

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS A Recertification Survey was initiated on 07/07/15 and concluded on 07/09/15 that found the facility not meeting the minimum requirements for recertification with deficiencies cited at the the highest scope and severity of a "G".	F 000	This plan of correction constitutes Mercy Sacred Heart's credible allegation of compliance for the cited deficiencies. Nothing in this plan of correction should be construed as admission by the facility of any violations of state or federal statutes, regulations, or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during an annual survey		
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 observation, interview, record review, review of the facility's policy, Fall Reports and Fall Trend Reports, it was determined the facility	F 280	F280 Corrective action for those residents found to have been affected by the deficient practice: 1. The plan of care for falls/safety for Resident #13 was reviewed and updated by DON and Nurse Manager on 7/16/2015 to include all identified interventions to prevent falls. Visual cues in the resident's room to remind her to ask for help were added to the care plan 2. The C.N.A. Care Card for Resident #13 was updated by Nurse Manager on 7/16/2015 to reflect falls risk and include the individualized interventions to prevent falls.	8/1/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Richard Walsh

Executive Director

8/19/15

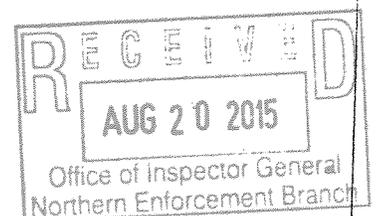
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

AUG 20 2015

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

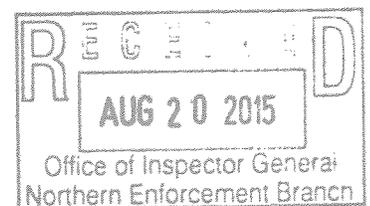
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 failed to review and revise fall care plans after falls occurred for one (1) of nineteen (19) sampled residents (Residents #13). The staff failed to revise the plan of care for Resident #13 when found on the floor by staff. The findings include: Review of the policy for Care Plans-Comprehensive, dated 04/11/11, revealed the Care Planning/ Interdisciplinary Team was responsible for the development of each resident's care plan and for periodic review and updating of the care plan. Review of the facility's policy for Using the Care Plan, dated December 2011, revealed the Care Planning/Interdisciplinary Team was responsible for reviewing any changes in the resident's care and for updating the care plan and the Nurse Aide Care Card. Review of the clinical record for Resident #13 revealed the facility admitted the resident on 01/21/15 with diagnoses of Senile Dementia, Anxiety, Peripheral Neuropathy, Diabetes, and Osteomyelitis. Review of the initial Minimum Data Set (MDS) assessment, dated 01/27/15, for Resident #13, revealed the facility had assessed Resident #13's cognition with a BIMS score of twelve (12) meaning the resident was interviewable. Further review revealed the facility had assessed Resident #13's transfer and ambulation as needing supervision with no set up or physical help required. Review of Resident #13's Comprehensive Care	F 280	How the facility identified other residents having the potential to be affected by the same deficient practice: 1. A comprehensive audit was completed for 100% of resident fall care plans from 7/13/15-7/16/15 to be certain that they were appropriate and accurate for each resident. Care plans were reviewed and updated to reflect falls risk and include individualized interventions to prevent falls for each resident. This work was completed by the Director of Nursing (DON), 2 Nurse Managers, and 2 MDS nurses. 2. An audit was completed of the C.N.A. Care Cards for 100% of residents from 7/13/15-7/16/15. Care Cards were updated to reflect falls risk and include individualized interventions to prevent falls for each resident. This work was completed by the Director of Nursing, 2 Nurse Managers, and 2 MDS nurses.	7/17/15	7/17/15



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

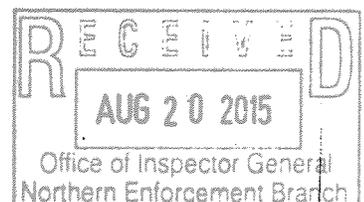
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206	
(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>Plan, dated 01/30/15, revealed Resident #13 was at risk for falls related to balance impairment with a goal that the resident would be free of injurious falls. Further review revealed interventions were to keep clutter from pathways, provide assistance with transfers, and toileting, provide enabling devices-walker and wheelchair, non-skid footwear, and physical therapy per physician order.</p> <p>Review of the Physical Therapy (PT) Progress and Discharge Summary dated 3/23/15, revealed Resident #13 was in therapy from 01/23/15 to 03/23/15 and was discharged from physical therapy due to lack of progress. Upon discharge from PT, Resident #13 was advised to use a wheelchair for all mobility, and to have assistance with all transfers. The PT Summary further listed precautions for Resident #13 of falls risk related to bilateral toe amputations, impulsivity, and poor safety awareness.</p> <p>Review of a Falls Report, dated 02/11/15 and Resident #13's Fall Trend Report, revealed Resident #13 was found sitting on the floor in his/her room in front of his/her recliner. Further review revealed the resident stated he/she sat down there and could not get up. The resident was assessed at that time to have no injuries. There were no new interventions put into place on the care plan to prevent further falls.</p> <p>Review of a Falls Report, dated 02/16/15 and Resident #13's Fall Trend Report, revealed Resident #13 was found in his/her room on the floor near his/her bed with his/her legs out in front and arms at the side. The resident stated he/she was getting up from the recliner to go to bed and slid to the floor. The resident was assessed at</p>	F 280	<p>Measures put into place or systemic changes made to ensure the deficient practice will not recur:</p> <ol style="list-style-type: none"> 1. "Plan of Care-Comprehensive" policy was been reviewed and revised by LNHA and DON. (Attachment 1) 2. "Using the Plan of Care" policy was reviewed and revised by LNHA and DON. (Attachment 2) 3. "Assessing Falls and Their Causes" policy was reviewed and revised by LNHA and DON. (Attachment 3) 4. "Falls Risk Assessment" policy was reviewed and revised. (Attachment 4) 5. "Falls and Fall Risk, Managing" policy was reviewed and revised by LNHA and DON. (Attachment 5) 6. The Falls Packet completed post fall was revised by LNHA and DON. (Attachment 6) 7. A "Fall Prevention Intervention List" was developed by LNHA and DON and placed in each MAR and C.N.A. book. (Attachment 7) 	7/27/15



