

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

PRINTED: 06/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/07/2012
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NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE LOUISVILLE, KY 40222
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F 000	INITIAL COMMENTS A standard health survey was initiated on 06/05/12 through 06/07/12 and a Life Safety Code survey was conducted on 06/05/12. Deficiencies were sited with the highest scope and severity of a "E" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to	F 279	*The Director of Resident Assessment and Care Planning develops a care plan for a Gastric Feeding Tube for Resident #2 based on the MDS and CAA (Care Area Summary) 6-6-2012. *The Director of Nursing reviews all care plans for residents with tube feedings to assure that care plans address all concerns identified in the CAAs 6-22-2012. *The facility clinical consultant reeducates all RAI/MDS Coordinators and the care plan team to address tube feeding areas identified in the CAAs 6-25-2012. Beginning 6-26-2012, the Director of Resident Assessment and Care planning audits each comprehensive care plan prior to completion to assure that all areas are addressed. The facility clinical consultant and the	7-10-12

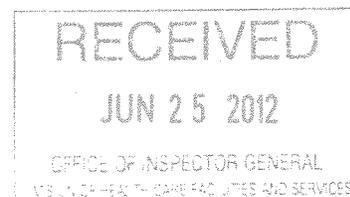
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Dorothy E. (Lisa) Biddle-Puffer* TITLE: *Administrator* (X6) DATE: *6-22-12*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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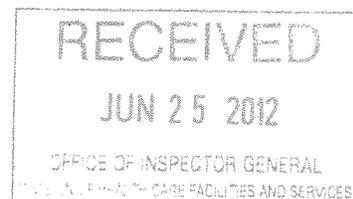
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F 279	<p>Continued From page 1</p> <p>develop a care plan for a Gastric Feeding Tube based on the admission Minimum Data Set (MDS) assessment for one (1) of seventeen (17) sampled residents (Resident #2). The facility identified in the admission MDS that the resident had a feeding tube.</p> <p>The findings included:</p> <p>Review of the facility's Care Plan Guidelines, undated, revealed care plans indicated in the MDS and CAAs (Care Area Summary) for new admissions are to be completed within fourteen (14) days, but are allowed twenty-one (21) days to revise the initial care plan.</p> <p>Review of the clinical record for Resident #2 revealed the facility admitted the resident on 05/11/12 with diagnoses of Parkinson's and Dysphagia (difficulty swallowing). The facility completed an admission MDS assessment on 05/18/12 which revealed the resident had difficulty swallowing and required a feeding tube.</p> <p>Observation of Resident #2's abdomen, on 06/06/12 at 10:40 AM, during a skin assessment revealed the resident had a Percutaneous Esophageal Gastric (PEG) feeding tube in place.</p> <p>Interview with the Director of Nursing (DON), on 06/06/12 at 2:30 PM, revealed Resident #2 should have been care planned for the feeding tube.</p> <p>Interview with the Director of MDS, on 06/07/12 at 3:30 PM, revealed she was unaware it was the MDS staff's responsibility to implement the care plan for a feeding tube. She said she thought</p>	F 279	<p>Director of Nursing audit 25% of newly developed care plans monthly to assure compliance.</p> <p>*The Director of Nursing reports the results of the audits to the Quality Assurance committee each quarter to ensure that proper care plan solutions are sustained.</p>		



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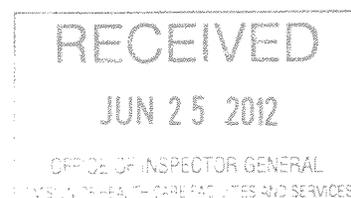
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F 279	Continued From page 2 Dietary was suppose to do the care planning for a feeding tube, but she is now aware it was the MDS Coordinator's responsibility to prepare the care plan for a resident's feeding tube.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) 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, and review of the facility's policy, it was determined the facility failed to revise the comprehensive care plan for two (2) of seventeen (17) sampled residents. The care plan for Resident #7 was not revised to address sensor alarms and the care plan for Resident #8 was not	F 280	*The Assistant Unit Manager revises the care plan for Resident #7 to remove the sensor alarms and for Resident #8 to remove the fall mats 6-7-2012. *The Unit Managers for both units audit all resident care plans to assure that the interventions are revised to reflect the actual care provided 7-10-2012. *The facility Clinical Consultant reeducates all RAI/MDS Coordinators and the care plan team regarding the revision of care plans to reflect actual care 6-25-2012. The Director of Nursing reeducates all nurses regarding the revision of care plans to reflect actual care 7-5-2012. The Director of Nursing leads the care plan team to audit 25% of all resident care plans on a monthly basis. *The Director of Nursing reports the results of these audits each quarter to the Quality Assurance	7-11-12 7-10-12 <i>Van B...</i> by PB 6-25-12	



