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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: 105179	(X2) MULTIPLE CONSTRUCTION OR GENERAL A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 05/13/2014
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT GLENVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An abbreviated survey was initiated on 05/12/14 and concluded on 05/13/14 for KY 21699 and KY 21699. KY 21699 was unsubstantiated with no regulatory violations. KY 21699 was unsubstantiated with deficiencies cited.	F 000		
F 282 SS=D	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, Certified Nursing Assistant (CNA) Worksheet, and review of the facility's Care Plans policy, it was determined the facility failed to ensure Care Plans were followed for two (2) of the four (4) sampled residents (Residents #3 and #4). The facility failed to ensure the safety alarms that were care planned for falls prevention were in place. The findings include: Review of the facility's policy Care Plans, dated 06/2007, revealed care plans should be initiated whenever needs are assessed. The care plan consisted of a problem statement, goals, and approaches for each problem. 1. The facility admitted Resident #3, on 02/16/07, with the diagnoses of a Stroke with right sided paralysis, Convulsions, Hypertension,	F282	1. Resident's tab alarm was immediately put in place and attached to resident #3 on 5/14/2014 Resident #4 sensor alarm was put in place on 5/14/2014 2. An audit will be completed by Director of Nursing/Assistant Director of Nursing/Minimum Data Set Nurse (MDS) and unit managers of all resident physician orders/care plans and Certified Nursing Assistant (CNA) care records by 5/28/2014 to insure all interventions are in place as ordered.	6-1-2014

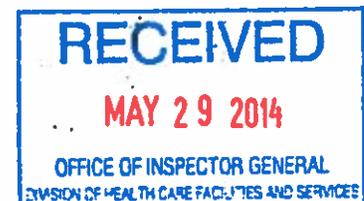
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Charles A. Meyer</i>	TITLE <i>Administrator</i>	(X6) DATE 5/29/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused 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 required to continue program participation.

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT GLENVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222		
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F 282	<p>Continued From page 1</p> <p>Depression, and Diabetes. The facility assessed the resident as a high risk for falls and identified two (2) non-injury falls on the Minimum Data Set (MDS), dated 03/01/04. Review of the resident's Comprehensive Care Plan, revealed a potential for injury related to falls with a goal to be free of injuries. The facility added the approach of a tab alarm, on 01/31/14, after the resident was found on the bathroom floor.</p> <p>Observations of Resident #3, on 05/13/14 at 8:15 AM, 1:05 PM, 1:30 PM, and 2:45 PM, revealed the resident was sitting in the wheelchair with no tab alarm in place.</p> <p>Review of the CNA Worksheet for Resident #3 revealed a tab alarm was listed under the comment section in all capital letters.</p> <p>...</p> <p>Interview with CNA #2, on 05/13/14 at 3:30 PM, revealed she did work on the hall but was not assigned to Resident #3. The CNA revealed she was aware the resident was care planned for a tab alarm and did see the resident self-propelling around the building without the tab alarm in place. However, the CNA revealed she did not notify the nurse.</p> <p>Interview with CNA #3, on 5/13/14 at 4:44 PM, revealed she was assigned to Resident #3 and knew the resident was to have an alarm in place. The CNA revealed the resident frequently removed the alarm and would hide it from staff. The CNA revealed she did notice it was not in place but did not tell the nurse because she got busy and forgot.</p> <p>2. The facility admitted Resident #4, on 08/06/13, with the diagnoses of Stroke, Diabetes,</p>	F 282	<p>3. Staff Development Coordinator will educate nursing staff by 5-31-2014 on monitoring for fall intervention placement and reporting to unit manager/charge nurse immediately if interventions are not in place. Unit manager/charge nurse will be educated by Staff Development Coordinator by 5-31-2014 to immediately replace fall interventions if reported missing or not in place. All nursing staff will be educated by 5-31-2014 on how to read and follow a care plan and CNA care record by Staff Development Coordinator.</p>	6-1-2014	