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

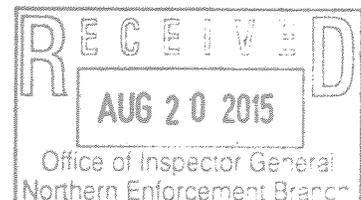
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 3</p> <p>that time to have no injuries. There were no new interventions put into place on the care plan to prevent further falls.</p> <p>Review of a Falls Report, dated 02/19/15 and Resident #13's Fall Trend Report, revealed Resident #13 was found in his/her room on the floor sitting in front of his/her recliner. Further review revealed the resident stated he/she was asleep and did not know how he/she fell. The resident was assessed at that time to have no injuries. The intervention added to the comprehensive care plan was to educate the resident on the importance of using the call light for assistance with transfers.</p> <p>Observation of Resident #13, on 07/08/15 at 2:55 PM, revealed the resident was in dining room #3 sitting in his/her wheelchair at a table with other residents playing bingo. There was a tab alarm on the resident's wheelchair.</p> <p>Observation of Resident #13, on 07/08/15 at 4:05 PM, revealed the resident was self propelling himself/herself in the wheelchair down the hall toward his/her room.</p> <p>Observation of Resident #13, on 07/09/15 at 11:35 AM, revealed the resident was in the common area outside the 300 dining room in his/her wheelchair participating in a sing-a-long with other residents. The tab alarm was on the resident's wheelchair.</p> <p>Interview with CNA #5, on 07/09/15 at 9:15 AM, revealed Resident #13 would go to the bathroom by himself/herself and was supposed to call for assistance when he/she needed to go to the bathroom. CNA #5 further stated the CNAs had</p>	F 280	<p>8. All nursing staff were educated on the changes to the "Plan of Care-Comprehensive," "Using the Plan of Care," "Assessing Falls and Their Causes," "Fall Risk Assessment," "Falls and Fall Risk, Managing" policies, the revised Falls Packet and the "Fall Prevention Intervention List." Education completed by LNHA, DON, and Nurse Manager between 7/27/15-8/1/15.</p> <p>9. All falls continue to be reviewed during scheduled Interdisciplinary Team (IDT) meetings with the facility Medical Director.</p> <p>10. All falls continue to be reviewed by the clinical team at morning meetings and added interventions discussed</p>	8/2/15	



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

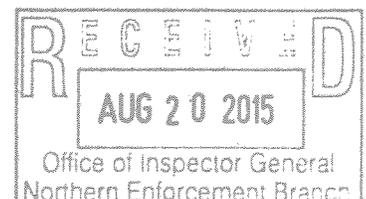
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 4 access to the residents' care plans and used the Activities of Daily Living log to see how a resident was supposed to be transferred. She further stated the nurses and CNAs communicated verbally after a resident fall about new interventions that were put into place. Interview with Resident #13, on 07/09/15 at 9:25 AM, revealed he/she was to call staff for assistance with transfers because his/her legs were weak. The resident stated he/she did not like to ask for help because he/she always thought he/she could do it himself/herself. Interview with Licensed Practical Nurse (LPN) #4, on 07/09/15 at 9:35 AM, revealed the unit nurse reviewed and updated the comprehensive care plan after a resident's fall. A group meeting with staff was held on the unit after a resident's fall to determine the root cause. LPN #4 stated sometimes it was determined new interventions did not need to be added to the care plan. She reported all nursing staff was responsible for monitoring the effectiveness of care plan interventions. LPN #4 stated Resident #13 was capable of asking for help and pulling the call light in his/her bathroom. Interview with the Nurse Manager for the long term care units, on 07/09/15 at 3:25 PM, revealed resident falls were discussed in the morning meetings which included the Nurse Managers, the Director of Nursing, the Executive Director, the Social Worker and Therapy. The fall trend reports were brought to the meeting and updated. After a resident's fall, the unit nurse would review the comprehensive care plan and add new interventions which would be reviewed in the morning meetings and revised if needed.	F 280	How the facility plans to monitor its performance to ensure that solutions are sustained: 1. The Nurse Manager or DON will audit the plan of care and C.N.A. Care Card for revisions and updates post falls. The audit will be completed on all residents who experience a fall for 1 month, 20% of residents who experience a fall for 3 months, and 20% of residents who experience a fall quarterly for the remainder of the year. 2. All findings will be reviewed and reported to CQI Committee.		



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

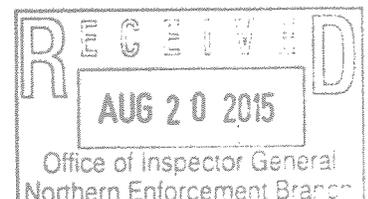
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206	
(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 5 Interview with the DON, on 07/09/15 at 3:50 PM, revealed after a resident fall, the comprehensive care plan was reviewed and interventions were added to keep the resident as safe as possible. She reported Resident #13 was alert and oriented and refused to call for assistance. The DON further stated new interventions should be added to the comprehensive care plan after every fall. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policy, it was determined the facility failed to follow the fall care plans for two (2) of nineteen (19) sampled residents (Residents #8, and #7). The staff failed to ensure Resident #8 received 1:1 supervision as care planned and Resident #7 was not provided the raised toilet seat with side arms as care planned to prevent falls for both residents. The findings include: Review of the policy for Care Plans-Comprehensive, dated 04/11/11, revealed the Care Planning/ Interdisciplinary Team was responsible for the development of each resident's care plan and for periodic review and updating of the care plan. The policy did not	F 280	F282 Corrective action for those residents found to have been affected by the deficient practice: 1.A raised toilet seat with side arms was placed on Resident #7's toilet on 7/9/2015. (Resident #7 expired on 7/13/2015 prior to plan of care review.) 2. The plan of care for falls/safety for Resident #8 was reviewed and updated by MDS Nurse and LNHA on 7/14/2015. Interventions to prevent further falls have been implemented. These interventions include implementation of a Tab alarm, escorting resident to a common area with supervision when not in bed in room, and obtaining a PRN order for an ant-anxiety medication if needed. Additional interventions were added on 7/22/2015 and 7/25/2015. These include using a floor mat next to bed on side nearest bathroom and assisting with toileting before assisting to bed, respectively.	8/1/15
F 282 SS=G		F 282		



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

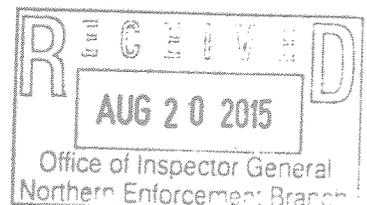
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 282	Continued From page 6 encompass following the care plan. Review of the facility's policy for Using the Care Plan, dated December 2011, revealed the Care Planning/Interdisciplinary Team was responsible for reviewing any changes in the resident's care and for updating the care plan and the Nurse Aide Care Card. The policy did not include following the care plan. 1. Review of the clinical record for Resident #8, revealed the facility admitted the resident on 08/15/10 with diagnoses of Advanced Alzheimer's Disease, Chronic Pain, Depression, and Hypertension. Review of the significant change MDS, dated 04/02/15, completed by the facility, revealed the facility assessed Resident #8 as not interviewable with a score of five (5) on the BIMS. The resident required extensive assistance of one (1) for transfers, dressing, eating, hygiene, and bathing, and total care with bathing. The resident was incontinent of bowel and bladder and had frequent pain. The resident received palliative care. Review of the care plan for Resident #8, dated 05/28/10 with revisions dated 07/04/15, revealed the resident was a high risk for falls related to balance impairment, the use of psychoactive medications, and a history of falls. Interventions included: bed low and locked; bed alarm; walker/wheelchair; monitor for safety; non-skid footwear; non-skid strips to the floor; alarm to the wheelchair; resident to the common area if restless; and increase of anti-anxiety medication. The care plan revealed the facility assessed Resident #8 as requiring one (1) to one (1) at the	F 282	3. The C.N.A. Care Card for Resident #8 was updated by MDS Nurse and LNHA on 7/14/2015 to include individualized interventions to prevent falls. 4. A visual inspection was completed on Resident #8 to verify all listed interventions were implemented. How the facility identified other residents having the potential to be affected by the same deficient practice: 1. An audit was completed 7/13/15-7/16/15 for all residents' plans of care for falls/safety. This audit was completed by the LNHA, DON, 2 Nurse Managers, and 2 MDS nurses. The plans of care were reviewed and updated to include individualized interventions to prevent falls. 2. A visual inspection was completed by the Night Shift Nursing Supervisor 7/13/15-7/16/15 for all residents to verify interventions were implemented. 3. The C.N.A. Care Cards for all residents were updated by the Night Shift Nursing Supervisor 7/13/15-7/16/15 to include individualized interventions to prevent falls.	7/17/15 7/17/15 7/17/15	