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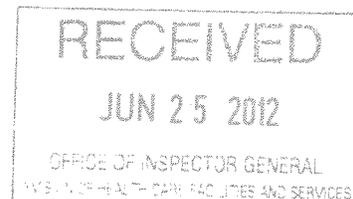
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F 280	Continued From page 3 revised to address fall mats. The findings include: Review of the facility's policy regarding the RAI Process and Care Planning, not dated, revealed the care plans were to be used by all staff and updated as necessary to reflect care provided. Additionally, care plan updates were to be ongoing and should not wait until the next quarterly review. 1. Review of the clinical record for Resident #7 revealed the facility admitted the resident on 12/23/11 with diagnoses of Acute Cerebrovascular Accident (CVA) with Right Hemiparesis and Osteoarthritis. The facility completed an admission Minimum Data Set (MDS) on 12/30/11 which revealed the resident was cognitive with a Brief Interview Mental Score (BIMS) of thirteen (13) and at risk for falls. The facility completed a comprehensive care plan for falls risk, on 01/05/12 and reviewed on 03/2012, which included the use of sensor alarms to the bed and chair to prevent falls. Review of the twenty-four (24) hour report, dated 05/09/12, revealed Resident #7's family member declined the use of the sensor alarm. Observation, on 06/05/12 at 10:55 AM, revealed Resident #7 sitting in an armchair in the resident's room without a sensor alarm in place. On 06/06/12 at 09:45 AM, interview with Licensed Practical Nurse (LPN) #1 revealed Resident #7 refused to use the sensor alarms on the bed or the chair and a family member returned the alarm	F 280	Committee for review to ensure that care plan revision solutions are sustained.		



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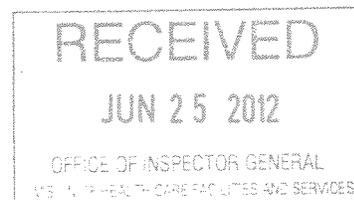
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F 280	<p>Continued From page 4 to the nurse's station to discontinue its use.</p> <p>Interview, on 06/07/12 at 10:05 AM, with Certified Nurse Aide (CNA) #1 revealed Resident #7 was no longer using the sensor alarm and had not used the alarm in a while.</p> <p>Interview, on 06/07/12 at 10:20 AM and 1:05 PM, with the Nurse Supervisor revealed the care plans were updated by the nurses when physician orders were received and a copy of the order was given to the nurse supervisor to compare to the comprehensive care plan. She stated she makes changes to the care plan based on the physician orders and the twenty-four (24) hour report. The Nurse Manager stated Resident #7 did not want to use the sensor alarms and a family member had returned the alarm to the nurse's station, which was documented on the twenty-four (24) hour report. She stated she should have removed the sensor alarm from the comprehensive care plan as it was no longer being used.</p> <p>On 06/07/12 at 1:23 PM, interview with the Director of Nursing (DON) revealed she was aware of Resident #7's family returning the sensor alarm to the nurse's station and stated the sensor alarm was a nursing intervention for safety and should have been discontinued on the care plan.</p> <p>2. Review of the clinical record for Resident #8 revealed the facility admitted the resident on 10/04/11 with diagnoses of Severe Weakness and Conditioning and Severe Aortic Stenosis. The facility completed an admission Minimum Data Set (MDS) on 10/11/11 which revealed the resident was cognitively impaired with a Brief</p>	F 280			



