

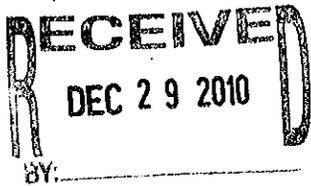
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/21/2010
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NAME OF PROVIDER OR SUPPLIER J J JORDAN GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 270 E CLAYTON LN LOUISA, KY 41230
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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)	(X6) COMPLETION DATE
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F 000	INITIAL COMMENTS A Recertification Survey was conducted 10/19/10-10/21/10, and an Abbreviated Survey investigating ARO #KY00014838 and ARO #KY00014839. A Life Safety Code Survey was conducted 10/21/10. Deficiencies were cited, with the highest Scope and Severity of an "E". ARO #KY00014838 was found to be substantiated with no deficiencies cited. ARO #KY00014839 was found to be unsubstantiated.	F 000	The preparation and execution of this response and the corresponding plan of correction does not constitute admission or agreement of the truth of facts alleged or the conclusion set forth in the statement of deficiency.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.	F 278	 The assessments for resident #2 were reviewed on 11/8/10 by the Director of Nursing and the Assistant Director of Nursing. The Minimum Data Assessments completed after 5/27/10 had the current dates and signatures in section AA9 & R2. The most recent assessments for all current residents were reviewed on 11/12/10 by the Assistant Director of Nursing. The AA9 date & R2b dates are correct. The RN Coordinators have attended MDS 3.0 Training on June 17-18, 2010, July 13-15, 2010 & August 10-12, 2010. The Director of Nursing conducted an in-service on 11/8/10 with RN Coordinators and other disciplines responsible for completing the MDS. The in-service covered the time frames for signing and dating assessments. A sample containing 10% of the residents' MDS will be reviewed monthly by the Director of Nursing or Assistant Director of Nursing for six months to ensure accuracy of signatures and dates on the current MDS. Findings will be reported to the PI committee quarterly.	11/13/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 12/17/10
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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 requisite to continued program participation.

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F 278	Continued From page 1 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the Registered Nurse (RN) coordinated each assessment as appropriate for certifying overall completion of the Minimum Data Sets (MDS) for one (1) of nineteen (19) sampled residents (Residents #2). Resident #2's MDS section AA signature dates were later than section R2b signature dates. The findings include: Review of the clinical record revealed Resident #2 was admitted to the facility on 06/01/05, with diagnoses which included Seizure Disorder, Hemiparesis, Traumatic Brain Injury, Depression, Hypertension, Aphasia and Osteoporosis. Review of the annual assessment, with an Assessment Reference Date of 05/17/10, revealed Section R2b was signed and dated by the RN as completed on 05/27/10. However Section AA9 was signed and dated by each discipline including the RN, who completed a section of the MDS, on 06/03/10, six (6) days after the completion date. Interview with RN #3 on 10/21/10, at 5:45 PM, revealed she was aware the AA9 date could be the same as the completion date or earlier but not later than the completion date. She further stated I don't know why it's later.	F 278			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	After the environmental tour on 10/20/2010 a contract plumber was called to investigate our water system.	11/12/2010	

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F 323	<p>Continued From page 2</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that the residents' environment remained free from accidental hazards as evidenced by water temperature above 110 degrees Fahrenheit in resident rooms and the front hall men's restroom.</p> <p>The findings include:</p> <p>Observation on 10/20/10 at 2:00 PM during the environmental tour revealed the water temperature was 116 degrees Fahrenheit in the front hall men's restroom and in resident rooms #124 and #211. Further observation revealed the water temperature was 114 degrees Fahrenheit in resident rooms #109 and #209; and, 118 degrees Fahrenheit in resident room #214.</p> <p>The temperature was adjusted on the hot water heaters and at 4:34 PM on 10/20/10 the water temperatures were obtained again. The water temperature was 98 degrees Fahrenheit in resident room #124 and 100 degrees Fahrenheit in resident rooms #109 and #306. Further observation revealed the water temperature was 102 degrees Fahrenheit in resident rooms #209, #211 and #303. In resident room #301, the water</p>	F 323	<p>A new mixing valve and a new temperature gauge was purchased and installed on 10/21/2010. All temperature gauges were calibrated. This ensured that no hot water temperatures would exceed 110 degrees and that water temperatures would stay in between 100 and 110 degrees at all times.</p> <p>Environmental staff then monitored water temperatures continuously from 10/20/10 until 8:30 am 10/23/10 in fifteen (15) different patient rooms and common areas to ensure that no other residents could be possibly exposed to water temperatures outside of guidelines. This sample size represented 25% of the 60 patient rooms. Water temperatures during this testing period remained below 110 degrees.</p> <p>The water temperature logs have been changed from monthly to bi-weekly to ensure water temperatures range between 100 degrees and 110 degrees. Samples will be taken alternatively on day shift and then later on evening shift by the environmental staff. This monitoring procedural change ensures compliance in the future concerning water temperatures.</p> <p>An annual service and inspection will be conducted on the hot water tanks, mixing valves, and temperature gauges by a third party contractor. This is a systematic change again implemented 10/21/10 to ensure ongoing compliance with water temperature regulations. This also verifies that all equipment necessary to ensure water temperature compliance is functioning properly and in good condition.</p> <p>Results of the water temperature testing will be submitted to and reviewed by the Performance Improvement Committee quarterly to ensure this solution maintains compliance.</p>	