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

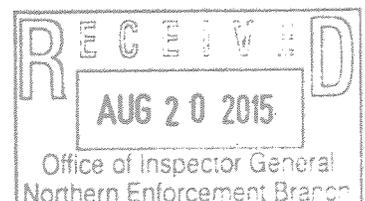
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 282	Continued From page 7 nursing station on 04/23/15. There was no documented evidence this intervention was implemented. Review of the Fall Reports, revealed Resident #8 sustained falls on 02/01/15 when found on the floor in the bathroom by staff with bruises to the left hip and thigh and above the left eyebrow. On 04/23/15 was found on the floor beside the bed with a hematoma to the forehead. On 07/04/15 the resident was found on the floor next to the recliner with a fractured wrist. Interview with CNA #1, on 07/09/15 at 9:44 AM, revealed one (1) to one (1) was not implemented for Resident #8. She stated there was not enough assistants to watch the resident all the time. She stated nursing staff tried to watch the resident when they could. She stated the resident fell even when staff tried to watch her. Interview with CNA #2, on 07/09/15 at 12:23 PM, revealed the supervision of Resident #8 was done as staff had time and the resident fell anyway. Interview with LPN #1, on 07/09/15 at 11:44 AM, revealed 1:1 did not mean one staff to be with the resident at all times. Everyone watches the resident, no one sits with him/her. She stated she watches the resident as she passes medications. If a resident falls, then she looks at the care plan for the interventions. Interview with the Director of Nursing, on 07/09/15 at 3:50 PM, revealed a new intervention should be added to the care plan to attempt to prevent further falls. She stated she was responsible for the nursing department; however,	F 282	Measures put into place or systemic changes made to ensure the deficient practice will not recur: 1. "Plan of Care-Comprehensive" policy was been reviewed and revised by LNHA and DON. (Attachment 1) 2. "Using the Plan of Care" policy was reviewed and revised by LNHA and DON. (Attachment 2) 3. A "Fall Prevention Intervention List" was developed by LNHA and DON and placed in each MAR and C.N.A. book. (Attachment 7) 4. All nursing staff were educated on the changes to the "Plan of Care-Comprehensive" and "Using the Plan of Care" policies and the "Fall Prevention Intervention List" 7/27/15-8/1/15. Education completed by LNHA, DON, and Nurse Manager 5. Falls are reviewed by the clinical team at morning meetings to review investigation and assure modifications to the fall care plans are made.	7/27/15 7/27/15 7/27/15 8/2/15	



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

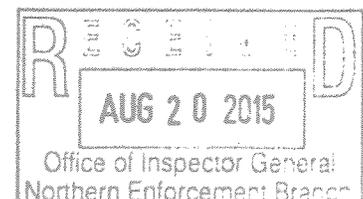
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206	
(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 282	<p>Continued From page 8</p> <p>she stated the facility did not have the resources to provide one (1) to one (1) supervision for a resident.</p> <p>2. Review of the clinical record for Resident #7, revealed the facility admitted the resident on 06/01/15 with diagnoses of Fractured Lumbar L1, Chronic Obstructive Pulmonary Disease, Schizophrenia, Hypertension, and Atrial Fibrillation.</p> <p>Review of the admission Minimum Data Set (MDS) assessment for Resident #7, completed by the facility on 06/07/15, revealed the facility assessed the resident as non-interviewable with a score of seven (7) on a Brief Interview for Mental Status (BIMS). The resident required extensive assistance of one (1) person for transfer, ambulation, dressing, hygiene and bathing. The resident was incontinent of urine frequently. The resident had frequent pain and received psychoactive medications.</p> <p>Review of the care plan for Resident #7, dated 06/15/15 revealed the resident was at high risk for falls related to fractured Lumbar Vertebra (L1), balance impairment, use of psychoactive medications, and a history of falls. Interventions for this risk were: to assist with toileting; transfers; and all activities of daily living; bed wheels locked; walker/wheelchair; non-skid footwear; PT/OT; and gait belt when walking.</p> <p>Review of a Fall Report, dated 06/23/15 at 12:25 PM, revealed Resident #7 was assisted to the bathroom and was being seated on the toilet. The nurse aide turned away from the resident to get wipes and the resident fell off the toilet and sustained a laceration on the left side of the</p>	F 282	<p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <p>1. The DON or Clinical Nurse Leader will audit the plan of care and C.N.A. Care Cards for revisions and updates post fall. A visual audit will be completed to check for implementation of listed interventions. These audits will be completed on all residents who experience a fall for one month, 20% of residents who experience a fall for 3 months, and 20% of residents who experience a fall quarterly for the remainder of the year.</p> <p>2. All findings will be reviewed and analyzed then reported to the CQI committee.</p> <p>3. DON or designee will audit and monitor 100% of resident care plans subsequent to a fall and complete a visual inspection of interventions for the next 30 days.</p>	



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 282	Continued From page 9 temple. The resident required sutures at the hospital. Review of the Fall Report, dated 07/06/15 at 6:45 AM, revealed Resident #7 was assisted to the bathroom and onto the toilet by a nurse aide. The nurse aide left the resident in the bathroom alone while she gathered supplies. The resident fell off the toilet and sustained a laceration to the left side of the forehead and required sutures at the hospital. Review of the care plan, dated 06/15/15 for Resident #7, revealed the facility added a raised toilet seat with armrests on 07/06/15. Observation of Resident #7's bathroom, on 07/07/15 at 3:14 PM and on 07/08/15 at 8:01 AM, revealed no raised toilet seat with armrests was in the resident's bathroom. Interview with Certified Nurse Aide (CNA) #1, on 07/09/15 at 12:13 PM, revealed the raised toilet with armrests, was not provided for Resident #7 until 07/09/15. Interview with Licensed Practical Nurse (LPN) #1, on 07/09/15 at 10:45 AM, revealed Resident #7 did have a raised toilet seat with armrests. She stated she did not know when it was brought to the resident's room. Interview with the Nurse Manager, on 07/09/15 at 12:45 PM, revealed she stated the care plan was revised after the fall on 07/06/15; however, she was not aware the raised toilet seat was not obtained on 07/06/15.	F 282			
F 323	483.25(h) FREE OF ACCIDENT	F 323			