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F 282	<p>Continued From page 2</p> <p>Hypertension, and Sleep Apnea. The facility assessed the resident utilizing MDS, on 01/30/14, as having a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicated the resident was cognitively intact, and had two (2) previous non-injury falls. Review of the resident's comprehensive plan of care revealed a problem statement for a potential for injury related to falls with an intervention to place a sensor alarm to the resident's bed after a fall on 05/02/14.</p> <p>Observation and interview with Resident #4, on 05/13/14 at 1:08 PM, revealed the resident was sitting up in a chair and a sensor alarm was noted on the bed. The resident revealed a facility staff member had just placed the alarm to the bed. The resident revealed he/she had never had an alarm before and did not see a use for the alarm since he/she was sitting in the chair and not in the bed.</p> <p>Interview with CNA #2, on 05/13/14 at 4:44 PM, revealed Resident #4's bed alarm was placed today. The CNA revealed she did not know when it was determined to place the alarm and did not know if it was listed on the CNA Worksheet.</p> <p>Review of the CNA Worksheet revealed a sensor alarm was listed under the comment section for Resident #4.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 05/13/14 at 2:20 PM, revealed he was aware Resident #3 was care planned for a fall alarm, however, he had not checked to see if it was in place. The LPN revealed Resident #4 had an alarm at one time, but it was not working. The LPN revealed the Unit Manager asked him to make sure the alarm was in place, which it was</p>	F 282	<p>4. Director of Nursing/Assistant Director of Nursing/Minimum Data-Set Nurse will monitor resident record review in clinical meeting to insure each resident has a comprehensive care plan that reflects fall interventions if indicated by the fall assessment that is completed on every resident upon admission and quarterly. Director of Nursing/Unit Managers will audit 10% of resident charts for compliance x 4 weeks then random for 2 months. This information will be discussed monthly in Quality Assurance (QA) meeting. If resolved, then 10% of record reviews will be monitored monthly in clinical meeting.</p> <p>Date of Compliance 6-1-2014</p>	6-1-2014



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F 282	Continued From page 3 not, and a new one had to be placed. Continued interview with LPN #2, on 05/13/14 at 5:10 PM, revealed the alarms were listed on the CNA Worksheet, and the CNA should have notified him that neither of the alarms were in place. The LPN revealed the purpose of the care plan was to inform the nursing staff of the resident's needs and to know what needed to be done to keep the residents safe and provide care. The LPN revealed not following the care plan placed the residents with known risk for injury at risk for a fall. Interview with the North Unit Manager, on 05/13/14 at 5:20 PM, revealed the CNA Worksheet was derived from the information on the Resident's care plan. The Unit Manager revealed the purpose of the care plan was to drive the resident's care. The Unit Manager revealed care plans are updated after each fall, and she periodically reviewed the interventions and made sure the interventions were all in place. The Unit Manager revealed this was last done in April, 2014. Interview with the Director of Nursing (DON), on 05/13/14 at 5:45 PM, revealed care plans were used to ensure the resident's are kept safe. The DON revealed she did follow up and round to ensure interventions were implemented, but did not know what happened that both Residents #3 and #4 were missing their alarms.	F 282		
F 323 89=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323	F323 1. Resident's tab alarm was immediately put in place and attached to resident #3 on 5/13/2014. Resident #4 sensor alarm was put in place on 5/14/2014 2. An audit will be completed by Director of Nursing/Assistant Director of	6-1-2014