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F 323	Continued From page 3 temperature was 104 degrees Fahrenheit. Interview on 10/20/10 at 2:45 PM with the Environmental Services Director revealed the water temperatures were checked monthly and had been within normal range. Further interview revealed he didn't know why the temperatures were so high. However, he adjusted the temperature below 100 degrees Fahrenheit on both water heaters. Interview on 10/20/10 at 5:00 PM with the Administrator revealed he didn't understand why the water temperatures suddenly increased, however a repairman was enroute to the facility. Further interview revealed that water temperatures were obtained monthly and were within normal range.	F 323	The administrator and environmental service director completed a comprehensive list of various environmental rounds by 10/22/10 to ensure that facility systems and environmental monitoring provided a safe environment for residents. Inspection rounds and monitoring logs ensured that the facility environment was free as possible of accident hazards and that all assistive devices were in place and functioning properly to prevent accidents. Results from these rounds mentioned above were provided to the performance improvement committee on 11/5/10. To ensure ongoing compliance these rounds will be completed regularly throughout the year and reported quarterly to the performance improvement committee.	
F 371 SS=E	483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by small and large steam table pans stored wet, scoops were stored	F 371	Steam table pans found upon inspection that were not dry were immediately rewashed, air dried and stored. Improperly stored scoops were immediately rewashed and stored properly so that all the handles faced the same direction. The five (5) plates of sandwiches and one (1) container of peanut butter and crackers found in the walk in cooler without a date were immediately thrown away. The scoop found in a bag of sugar was immediately removed, washed and properly stored in the bin beside of the sugar container. The sugar in the bin was discarded. The Dietary Manager then conducted an inspection of the entire dietary area and dining room on 10/19/10 to determine any other possible sanitary issues present. This was to	11/12/2010

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F 371	<p>Continued From page 4</p> <p>Improperly. Five (5) containers of sandwiches and one (1) container of cheese and crackers were stored in the walk-in refrigerator with no date; and, the scoop was stored in the sugar.</p> <p>The findings include:</p> <p>1. Observation on 10/19/10 at 12:20 PM, on initial tour revealed small and large steam table pans were stored wet, water was noted to drip from the pans.</p> <p>Interview with the Dietary Manager (DM) on 10/19/10 at 12:25 PM, revealed the pans were stored wet which could lead to bacteria-growth on the pans.</p> <p>Interview with Cook #6 on 10/19/10 at 12:25 PM, revealed the pans should be air dried and not stored wet due to the growth of bacteria.</p> <p>2. Observation on 10/19/10 at 12:35 PM, revealed scoops were stored improperly with handles going in all directions.</p> <p>Interview with the DM on 10/19/10 at 12:35 PM, revealed the scoops should be stored upside down with the handles all pointing out.</p> <p>3. Observation on 10/19/10 at 12:45 PM, revealed five (5) plates of sandwiches covered with plastic wrap and one (1) container of peanut butter and crackers covered with plastic wrap sitting in the walk in cooler with no date.</p> <p>Interview with Dietary Aide #8 on 10/19/10 at 1:00 PM, revealed she had made four (4) of the sandwich plates for snacks. She continued stating that she forgot to date them, she removed</p>	F 371	<p>ensure that storage, preparation and distribution of food was under sanitary conditions.</p> <p>Systematic changes began with all dietary staff in-serviced on 10/19/10 and 10/20/10 by the dietary manager regarding proper drying procedures for the large steam table pans, the proper labeling of food stored in the walk in cooler, the proper storage of the sugar scoop and the proper storage of serving scoops after cleaning.</p> <p>As a systematic change to ensure sanitary conditions of food preparation, storage and distribution, the Dietary Manager also added a new storage area for the large steam table pans that ensures proper sanitary drying in compliance with regulations.</p> <p>Further systematic changes by the dietary manager in conjunction with our dietary consultant included a log and procedure to monitor the compliance of dietary personnel regarding labeling/dating of food stored in the walk in, serving scoop storage, sugar bin scoop storage and the storage of the large steam table pans.</p> <p>The dietary manager will spot check on a random basis no less than once per week, the compliance in the preparation of food, storage and distribution. Any exceptions noted shall be logged and corrected on the spot by the dietary manager to ensure dietary sanitation. These compliance logs will be submitted and reviewed quarterly by the Performance Improvement Committee on a quarterly basis.</p>	
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F 371	Continued From page 5 the sandwiches, dated them and returned them to the walk-in cooler. Interview with the DM on 10/19/10 at 1:10 PM, revealed everything should be dated prior to placing it in the cooler. She further stated she threw the container of sandwiches and the peanut butter and crackers away. 4. Observation on 10/19/10 at 12:55 PM, during the initial tour of the dry storage area revealed the scoop was stored in the sugar bag. Interview with the DM on 10/19/10 at 1:10 PM, revealed the facility's procedure was to store the scoop in the container beside the bag of sugar.	F 371			
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain all essential mechanical and electric equipment in a safe operating condition as evidenced by the build up of ice on the walk-in freezer floor. The findings include: Observation on 10/19/10 at 12:40 PM, on initial tour revealed a build up of ice on the floor of the walk in freezer. The freezer temperature at that time registered five degrees below zero (-5	F 465	Ice build up on the walk in freezer floor was immediately removed and the maintenance department checked the freezer and then tightened the freezer door handle on 10/19/10. New gaskets for the door were ordered, received and installed by 11/10/10. All other refrigerated appliances were checked by the Dietary Manager to ensure there were no ice buildups on the floor on 10/19/10. All sealing gaskets were inspected by the Dietary Manager on all refrigerated appliances to ensure they were properly functioning on 10/19/10. The Dietary Manager in-service trained all the dietary staff on how to monitor the refrigerated appliances for ice build up and proper gasket sealing on the doors on 10/19/10. Dietary staff were also trained on a new log and how to complete the log. This in-service training and log addressed all of the refrigerated appliances in the facility to ensure compliance in the future.	11/2/2010	