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

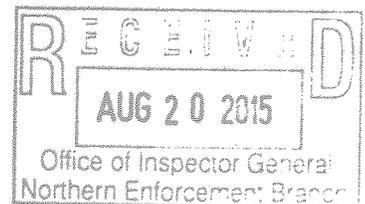
PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206	
(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 SS=G	Continued From page 10 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, review of the facility's policy, Fall Reports, and Fall Trend Reports, it was determined the facility failed to provide adequate supervision and assistive devices based on assessment of the residents' needs for three (3) of nineteen (19) sampled residents (Residents #7, #8, #13) and failed to implement resident specific interventions to prevent falls. In addition, the facility failed to complete investigations and determine the root cause of falls to develop an appropriate intervention to prevent future falls. Resident #8 had a total of five (5) falls between 02/01/15 and 07/04/15. Of those five falls, the resident sustained bruising to the hip and thigh from a fall on 02/01/15; a blood filled swelling to the forehead during the fall on 04/23/15; and, the fall on 07/04/15 resulted in the resident sustaining a fractured wrist requiring an emergency room visit. Resident #7 fell from the toilet and sustained lacerations to the head requiring emergency room visits for sutures twice, once on 06/23/15 and again on 07/06/15.	F 323	F323 Corrective Action for those residents found to have been affected by the deficient practice: 1. A raised toilet seat with side arms was placed on Resident #7's toilet on 7/9/2015. (Resident #7 expired on 7/13/2015 prior to additional interventions.) 2. A fall risk assessment was been completed on Resident #8 and #13 on 8/10/2015. These assessments were completed by the Nurse Manager and DON respectively. The plan of care for falls/safety for these residents was reviewed and interventions were deemed appropriate. The plan of care for falls/safety for Resident #8 was reviewed and updated by MDS Nurse and LNHA on 7/14/2015. The interventions include implementation of a Tab alarm, escorting resident to a common area with supervision when not in bed in room, and obtaining a PRN order for an anti-anxiety medication if needed. Additional interventions were added on 7/22/2015 and 7/25/2015. These include using a floor mat next to bed on side nearest bathroom and assisting with toileting before assisting to bed, respectively. The plan of care for falls/safety for Resident # 13 was reviewed and updated by Nurse Manager and MDS nurse on 7/16/2015. The additional intervention was to post visual cues for resident in room.	8/10/15

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

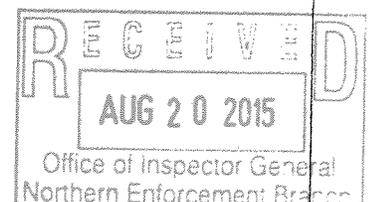
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 11 In addition, Resident #13 was found on the floor by staff on 02/11/15, 02/16/15, 02/19/15 with no injuries. However, the facility failed to complete a root cause analysis to determined the cause of the falls. The findings include: Review of the facility's policy for Fall Risk Assessment, dated 04/21/11, revealed all residents were assessed for fall risks on admission, quarterly, annually, with a significant change in condition and after a fall. Review of the facility's policy for Falls and Fall Risk Management, dated 04/21/11, revealed staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to minimize complications from falling. The staff would monitor and document each resident's response to interventions to reduce the risk of falls. If the resident continued to fall, staff would reconsider whether the measures needed to be changed. Review of the facility's policy for Assessing Falls and Their Causes, dated 09/27/13, revealed the purpose of the policy was to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. An occurrence report would be completed as well as a fall analysis. Interventions would be implemented to reduce the risk of additional falls. The care plan would be reviewed and revised if necessary. The staff would fill out a post fall assessment which consisted of a neurological and vital sign assessment.	F 323	3. The C.N.A. Care Cards for Residents #8 and #13 were updated by Night Shift Nursing Supervisor on 7/16/2015 to include updated interventions from care plans to prevent falls. 4. A visual inspection was completed on Residents #8 and #13 by Night Shift Nursing Supervisor on 7/16/2015 to verify all listed interventions were implemented. 5. Signs were posted in Resident #13's room by DON on 7/17/2015 to remind resident to call for assistance. 6. Medications were adjusted for Resident #8 by resident's primary care physician to address her anxiety on 7/6/15 and 7/8/15.		



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

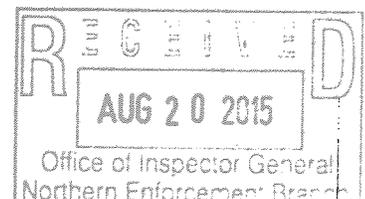
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 12 1. Review of the clinical record for Resident #8, revealed the facility admitted the resident, on 08/06/10, with diagnoses Advanced Alzheimer's Disease, Chronic Pain, Depression, and Recurrent Clostridium Difficile. Review of the significant change Minimum Data Set(MDS) assessment, dated 04/02/15, revealed the facility assessed the resident as not interviewable with a BIMS score of five (5). The resident required extensive assistance of one (1) with transfers, dressing, eating, hygiene and total care with bathing. The resident was incontinent of bowel and bladder. The resident required limited assistance of one (1) to walk and the resident had frequent pain. Review of the comprehensive care plan for Resident #8, dated 05/28/10 and updated on 07/04/15, revealed the resident was a high risk for falls. Fall interventions included: bed and chair alarms and locked wheels; non-skid footwear; remind resident to use walker; one to one supervision at the nurse's station (added 04/23/15); bring the resident to the common area if restless; give anti-anxiety medication as needed (added 06/21/15); and increase anti-anxiety medication (added 07/04/15). The care plan listed falls for; 04/23/15 with no injuries; 06/21/15 with no injuries; and 07/04/15 documented the resident fell from a chair. The facility identified risk factors of restlessness, pain, functional decline, impaired vision, use of alarms, and cognitive impairment as fall risks through out the care plan; however, review of the CNA care card revealed the facility did not communicate those risks or the interventions to the care card. Review of the Fall Report for Resident #8, dated	F 323	How the facility identified other residents having the potential to be affected by the same deficient practice: 1. An audit was completed for 100% of residents' plans of care for falls/safety 7/13/15-7/16/15. This was completed by LNHA, DON, 2 Nurse Managers, and 2 MDS Nurses. The plans of care have been reviewed and updated to include individualized interventions to prevent falls. 2. A visual inspection was completed by Night Shift Nursing Supervisor 7/13/15-7/16/15 for all residents to verify interventions were implemented. 3. The C.N.A. Care Cards for all residents were updated by Night Shift Nursing Supervisor 7/13/15-7/16/15 to include individualized interventions to prevent falls.	7/17/15 7/17/15 7/17/15	



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 13 02/01/15, revealed the resident was found on the floor trying to get to the bathroom. Review of the Fall Trend Report for Resident #8, undated, revealed the resident sustained bruising of the hip and thigh during a fall on 02/01/15. X-ray of the areas revealed no fractures. The cause of the fall was poor safety awareness on the resident's part. Review of the care plan revealed it had been revised to reflect mats placed on the floor. Review of the Fall Report, dated 02/15/15, revealed Resident #8 was found on the floor beside the bed with no injury. The resident stated he/she was going to lunch. Review of the Fall Trends Report, undated, revealed Resident #8 fell on 02/15/15 while trying to go to lunch. There were no injuries and the cause of the fall was the resident's poor safety awareness. The care plan was revised to reflect the addition of a bed alarm. Review of the Fall Report for Resident #8, dated 04/23/15, revealed the resident was found on the floor by the bed with the alarm sounding. There were no injuries. Review of the Fall Trends Report, undated, revealed Resident #8 fell on 04/23/15. The resident sustained a hematoma to the forehead. The facility spoke to the family regarding terminal restlessness. The cause of the fall was determined to be the resident's poor safety awareness. The care plan was revised to reflect the increased in dose of Ativan (anti-anxiety). Review of the Fall Report for Resident #8, dated	F 323	Measures put into place or systemic changes made to ensure the deficient practice will not recur: 1. "Plan of Care-Comprehensive" policy was reviewed and revised by LNHA and DON. (Attachment 1) 2. "Using the Plan of Care" policy was reviewed and revised by LNHA and DON. (Attachment 2) 3. "Assessing Falls and Their Causes" policy was reviewed and revised by LNHA and DON. (Attachment 3) 4. "Falls Risk Assessment" policy was reviewed and revised. (Attachment 4) 5. "Falls and Fall Risk, Managing" policy was reviewed and revised by LNHA and DON. (Attachment 5) 6. The Falls Packet completed post fall was revised by LNHA and DON. (Attachment 6) 7. A "Fall Prevention Intervention List" was developed by LNHA and DON and placed in each MAR and C.N.A. book. (Attachment 7)	7/27/15 7/27/15 7/27/15 7/27/15 7/27/15 7/27/15 7/27/15	



