleansing residents' hands prior to the meal. The staff member was opening hand hygiene packets and using the wipes to sanitize residents hands. After cleaning each residents hands, she placed the soiled wipe in a container and moved to the next resident. She was not observed to sanitize her hands between residents.</p> <p>Interview with Unit Manager #2, on 11/08/12 at 3:00 PM, revealed she should have sanitized her hands between residents to prevent the spread of infection and had received training.</p>	F 441	<p>F325 The Unit Managers and all nurses will be in-serviced by Staff Development Coordinator on <i>Weight and Height</i> procedure, <i>Obtaining Accurate Weekly Weights</i> procedure, and how to complete the form GSS #196, titled <i>Nutrition Risk Notification</i> by December 21, 2012.</p> <p>4. The HIM Director or MDS Nurse will audit the completion of weekly weights weekly x 3 months then monthly thereafter to ensure that the weights are accurate and are free from discrepancy. up to date, accurate and effective. The Staff Dev. Coordinator and the Unit Managers will report the results of the audits to the QA committee monthly x 6 months for further review and recommendations. If additional audits are recommended by the QA committee, they will continue to be reviewed monthly until the QA committee agrees that compliance has been established and will be maintained. Failure of nurse to accurately take weekly weights and to refer to NAR committee may result in corrective action</p> <p>5. All corrective measures will be completed by 12/22/12.</p>	
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F441

1. Wound integrity on resident's #2 and #5 was assessed on November 8, 2012 by wound care nurse to ensure that integrity was not compromised during dressing change observed by surveyor. Wound care nurse continues to weekly monitor, observe, and document wound progress each week on the Wound Care Flow Sheet (GSS#487). It was noted that there are no signs of infection since the observed dressing change on November 8, 2012. The Staff Development Nurse and Unit Manager for D hall will complete the computer modules: *Infection Control (full version)*, *Hand Hygiene, Bloodborne Pathogens (full version)*, and *Back to Basics of Wound Healing* by December 11, 2012. All Nurses and CNA's will complete the *Hand Hygiene* module by December 21, 2012; all as needed staff will be expected to have this module completed by December 21, 2012 before they will be scheduled to work. The Staff Development Nurse, Unit Manager, all nurses and CNAs will complete a post test after all of their required training with a passing score of 80 or above to ensure their understanding of the above listed computer modules.

2. A chart review of 100% of all resident's conditions were reviewed 11/13/12 – 11/19/12 by the MDS Nurses. No resident conditions were identified related to the lack of universal precautions and hand sanitation as evidenced by a reduction in our facility's infection rate of 13.9% in October 2012 to 8.8% in November 2012. The Staff Development Nurse and Unit Manager for D hall will complete the computer modules: *Infection Control (full version)*, *Hand Hygiene, Bloodborne Pathogens (full version)*, and *Back to Basics of Wound Healing* by December 10, 2012.



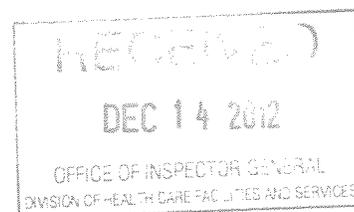
F441

All Nurses and CNA's will complete the *Hand Hygiene* module by December 19, 2012; all as needed staff will be expected to have this module completed by December 19, 2012 before they will be scheduled to work. All residents at bare minimum should be afforded the standard of universal precautions, which includes proper hand hygiene and sanitation.

3. The Staff Development Nurse, Unit Manager and/or a Wound Care Nurse will instruct all nurses on wound care and wound dressings by December 21, 2012. This class will incorporate a teach and return demonstration method of instruction that will highlight GSS procedures and guidelines on *Gowning, Gloves, Masks, Goggles; Hand Hygiene and Handwashing; and Wound Dressing Change*. If issues are identified during the return demonstration portion of the class, the employee will be re-educated on proper wound care/dressing and asked to conduct a second return demonstration to ensure understanding. The re-education will highlight areas of concern. Return demonstrations with re-education as indicated will continue until compliance is achieved.

4. All nurses will be observed by the DON, Unit Manager or Staff Development Nurse by 12/21/12 then monthly x 3 months as they perform a dressing change using proper procedure. All newly hired Nurses and CNA's will complete *Infection Control (fundamentals), Hand Hygiene, Bloodborne Pathogens (fundamentals), and Back to Basics of Wound Healing* computer modules before working with residents. The DNS will ensure that this standard is kept by auditing completion every 3 months and upon each new employee orientation x 6 months. The Unit managers will randomly check 50% of CNAs hand sanitation of residents in dining room during 1 meal a day x 5 days then bi monthly x4 and 1 x monthly x 3 months thereafter. The results of the audits will be reported to the QA Committee monthly x 7months for further review and recommendations. If additional audits are recommended by the QA committee, they will continue to be reviewed monthly until the QA committee agrees that compliance has been established and will be maintained.