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F 465	<p>Continued From page 6 degrees Fahrenheit).</p> <p>Interview with the Dietary Manager on 10/19/10 at 12:40 PM, revealed the staff break the ice loose and remove the ice 2-3 times a week. She further stated it was a fall risk, and they knew it was there and were careful. She stated she would have maintenance to look at it.</p> <p>Interview with the Dietary Manager on 10/20/10 at 11:15 AM, revealed maintenance had checked the walk-in freezer and had tightened the freezer door handle and ordered a new door gasket.</p>	F 465	<p>The Dietary Manager or the Assistant Dietary Manager will spot inspect weekly all appliances and review the daily log for six months. The results and logs will be submitted to the Performance Improvement Committee each quarter</p> <p>The dietary manager along with the environmental service director completed rounds of the entire dietary department and the adjacent dining area on 10/22/10 to identify any other potential items of concerns that might adversely affect the facility's ability to provide a safe, functional, sanitary and comfortable environment for our residents, our staff and the general public that visit our facility. Any deficiencies noted were immediately corrected that day. The dietary manager also examined various logs, and made some systematic changes in those logs, to further ensure monitoring and compliance going forward. The administrator and environmental service director on 10/22/10 completed rounds of the entire facility to ensure compliance with this regulation. These results were presented to and reviewed by the performance improvement committee on 11/05/10 and will be presented each quarter to maintain compliance.</p>	

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on October 21, 2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was a "D".	K 000	The preparation and execution of this response and the corresponding plan of correction does not constitute an admission or agreement of the truth of facts alleged or the conclusion set forth in the statement of deficiency.	
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview on 10/21/2010, it was determined that the facility failed to ensure fire/smoke corridor doors are functioning properly to resist passage of smoke, according to NFPA standards. The findings include: Observation on 10/21/2010 at 11:00 AM with the Maintenance Director, revealed one of the fire/smoke doors on the 200 Hallway next to rooms 106 and 107 would not close properly when tested. Interview with the Maintenance Director on	K 027	The Fire door next to rooms 106 and 107 was immediately adjusted and all other fire doors throughout the facility were inspected for compliance. Measures to ensure future compliance include a biweekly inspection with results reported in a log by the Environmental Services Director. Any doors noted out of compliance will then be adjusted immediately upon day of inspection. This log is submitted and reviewed quarterly by the Performance Improvement Committee to monitor and ensure the solution is sustained.	11/12/10

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BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR 11/12/10
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K 027	Continued From page 1 10/21/2010 at 11:00 AM, indicated that he was not aware that the door was not closing properly. Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 15-1.4 Repairs Repairs shall be made and defects that would interfere with the operation shall be replaced immediately.	K 027		