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

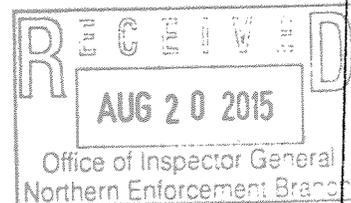
PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206
--	--

(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
--------------------	--	---------------	---	----------------------

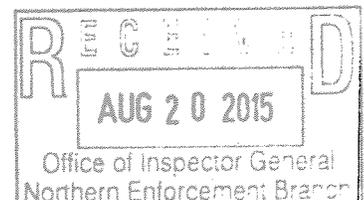
F 323	<p>Continued From page 14</p> <p>04/23/15, revealed the resident was found on the floor with the bed alarm disabled by the resident. The facility determined the resident removed the alarm and the alarm was to be placed on the resident's clothing where it would be hard to remove. One (1) to one (1) supervision, dated 04/23/15, was listed on the resident's care plan after the fall.</p> <p>Review of the Fall Trend Report, undated, revealed Resident #8 fell on 04/23/15 and required x-rays of the hip and the resident sustained a hematoma to the forehead related to the resident's poor safety awareness.</p> <p>Review of the Fall Report for Resident #8, dated 06/21/15, revealed the resident was found on the floor next to the bed while the alarm was sounding. The resident reported no pain and he/she wanted to get up. There was no documented evidence of injury.</p> <p>Review of the Fall Trend Report, undated, revealed Resident #8 fell on 06/21/15, and the alarm was sounding. The resident's fall was due to the resident's poor safety awareness. The facility determined the resident was to be brought to the common area if restless.</p> <p>Review of the Fall Report for Resident #8, dated 07/04/15, revealed the resident was seated in a recliner in the common area when the alarm sounded. The resident was found on the floor with an injury to the left wrist.</p> <p>Review of the Fall Trend Report, undated, revealed the resident was sent to the emergency room on 07/04/15 after a fall and was diagnosed with a fractured left wrist. The cause of the fall</p>	F 323	<p>8. All nursing staff were educated on the changes to the "Plan of Care-Comprehensive," "Using the Plan of Care," "Assessing Falls and Their Causes," "Fall Risk Assessment," "Falls and Fall Risk, Managing" policies, the revised Falls Packet and the "Fall Prevention Intervention List" 7/27/15-8/1/15. Education completed by LNHA, DON, and Nurse Manager.</p> <p>9. All falls continue to be reviewed during scheduled Interdisciplinary Team (IDT) meetings with the facility Medical Director.</p> <p>10. All falls continue to be reviewed by the clinical IDT team at morning meetings and added interventions discussed.</p>	8/2/15
-------	---	-------	---	--------



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

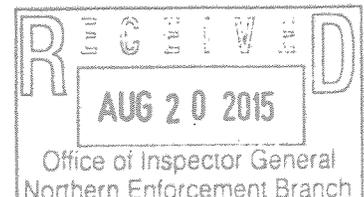
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206	
(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 15 was the resident's poor safety awareness.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 07/09/15 at 9:44 AM, revealed Resident #8 was confused and restless at times. She stated the resident was a fall risk and was on one (1) to one (1) supervision, which was not started due to staffing. She stated that meant everyone tried to keep an eye on the resident as they were able. She stated she did not have any information on why the resident was restless.</p> <p>The CNA continued to state the resident had declined in all functions; however, the care card advised staff to assist and the resident required extensive care. She stated the resident could not use a walker anymore and needed a wheelchair. She stated the resident was kept in the common area unless in bed and the resident had alarms. She stated the alarms let staff know when a resident fell and they did not prevent falls.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/09/15 at 11:44 AM, revealed one (1) to one (1) supervision did not mean one (1) person watching one (1) resident. She stated everyone watched Resident #8 for falls. She stated no one sat with the resident, rather all staff tried to keep an eye on the resident. She stated the nurses were responsible for the initial fall assessment and developing the initial care plan. She stated the nurse filled out a fall report if a resident fell on their shift. She stated she did not evaluate the resident for new fall risks or hazards after a fall or evaluate the efficacy of the fall care plan to see if new interventions would be more effective. She stated she would add a new intervention if needed. She stated she was trained on completing a fall report; however, she was not</p>	F 323	<p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <p>1. The DON or Clinical Nurse Leader will audit the plan of care and C.N.A. Care Cards for revisions and updates post fall. A visual audit will be completed to check for implementation of listed interventions. These audits will be completed on all residents who experience a fall for one month, 20% of residents who experience a fall for 3 months, and 20% of residents who experience a fall quarterly for the remainder of the year.</p> <p>2. The DON or Clinical Nurse Leader will audit the Fall Root Cause Analysis and Investigation forms for completion of investigation leading to interventions. These audits will be completed on all residents who experience a fall for 1 month, 20% of residents who experience a fall for 3 months, and 20% of residents who experience a fall quarterly for the remainder of the year.</p> <p>3. All findings will be reviewed and analyzed then reported to the CQI committee.</p>	



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

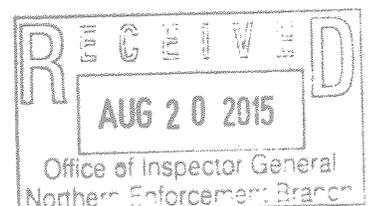
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 16</p> <p>trained on determining the cause of the fall or identifying new risk factors or hazards. She stated she did not look to see what the facility did not do that may have caused the fall. The cause was always what the resident did to cause the fall.</p> <p>Interview with the Nurse Manager, on 07/09/15 at 12:45 PM, revealed the nurse completed a falls assessment on each resident at admission and started the initial care plan. She stated the nurse working when a resident fell was responsible for completing the falls report, determining the cause of the fall and adding interventions as indicated. She stated the interdisciplinary team reviewed the fall report the next day and made additions as indicated. She stated the care plan should be reviewed and revised based on the fall report and all nurses were trained on determining the root cause of a fall which usually was what the resident did prior to the fall. She stated Resident #8 had fallen related to poor safety awareness. She stated she had been trained on determining the cause of a fall and identifying new risk factors and hazards; however, she had not thought about the cause of the fall being caused something the facility did not do. She stated she was responsible for reviewing fall reports at the daily meeting and ensuring all the paper work was completed accurately.</p> <p>Interview with the Director of Nursing (DON), on 07/09/15 at 3:50 PM, revealed the facility was unable to provide one (1) to one (1) supervision to residents due to staffing. She stated she was responsible for the nursing department. She stated it was her opinion the cause of falls was poor safety awareness, if the resident had any physical impairments. She never thought about</p>	F 323	4. MDS nurses will reassess all residents specifically for falls quarterly in conjunction with quarterly MDS assessment for the rest of the year and will amend care plans as necessary as a result.		