5. All Corrective measures will be completed by 12/22/12.



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  11/09/2012
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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229
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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: 1980</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story with a partial basement, Type III unprotected.</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet / dry) sprinkler system.</p> <p>GENERATOR: Type II, 60 KW generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 11/09/12. The Good Samaritan Society - Jeffersontown was found not in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p><b>Plan of Correction</b></p> <p>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>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *12/13/12*

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.

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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K 000

Continued From page 1  
Deficiencies were cited with the highest deficiency identified at D level.

K 000

**K018**

K 018  
SS=D

NFPA 101 LIFE SAFETY CODE STANDARD

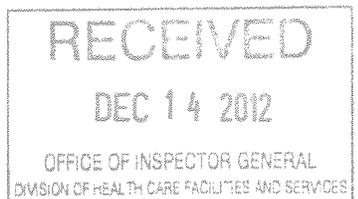
K 018

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3

Roller latches are prohibited by CMS regulations in all health care facilities.

1. The Environmental Services Director (ESD) adjusted the strike plate on the door of resident room C14 so the door would latch completely and remain closed to resist the passage of smoke in the event of an emergency on 11/12/12.  
2. The ESD checked all resident room doors within the facility to ensure that they all latch completely and remain closed to resist the passage of smoke in the event of an emergency on 12/4/12.  
3. The ESD or Maintenance Tech will inservice all staff to ensure that they understand that all resident room doors in a sprinklered building must latch properly to resist the passage of smoke by 12/21/12. ESD or Maintenance Tech will also inservice all working staff during quarterly fire drill to ensure that they understand that all resident room doors must latch properly to resist the passage of smoke by 12/21/12. They also inserviced all Maintenance staff on 11/12/12 on how to resolve any issues involving doors that will not latch properly and to report any unresolved issues to the ESD immediately for repair. All staff will complete a written post-test with a passing score of 80 or above to ensure understanding that all resident room doors in a sprinklered building must latch properly to resist the passage of smoke. All Maintenance Staff post test will not only test their knowledge of the above but will include comprehension of how to resolve any issues related to the inability of a resident room door to close and latch properly. All post-tests will be completed by 12/21/12.

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, approximately thirty (30) residents, staff, and visitors. The facility has ninety-eight (98) certified beds and the census



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K 018 Continued From page 2  
was eighty-three (83) on the day of the survey.

The findings include:

Observation, on 11/09/12 at 1:25 PM, with the Environmental Services Director and the Maintenance Person revealed the door to resident room C14 did not latch when tested.

Interview, on 11/09/12 at 1:25 PM, with the Environmental Services Director and the Maintenance Person revealed the door would not latch and remain closed to resist the passage of smoke in the event of an emergency.

Reference: NFPA 101 (2000 edition)

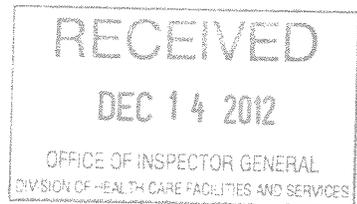
19.3.6.3.1\* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.

Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.  
Exception No. 2: In smoke compartments

K 018

K018  
4. The ESD or Maintenance Technician will audit all resident room doors within the facility weekly x 1 month then monthly thereafter to ensure that they latch properly to resist the passage of smoke. The results of the audits will be reported to the QA Committee monthly x 6 months for further review and recommendations. If additional audits are recommended by the QA committee, they will continue to be reviewed monthly until the QA committee agrees that compliance has been established and will be maintained.  
5. All corrective actions will be completed by 12/22/12.

**K029**  
1. The Environmental Services Director (ESD) and Maintenance Technician removed and replaced the old wood door to the affected dry storage area with a metal fire rated door and frame with self closing device on 11/20/12.  
2. The ESD and Maintenance Technician reviewed all storage areas over 100 sq feet in the facility to ensure that all doors contain self closing devices. 12/4/12.  
3. On 12/4/12, the ESD in-serviced all Maintenance staff to ensure that they understand that all storage areas over 100 square feet must have doors that contain self closing or automatic closure devices. On 12/4/12, the ESD also in-serviced them on how to resolve the issue if identified and asked them to notify the ESD immediately of any concerns regarding storage area door closures for immediate repair.