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F 323	Continued From page 4 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, the facility's fall investigations, and the Certified-Nursing Assistant (CNA) Worksheet it was determined the facility failed to ensure two (2) of the four (4) sampled residents (Resident #3 and #4) received adequate supervision and assistance devices to prevent accidents. Both Residents #3 and #4 did not have safety alarms in place that were care planned for use to prevent injury related to falls. The findings include: The facility did not provide a policy on supervision or falls prevention. 1. The facility admitted Resident #3, on 02/16/07, with the diagnoses of a Stroke with resulting right sided paralysis, Convulsions, Hypertension, Depression, and Diabetes. The facility assessed the resident as a high risk for falls and identified two (2) non-injury falls on the Minimum Data Set (MDS), dated 03/01/04. Review of the resident's comprehensive plan of care revealed a potential for injury related to falls. Review of the facility's investigation of the falls revealed, on 01/24/14, the resident was found on the floor of the bathroom and the facility placed a sensor alarm to alert staff when the resident attempted to self-transfer. On 01/31/14, the resident was again found on the bathroom floor. The facility	F 323	Nursing/Minimum Data Set Nurse (MDS) and unit managers to insure resident have proper use of safety measures determined by care plans/Fall risk assessments by 5-28-2014. All required safety devices will be checked to insure each is in place and working properly. 3. All nursing staff will be in-serviced and re-educated on fall policy, procedure, follow-up and risk factors by 5-31-2014 4. Residents who have fall interventions will have safety rounds conducted by the assigned nursing assistant every 2 hours to insure all interventions are in place and functional. Weekly safety rounds will be conducted by Unit Managers/Charge Nurse to insure all safety devices and fall interventions are in place and working	6-1-2014



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F 323	<p>Continued From page 5</p> <p>discontinued the sensor alarm and placed a tab alarm. The resident subsequently fell again, on 04/10/14 and 04/29/14.</p> <p>Observations of Resident #3, on 05/13/14 at 8:15 AM, 1:05 PM, 1:30 PM, and 2:45 PM, revealed the resident was up in the wheelchair with no tab alarm in place.</p> <p>Review of the CNA Worksheet revealed Resident #3 had a tab alarm listed under the comment section in all capital letters.</p> <p>Interview with CNA #2, on 05/13/14 at 3:30 PM, revealed she did work on the hall with Resident #3, but was not assigned to that resident. However, the CNA revealed she did see the resident self-propelling around the building and was aware the resident was care planned for a tab alarm. The CNA revealed she did not see the alarm in place and did not notify the nurse.</p> <p>Interview with CNA #3, on 5/13/14 at 4:44 PM, revealed she was assigned to Resident #3, and was aware the resident was supposed to have an alarm in place. The CNA revealed the resident frequently removed the alarm and would hide it from the staff. The CNA revealed she did notice it was not in place, but did not tell the nurse because she got busy and forgot. Furthermore, the CNA revealed she had not even seen the alarm since last week. The CNA revealed the purpose of the tab alarm was to alert the staff when the resident got up without assistance and to help in the prevention of falls.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 05/13/14 at 2:20 PM, revealed he was aware Resident #3 should have a tab alarm in place,</p>	F 323	<p>properly. Tracking and trending on all falls will be monitored by the DON/Unit Managers. Results will be reviewed and discussed monthly in QA meeting.</p> <p>Date of Compliance 6-1-2014</p>	6-1-2014	



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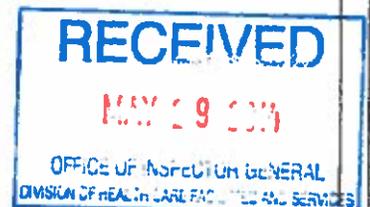
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F 323	<p>Continued From page 8</p> <p>however he had not checked to see if it was in place. Continued interview, on 05/13/14 at 5:10 PM, revealed he did not check to ensure the alarm was in place until the surveyor inquired about the resident's alarm. The LPN revealed he normally checked alarm placement while doing treatments, but had not had a chance to check them. The LPN revealed the alarm was listed on the CNA worksheet and the CNA should have notified him it was not in place. The LPN revealed alarms were used for safety reasons and to assist in the prevention of falls. The LPN revealed a potential risk for falls without the tab alarm in place.</p> <p>2. The facility admitted Resident #4, on 08/06/13, with the diagnoses of Stroke, Diabetes, Hypertension, and Sleep Apnea. The facility assessed the resident utilizing the MDS, on 01/30/14, as having a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicating the resident was cognitively intact, and had two (2) previous non-injury falls. Review of the resident's comprehensive plan of care revealed a potential for injury related to falls with an intervention to place a sensor alarm to the resident's bed. Review of the facility's investigation of the resident's fall, 05/02/14, revealed the resident fell in his/her room and the facility was to place a sensor alarm.</p> <p>Observation and interview with Resident #4, on 05/13/14 at 1:08 PM, revealed the resident was sitting up in a chair, and a sensor alarm was noted to be on the bed. The resident revealed he/she was curious as to why someone had just come in his/her room and placed an alarm to the bed. The resident revealed he/she had never had one before. The resident revealed at the</p>	F 323		