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

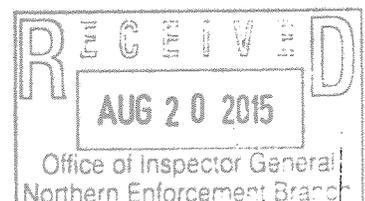
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 17</p> <p>the cause of the fall being anything else but the resident's fault. She stated all fall reports were reviewed at the daily nursing meeting and new interventions were added as needed. She stated all the nurses were trained to identify the cause of the fall; however, the cause was usually what the resident did to cause the fall, not the facility.</p> <p>2. Review of the clinical record for Resident #7, revealed the facility admitted the resident, on 06/01/15, with diagnoses of Schizophrenia, Closed Fracture of Lumbar One, Osteoporosis, Obsessive Compulsive Disorder and Chronic Obstructive Pulmonary Disease.</p> <p>Review of the admission Minimum Data Set (MDS) assessment, completed by the facility on 06/07/15, revealed the facility assessed the resident as not interviewable with a score of seven (7) of fifteen (15) on the Brief Interview for Mental Status (BIMS). The resident required extensive assistance of one (1) assistant for transfers, walking, hygiene, and toileting. The resident could be restless and received antipsychotic medications related to psychiatric diagnoses.</p> <p>Review of the therapy notes, dated 06/30/15, revealed Resident #7 was discontinued from Occupational and Physical Therapies related to the resident's failure to progress over a two (2) week period.</p> <p>Review of the comprehensive care plan for Resident #7, dated 06/15/15, with a target date of 06/19/15, revealed the resident was at risk for falls related to the pain from the lumbar fracture, balance impairment, use of psychotropic medications, and a history of falls. Interventions</p>	F 323			



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

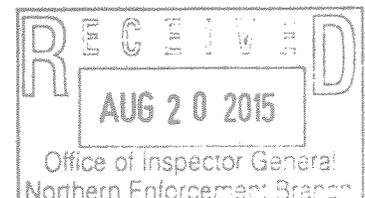
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 18</p> <p>for the prevention of injurious falls included: assist with toileting, transfers, and all activities of daily living; bed low; bed wheels locked; walker or wheelchair; call light in reach; monitor for safety changes and intervene as necessary; and non-skid shoes. All the interventions were dated 06/15/15 until the intervention on 07/06/15 for a raised toilet seat with arms. There was no documented evidence the facility communicated the identified risk factors for Resident #7 to the CNAs that the resident needed a raised toilet seat with arms. There was no documented evidence the facility communicated the resident's need for extensive assistance with ambulation and toileting, pain, fractured lumbar vertebra, and use of psychoactive medication to CNAs to attempt to prevent falls.</p> <p>Review of the Fall Report for Resident #7, dated 06/23/15, revealed the resident was assisted to sit on the toilet by a Certified Nurse Aide (CNA). The report continued to reveal the CNA turned to get the resident a wipe when the resident fell to the floor sustaining a laceration to the left side of the head.</p> <p>Review of the Fall Trend Report, not dated, revealed Resident #7 fell on 06/23/15 while in the bathroom. The resident was sent to the hospital emergency room and required sutures to close a laceration. The facility determined the resident fell due to pain, because the resident stated to the staff she stepped the wrong way while trying to sit down on the toilet; the report stated the resident denied any pain. The facility determined the resident needed nursing staff to remain with him/her while in the bathroom and the resident was to be walked using a gait belt.</p>	F 323			



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 19</p> <p>Interview with the Nurse Manager, on 07/09/15 at 12:45 PM, revealed Resident #7 fell related to weakness and pain.</p> <p>Review of the Nurse Aide Care Card for Resident #7, dated 03/03/15, revealed there was no documented evidence the card was updated to require staff to stay in the bathroom with the resident after the fall on 06/23/15.</p> <p>Review of the Fall Report for Resident #7, dated 07/06/15, revealed the resident, assisted by a CNA, was on the toilet. The CNA left the resident in the bathroom and went to the closet to obtain supplies. While the CNA was gone, the resident fell off the toilet sustaining a laceration and a hematoma to the forehead.</p> <p>Review of the Fall Trend Report, not dated, revealed Resident #7 fell on 07/06/15 and required a hospital emergency room visit and sutures. The resident was assessed as a high risk for falls. The facility determined the resident's fall was due to weakness.</p> <p>Review of the Fall Trend Report, undated, for Resident #7, revealed the facility determined that nursing staff was to remain with the resident in the bathroom while toileting. Even though review of the care plan revealed the intervention was discontinued on the care plan.</p> <p>Review of the Fall Trend Report for Resident #7, revealed the resident fell on 06/23/15 related to possible pain. The resident fell on 07/06/15 related to weakness and pain. In addition, the resident was to use a gait belt when toileting the resident and stay in the bathroom with the resident. There was no documented evidence on</p>	F 323			



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

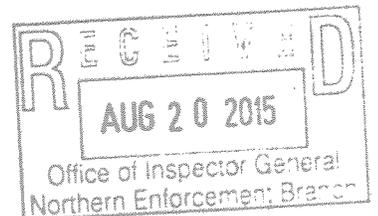
PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206
--	--

(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
--------------------	--	---------------	---	----------------------

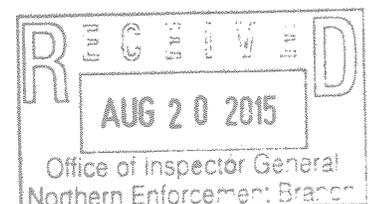
F 323	<p>Continued From page 20</p> <p>the care plan or the resident care guide that staff was instructed to remain with the resident when toileting.</p> <p>Interview with CNA #3, on 07/08/15 at 10:06 AM, revealed Resident #7 had fallen while on the toilet on 06/23/15. She stated the resident needed to be walked using a gait belt at times. She stated sometimes it was easier to use a wheelchair. She stated the resident did not have a raised toilet seat with armrests and had heard nothing about it. She stated it was not on the care guide for the aides. She revealed the nurse updated the care guide used by the aides; however, she was not sure when the guide was last updated. She stated she depended on the care guide and what the nurse told her to give the correct care. She stated she was not aware staff needed to remain with the resident when toileting.</p> <p>Interview with CNA #6, on 07/08/15 at 10:56 AM, revealed she was trained on falls and fall prevention. She stated she used the nurse aide care card for information regarding the resident. She stated she was aware of Resident #7's falls; however, she had not cared for the resident recently and had no knowledge regarding the raised toilet seat. She stated she had received training on falls.</p> <p>Interview with CNA #1, on 07/09/15 at 12:13 PM, revealed Resident #7 had just been provided with a raised toilet seat with armrests on 07/09/15. She stated the resident did not get a raised toilet on 07/06/15 as indicated on the care plan. She stated the resident's care card gave no instructions to remain with the resident when the resident was toileted.</p>	F 323		
-------	---	-------	--	--