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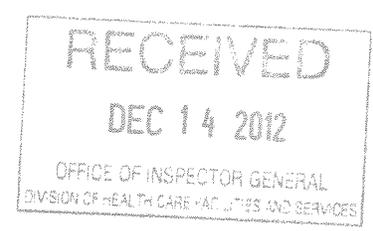
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185268</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/09/2012</b>
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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>
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K 018	<p>Continued From page 3 protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.</p>	K 018	<p><b>K029</b></p> <p>All Maintenance Technicians will complete a written post test with a passing score of 80 or above to ensure their understanding that all storage areas over 100 square feet must have doors that contain self closing or automatic closure devices. The post test will also cover how to resolve identified issues related to the closing devices on doors of storage areas over 100 square feet and to whom to report any issues. This will be completed by 12/21/12.</p> <p>4. The ESD or Maintenance Technician will audit all storage areas over 100 square feet 1 x monthly x 6 months to ensure that they contain self closing or automatic closing devices and they are functioning properly. The results of the audits will be reported to the QA Committee monthly x 6 months for further review and recommendations. If additional audits are recommended by the QA committee, they will continue to be reviewed monthly until the QA committee agrees that compliance has been established and will be maintained.</p> <p>5. All corrective actions will be completed by 12/22/12.</p>	
K 029 SS=D	<p>19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system</p>	K 029	<p><b>K147</b></p> <p>1. The Maintenance Tech installed a ground fault circuit interrupter (GFCI) outlet in the physical therapy department in which to plug the hydrocollator on 11/12/12.</p> <p>2. The Environmental Services Director (ESD) and Maintenance Technician checked all outlets within the facility to determine whether they require a GFCI as required in wet areas. 12/4/12.</p> <p>3. On 12/4/12, The ESD in-serviced all Maintenance employees to inform them that all outlets in wet areas must be a GFCI outlet. On 12/4/12, they were also informed to install GFCI outlets in wet areas if they identify an area and to report any unresolved issues concerning the need for GFCI outlets to the ESD immediately for repair.</p>	



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K 029	<p>Continued From page 4</p> <p>option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments and the Kitchen Staff. The facility has ninety-eight (98) certified beds and the census was eighty-three (83) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/09/12 at 10:15 AM, with the Environmental Services Director and Maintenance Person revealed the Kitchen had two (2) separate Dry Storage Rooms. One (1) of the Dry Storage Rooms did not have a self-closing device installed on the door.</p> <p>Interview, on 11/09/12 at 10:15 AM, with the Environmental Services Director and the Maintenance Person revealed they were not aware of the one (1) Dry Storage Room door not being equipped with a self-closing device.</p>	K 029	<p>K147</p> <p>All Maintenance Technicians will complete a written post test with a passing score of 80 or above to ensure that they understand that all outlets in wet areas must be a GFCI outlet and they understand how to install GFCI outlets. All post tests will be completed by 12/21/12.</p> <p>4. The ESD or Maintenance Technician will audit to ensure that facility equipment containing water are plugged into GFCI outlets 1 x monthly x 6 months, then quarterly thereafter. The results of the audits will be reported to the QA Committee monthly x 6 months for further review and recommendations. If additional audits are recommended by the QA committee, they will continue to be reviewed monthly until the QA committee agrees that compliance has been established and will be maintained.</p> <p>5. All corrective actions will be completed by 12/22/12.</p>	
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K 029	Continued From page 5  Reference:  NFPA 101 (2000 Edition).  19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.	K 029		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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K 147 Continued From page 6

K 147

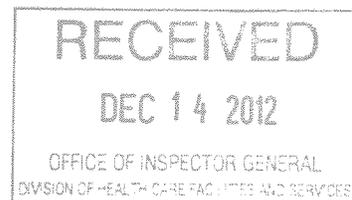
This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents in physical therapy and staff. The facility has ninety-eight (98) certified beds and the census was eighty-three (83) on the day of the survey.

The findings include:

Observation, on 11/09/12 at 10:40 AM, with the Environmental Services Director and the Maintenance Person revealed the hydrocollator (containing hot water) located in the Physical Therapy Department was not plugged into a ground fault circuit interrupter (GFCI) outlet as required in wet areas.

Interview, on 11/09/12 at 10:40 AM, with the Environmental Services Director and the Maintenance Person revealed they were not aware of the hydrocollator located to the Physical Therapy Department, was plugged into a standard electrical outlet, instead of the required GFCI outlet.

Reference: NFPA 99 (1999 edition)  
3-3.2.1.2 D



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K 147

Continued From page 7  
  
Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.

K 147