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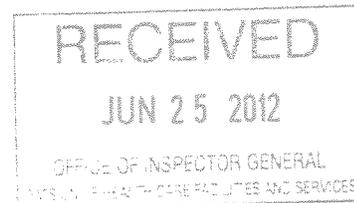
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F 280	<p>Continued From page 5</p> <p>Interview Mental Score (BIMS) of nine (9) and at risk for falls. The facility completed a comprehensive care plan for falls, on 10/12/11 and reviewed on 04/2012, which included the use of fall mats on the floor on the sides of the bed.</p> <p>Observation, on 06/05/12 at 2:50 PM, revealed Resident #8 lying in bed without the fall mats in place.</p> <p>Interview, on 06/07/12 at 10:05 AM, with Certified Nursing Aide (CNA) #1 revealed Resident #8 had fall mats at one time but had not used them for some time.</p> <p>Interview, on 06/07/12 at 10:12 AM, with Licensed Practical Nurse (LPN) #2 revealed Resident #8 did not currently use fall mats and was unsure if the resident had ever used fall mats.</p> <p>On 06/07/12 at 1:05 PM, interview with the Nurse Supervisor revealed Resident #8 was not using fall mats next to the bed. The Nurse Supervisor stated the comprehensive care plan should have been updated to indicate the fall mats were discontinued.</p> <p>Interview, on 06/07/12 at 1:23 PM, with the Director of Nursing (DON) revealed the resident was noncompliant with using the mats and the comprehensive care plan for Resident #8 should have been updated to show the use of the fall mats had been discontinued.</p>	F 280			



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1991 (original building), 2011 (physical therapy modifications and addition)</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III unprotected.</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, wet sprinkler system; hydraulically designed.</p> <p>GENERATOR: Type II, 55 KW generator; fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 06/05/12. Jefferson Place was found not in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000			



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

TITLE

(X6) DATE

Dorothy E. Biddle - Luffen

Administrator

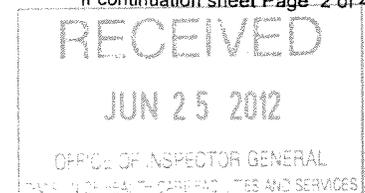
6-22-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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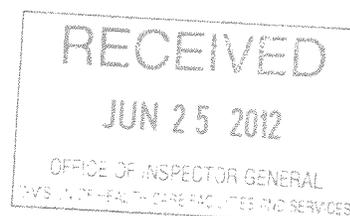
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K 000	Continued From page 1	K 000			
K 029 SS=E	<p>Deficiencies were cited with the highest scope and severity identified at E level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, approximately thirty-five (35) residents, staff and visitors. The facility is licensed for seventy-two (72) beds and the census was sixty-eight (68) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 06/05/12 between 9:00 AM and 11:00 AM, with the Director of Maintenance</p>	K 029	<p>*The Director of Maintenance installs self closing devices on doors to the Storage Room adjacent to Room 300, Dry Storage Room in the Kitchen, and the Medical Records Room 6-22-2012.</p> <p>*The Director of Maintenance inspects all areas considered hazardous including fuel-fired heater rooms, central/bulk laundries larger than 100ft2, paint shops, repair shops, soiled linen rooms, trash collection rooms, rooms or spaces larger than 50ft2 including used for storage of combustible supplies. The Director of Maintenance inspects to assure that all hazardous areas identified have self-closing doors by 6-8-2012.</p> <p>*The Director of Maintenance inspects each quarter all areas considered hazardous including fuel-fired heater rooms, central/bulk laundries larger than</p>	7-10-12	



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K 029	<p>Continued From page 2</p> <p>revealed the doors to the Storage Room adjacent to Room 300, Dry Storage Room in the Kitchen, and the Medical Records Room did not have self closing devices installed on the doors.</p> <p>Interviews, on 06/05/12 between 9:00 AM and 11:00 AM, with the Director of Maintenance revealed he was not aware of the three (3) storage rooms being categorized as hazardous storage areas, and the requirement that the doors be equipped with self closing devices.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), 	K 029	<p>100ft², paint shops, repair shops, soiled linen rooms, trash collection rooms, rooms or spaces larger than 50ft² including used for storage of combustible supplies. The Director of Maintenance inspects to assure that all hazardous areas identified have self-closing doors.</p> <p>*The Director of Maintenance reports the results of these inspections each quarter to the Quality Assurance Committee for review to ensure that self-closing doors to protect hazardous areas are sustained.</p>	



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K 029	Continued From page 3 including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029			