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

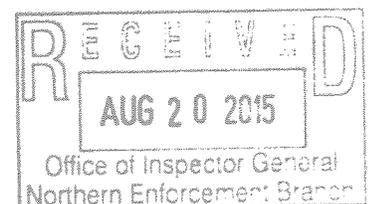
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 21</p> <p>Interview with CNA #2, on 07/09/15 at 12:23 PM, revealed Resident #7 was provided with a raised toilet seat on 07/09/15 and had no assistive device in the bathroom prior to 07/09/15 and there were no instructions on the nurse aide care guide to remain in the bathroom when the resident was toileted.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/09/15 at 10:44 AM, revealed Resident #7 has had a couple of falls and had lacerations to the head. She stated the nurse working when the fall occurred filled out an incident report and the paper work to describe how the fall happened. She stated she had never heard of determining the root cause of the fall. She stated the nurse ensured safety interventions were in place and that all the information was entered into the computer. She stated nurse management reviewed all the reports. She stated she was aware that Resident #7 had a raised toilet with armrests; however, she stated she did not know when the toilet was put into place.</p> <p>3. Review of the clinical record for Resident #13 revealed the facility admitted Resident #13 on 01/21/15 with diagnoses to include Senile Dementia, Anxiety, Peripheral Neuropathy, Diabetes, and Osteomyelitis.</p> <p>Review of an initial Minimum Data Set (MDS) assessment, dated 01/27/15, for Resident #13 revealed the facility had assessed Resident #13's cognition as moderately impaired with a Brief Interview for Mental Status and a score of twelve</p>	F 323			



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

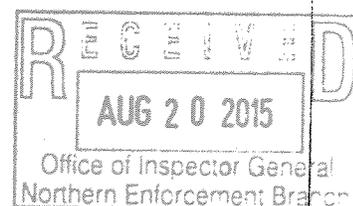
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 22</p> <p>(12) meaning the resident was interviewable. Further review revealed the facility had assessed Resident #13's transfer and ambulation as needing supervision with no set up or physical help required.</p> <p>Review of Resident #13's Comprehensive Care Plan, dated 01/30/15, revealed Resident #13 was at risk for falls related to balance impairment with a goal that the resident would be free of injurious falls. Further review revealed interventions to keep clutter from pathways, assistance with transfers, and toileting, provide enabling devices, non-skid footwear, and physical therapy per physician order.</p> <p>Review of the Physical Therapy (PT) Progress and Discharge Summary, dated 03/23/15, revealed Resident #13 was in therapy from 01/23/15 to 03/23/15 and was discharged from physical therapy due to lack of progress. Upon discharge from PT Resident #13 was advised to use a wheelchair for all mobility and to have assistance with all transfers. The PT Summary further listed precautions for Resident #13 of falls risk related to bilateral toe amputations, impulsivity, and poor safety awareness.</p> <p>Review of a Falls Report, dated 02/11/15, and Resident #13's Fall Trend Report, revealed Resident #13 was found sitting on the floor in his/her room in front of his/her recliner. Further review revealed the resident stated he/she sat down there and could not get up. Additional review revealed the resident was assessed at that time to have no injuries. Continued review</p>	F 323			



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 23</p> <p>revealed the root causes identified included poor safety awareness and the resident disregards instructions to ask for assistance from staff, no new intervention was put into place to prevent further falls.</p> <p>Review of a Falls Report dated 02/16/15 and Resident #13's Fall Trend Report, revealed Resident #13 was found in his/her room on the floor near his/her bed with his/her legs out in front and arms at the side. Further review revealed the resident stated he/she was getting up from the recliner to go to bed and slid to the floor. The resident was assessed at that time to have no injuries. Continued review revealed the root cause identified was the resident did not call for help. No new interventions were put into place to prevent further falls.</p> <p>Review of a Falls Report dated 02/19/15 and Resident #13's Fall Trend Report, revealed Resident #13 was found in his/her room on the floor sitting in front of his/her recliner. Further review revealed the resident stated he/she was asleep and did not know how he/she fell. The resident was assessed at that time to have no injuries. Continued review revealed the root causes identified included the resident disregards instructions to call for help before getting up and poor safety awareness. The intervention added to the comprehensive care plan was to educate resident on importance of using the call light for assistance with transfers.</p> <p>Interview with Certified Nurse Aide (CNA) #5, on 07/09/15 at 9:15 AM, revealed Resident #13</p>	F 323			



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

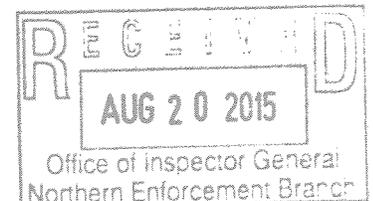
PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 24</p> <p>would go to the bathroom by himself/herself and was supposed to call for assistance when he/she needed to go to the bathroom. CNA #5 further stated the CNAs had access to the residents' care plans and used the Activities of Daily Living log to see how a resident was supposed to be transferred. She further stated the nurses and CNAs communicated verbally, after a resident's fall, about new interventions that were put into place.</p> <p>Interview with Resident #13, on 07/09/15 at 9:25 AM, revealed he/she was to call staff for assistance with transfers because his/her legs were weak. The resident stated he/she did not like to ask for help because he/she always thought he/she could do it himself/herself.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 07/09/15 at 9:35 AM, revealed group meetings were held on the unit after a resident fall to determine the root cause. She stated all nursing staff was responsible for monitoring the effectiveness of care plan interventions. She also stated sometimes new interventions were not added to the care plan. LPN #4 stated Resident #13 was capable of asking for help and pulling the call light in the bathroom.</p> <p>Interview with the Nurse Manager for the long term care units, on 07/09/15 at 3:25 PM, revealed resident falls were discussed in the morning meetings which included the Nurse Managers, the Director of Nursing, the Executive Director, the Social Worker and Therapy. The fall trend reports were brought to the meeting and updated.</p>	F 323			

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

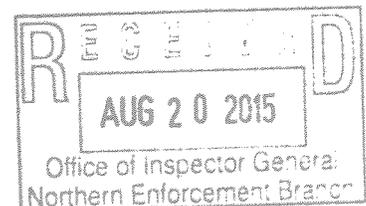
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 25 She stated the root cause of a fall was determined by the nurse on the unit at the time of the fall and reviewed in the morning meetings and revised if needed. Poor safety awareness was used as a root cause for a resident who did not follow safe procedures or was unable to understand what was safe or unsafe to do. After a resident fall, the unit nurse would review the comprehensive care plan and add new interventions which would be reviewed in the morning meetings. Interview with the Director of Nursing (DON), on 07/09/15 at 3:50 PM, revealed after a resident fall, the comprehensive care plan was reviewed and interventions were added to keep the resident as safe as possible. She stated poor safety awareness as a root cause would mean the resident had a physical disability. She stated Resident #13 was alert and oriented and refused to call for assistance. The DON further stated new interventions should be added to the comprehensive care plan after every fall.	F 323			
F 502 SS=E	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure three (3) of four (4) nursing units, Units 600, 500, and 300, were free from expired vacutainer blood specimen tubes.	F 502		7/23/15	