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F 323	<p>Continued From page 7</p> <p>beginning of the month he/she lost their balance after getting up to go to the bathroom and fell. However, the resident revealed no one had ever come in and placed an alarm and this was the first time ever seeing it. The resident revealed the alarm was not much use anyway on the bed since he/she was usually in the chair. Observation of the resident, on 05/13/14 at 1:20 PM, revealed the resident got up from his/her and ambulated to the bathroom without calling for assistance.</p> <p>Interview with CNA #2, on 05/13/14 at 4:44 PM, revealed Resident #4's alarm was placed today. The CNA revealed the resident never called for help and staff usually found him/her already in the bathroom. The CNA revealed she did not know if the resident should have had the alarm prior to today and did not know if it was listed on the CNA Worksheet.</p> <p>Review of the CNA Worksheet revealed a sensor alarm was listed under the comment section.</p> <p>Interview with LPN #2, on 05/13/14 at 2:20 PM, revealed Resident #4 used to have an alarm a while back but it wasn't working so the facility had to order more. The LPN revealed he was told today by the Unit Manager to make sure the resident's alarm was in place. The LPN revealed the alarm was not in place and someone from supply had brought one over for us to be placed on the resident's bed. Continued Interview, on 05/13/14 at 5:10 PM, revealed the resident's alarm was on the CNA Worksheet and no one told him it was not on the bed. The LPN revealed it had been awhile since it was care planned, and he forgot that it should have been there. The LPN revealed the alarm was not a physician's</p>	F 323			



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F 323	<p>Continued From page 8</p> <p>order so it was not on the Treatment Administration Record (TAR) to alert staff to check and make sure it was in place. The LPN revealed he just did not catch that the alarm was missing. The LPN revealed the alarms were used for safety to help prevent falls.</p> <p>Interview with the North Unit Manager, on 05/13/14 at 5:20 PM, revealed Resident #3 did not like the lab alarm and would take it off. The Unit Manager revealed re-educating the resident, helped and he/she would let you put it back in place. The Unit Manager revealed she was not aware that it was not in place. The Unit Manager revealed Resident #4's sensor alarm did not work and it needed a new battery. The Unit Manager revealed she did ask the nurse to check if it was in place because it had been awhile since they were to order supplies. The Unit Manager revealed a potential for the residents to fall, and the alarms were in place to alert staff if they got up unassisted. The Unit Manager revealed she ensured the alarms were in place by making sure it was listed on the CNA Worksheet and rounding once a month. The Unit Manager revealed the rounds were last completed in April 2014.</p> <p>Interview with the Director of Nursing (DON), on 05/13/14 at 5:45 PM, revealed Resident #3 normally self-propelled around the building and she would ensure it was in place when she saw the resident in the hall. The DON revealed she did not know how it was missed. The DON revealed she assumed Resident #4's alarm was in place. The DON revealed the alarms were used to alert staff when a resident attempted to transfer themselves. The DON revealed falls are discussed in the morning meetings and the charts were reviewed at that time to ensure the TAR's,</p>	F 323			



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F 323	Continued From page 9 care plans, and CNA sheets are updated. The DON revealed she did not know what happened for both alarms to be gone and not in place. (see F 282)	F 323			

