

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/22/2024
NAME OF PROVIDER OR SUPPLIER  Saint Joseph Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2308 Reno Drive NE Louisville, OH 44641	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35765</p> <p>Based on review of the medical record, review of the call light audit reports, and interview with the staff the facility failed to answer call lights timely for Resident #10 and #58. This affected two residents (Resident #10 and #58) of three residents reviewed for call light response times. The facility census was 57.</p> <p>Findings included:</p> <p>1. Review of the medical record revealed Resident #58 was admitted to the facility on [DATE] . Diagnoses included urinary tract infection, sepsis, weakness, and cognitive communication deficit. She was discharged to home on 05/31/24.</p> <p>Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #58 had moderately impaired cognition. She needed some help with self-care and required substantial assistance with toilet transfers.</p> <p>Review of the call light audit report revealed Resident #58 had a call light activated for 48 minutes on 05/26/24 at 8:58 A.M. and a call light that was activated for 42 minutes on 05/28/24.</p> <p>On 08/22/24 at 9:42 A.M. an interview with Family Member #300 revealed her mother's call light was on for over 40 minutes a couple times and that was unacceptable. She stated she told the Administrator about it.</p> <p>2. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE]. Diagnoses included multiple sclerosis, neurological dysfunction of the bladder, diabetes, kidney disease, congenital dilatation of the esophagus and arthritis.</p> <p>Review of the Admission MDS assessment dated [DATE] revealed Resident #10 had intact cognition.</p> <p>Review of the call light audit record revealed on 08/19/24 Resident #10 had her call light activated for 56 minutes.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/22/24 at 9:25 A.M. an interview with Resident #10 revealed turnaround time was terrible because this week she had to wait 45 minutes to an hour to get her call light answered more than one time. She stated it was in the morning. She stated she usually got up in the chair to eat breakfast but they had not gotten her up yet so she turned her call light on. She stated after about 20 minutes they brought her breakfast tray in and set in over on the table where she could not reach it and it was another 35 to 40 minutes before they finally came in to get her up in the chair. She stated her breakfast was cold by then. She stated it happened two more time that day. She stated she understands 10 to 15 minutes but 45 minutes to an hour was ridiculous amount of time to wait until her call light was answered by staff.</p> <p>On 08/22/24 at 11:55 A.M. an interview with the Director of Nursing (DON) confirmed the long call light for Resident #10 and #58 on the call light audit report. She stated she would look into why they were so long.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155664.</p>		