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

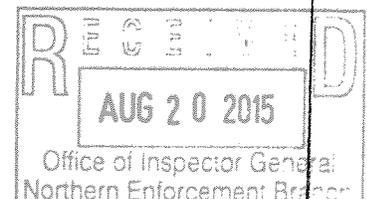
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 502	Continued From page 26 The findings include: The facility did not provide a policy related to laboratory supplies. Observation, on 07/09/15 at 8:10 AM, revealed three (3) yellow top vacutainer blood specimen tubes with an expiration date of May 2013 and four (4) yellow top vacutainer blood specimen tubes with an expiration date of November 2014, were stored in the medication room on the 600 Unit. Observation, on 07/09/15 at 8:30 AM, revealed ten (10) purple top vacutainer blood specimen tubes with an expiration date of December 2014, were stored in a laboratory supply drawer in the 500 Unit nurse's station. Observation, on 07/09/15 at 8:45 AM, revealed eighteen (18) red top vacutainer blood specimen tubes with an expiration date of May 2015, were stored in a laboratory supply drawer in the 300 Unit nurse's station. Interview, on 07/09/15 at 8:10 AM, with Registered Nurse (RN) #1, revealed the facility did not monitor laboratory supplies for expired dates. RN #1 stated vacutainer blood specimen tubes were ordered as needed from the laboratory. She stated contracted personnel provided phlebotomy services daily and brought their own supplies. However, the nurses on the unit did obtain blood specimens on occasion. Interview, on 07/09/15 at 8:15 AM, with the Nurse Manager for the 600 Unit revealed there was no audit system in place to monitor expired	F 502	F502 Corrective action for those residents found to have been affected by the deficient practice: 1.Expired vacutainer blood specimen tubes were removed from 600, 500, and 300 units by clinical staff and verified to be removed by DON. How the facility identified other residents having the potential to be affected by the same deficient practice: 1.All residents had the potential to be affected by this practice There were no identifiable residents, however, that were impacted.. All units were audited by DON, 2 Nurse Managers, LNHA, and 2 MDS Nurses and expired vacutainer blood specimen tubes found on 600, 500, and 300 units were removed. The removal of all tubes was verified by DON.	7/10/15	7/10/15



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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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 502	<p>Continued From page 27</p> <p>laboratory supplies. She further stated Registered Nurses did draw Vancomycin peak and troughs from Peripherally Inserted Central Catheters (PICC), all other blood specimens were collected from contracted personnel on a daily basis.</p> <p>Interview, on 07/09/15 at 8:50 AM, with the Nurse Manager revealed there was no facility policy regarding laboratory supplies. She stated there was no audit system in place to check for expired dates of laboratory supplies. She further stated if an expired vacutainer tube was used to collect a blood specimen it could negatively effect the laboratory result.</p> <p>Interview, on 07/09/15 at 9:05 AM, with the vendor Account Manager revealed the contracted personnel who obtained blood specimens at the facility used their own supplies. She further stated the vendor provided the facility with in date vacutainer blood specimen tubes when needed and it was the facility's responsibility to monitor the expiration dates.</p> <p>Interview, on 07/09/15 at 3:50 PM, with the Director of Nursing (DON), revealed there was no audit system in place to monitor expiration dates for laboratory supplies. Contracted personnel obtained blood specimens daily from residents and used their own supplies. She further reported if an expired vacutainer blood specimen tube was used to obtain blood from a resident it would have to be discarded and another specimen obtained.</p>	F 502	<p>Measures put into place or systemic changes made to ensure the deficient practice will not recur:</p> <p>1. Vacutainer blood specimen tubes are now only located on the 600 Unit.</p> <p>2. The Day Shift Supervisor was educated 1:1 by the DON on 7/29/2015 as to the regulation and the expectation for monitoring compliance. The Day Shift Supervisor will check weekly for expired vacutainer blood specimen tubes and dispose of any that have expired or will soon expire.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <p>1. The DON or Clinical Nurse Leader will audit the vacutainer blood specimen tubes monthly times 4 and quarterly for the remainder of the year.</p> <p>2. All findings will be reviewed and analyzed then reported to the CQI committee.</p>	7/23/15	



AUG 11 2015

OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/07/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206	

(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
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1999, 2008</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Protected.</p> <p>SMOKE COMPARTMENTS: Ten (10) smoke compartments.</p> <p>FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic sprinkler systems. Dry System in the attic space and exterior and a Wet System in the interior.</p> <p>GENERATOR: Two (2) Type II generators. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 07/07/15. The facility was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate</p>	K 000	<p>K046</p> <p>Corrective action for those residents found to have been affected by the deficient practice:</p> <p>1. The battery powered emergency light fixture located in the 400 Hall Mechanical Room was replaced on 7/7/2015 by the Maintenance Technician.</p> <p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <p>1. All battery powered emergency light fixtures were checked for proper functioning by Maintenance Technician on 7/7/2015.</p>	7/9/15

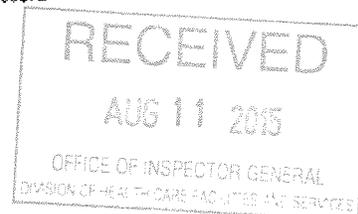
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ 8/11/15

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.

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

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

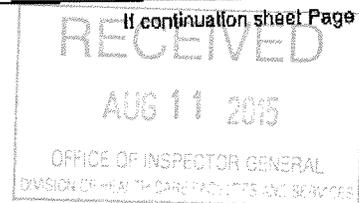
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/07/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206	
(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
K 000	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).	K 000	<p>Measures put into place or systemic changes made to ensure the deficient practice will not recur:</p> <p>1. Battery powered emergency light fixtures will be dated when replaced and then replaced every 5 years if not functioning prior to that time. 2. Testing of battery powered emergency light fixtures will be increased to every 2 weeks.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <p>1. The Director of Maintenance of designee will test all battery powered emergency light fixtures weekly for 3 months and then every two weeks for the remainder of the year. 2. All findings will be reviewed And analyzed then reported to the CQI committee.</p>	
K 046 SS=D	<p>Deficiencies were cited with the highest deficiency identified at D level. NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide proper functioning of battery-powered emergency lighting in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of ten (10) smoke compartments, approximately thirty (30) residents, staff and visitors. The facility has one-hundred and twenty-one (121) certified beds and the census was ninety-one (91) on the day of the survey.</p> <p>The findings include: Observation, on 07/07/15 at 10:21 AM, with the Director of Hospitality Services and the Maintenance Tech revealed the battery-powered emergency light fixture located in the 400 Hall Mechanical Room, did not function when tested. Interview, on 07/07/15 at 10:23 AM, with the Director of Hospitality Services and the</p>	K 046		



PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/07/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206	
(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
K 046	<p>Continued From page 2</p> <p>Maintenance Tech revealed the battery-powered emergency light fixture located in the 400 Hall Mechanical Room had functioned properly when the Maintenance Tech had conducted the required thirty (30) second monthly test on 07/02/15. Review of the facility's records confirmed the required monthly testing had been conducted the previous week.</p> <p>The census of ninety-one (91) was verified by the Executive Director on 07/07/15. The survey findings were acknowledged by the Executive Director and verified by the Director of Hospitality Services at the exit interview on 07/07/15.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency Illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for</p>	K 046		



PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2015
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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	
K 046	Continued From page 3 not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046			

