

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

PRINTED: 07/31/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185349</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/19/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>JEFFERSON PLACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1705 HERR LANE LOUISVILLE, KY 40222</b>
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F 000	INITIAL COMMENTS	F 000		
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to promote care for residents in a manner to enhance each residents dignity for three (3) of sixteen (16) sampled residents, Residents #1, #2 and #3 and two (2) of four (4) Unsampld residents, Resident #C and #D. The facility staff failed to not knock on doors before entering rooms of Resident's #1, #2, #C and #D. In addition, staff stored personal items in Resident #3's room.</p> <p>The findings include:</p> <p>The facility did not provide a policy on knocking on residents' doors prior to entering; however, a printed Job Behaviors Consistent With Good</p>	F 241	<p>*The Director of Social Services or her assistant interview Residents #1, #2, #3, #C and #D by 8-12-13 to ensure they express no anxiety, anger, fear or other evidence of loss of self-esteem. Residents #1, #3, and #C express concerns on 8-8-13 and 8-9-13, and the Director of Social Services develops plans of care on the same dates. On 7-18-2013, the LPN supervisor removes the bottle of Mountain Dew from the room of Resident #3.</p> <p>*The Director of Social Services or her assistant interviews all interviewable residents by 8-23-13 to ensure they express no anxiety, anger, fear or other evidence of loss of self-esteem. The Director of Social Services or her assistant contacts the families of all residents who are not interviewable by 8-23-13 to ensure the residents express</p>	8-28-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Dorothy Biddle-Luffen</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>X 8-26-13</i>
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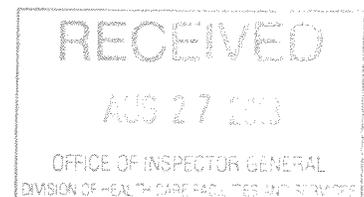
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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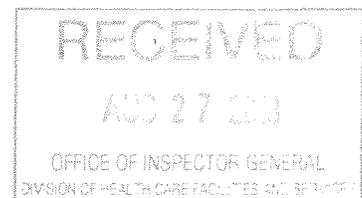
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F 241	<p>Continued From page 1</p> <p>Guest Relations, undated, was provided and revealed one bullet point that included staff would demonstrate an understanding of dignity and respect for residents as one of the resident rights.</p> <p>Review of Resident #3's clinical record revealed the facility admitted the resident on 11/21/12, with diagnoses of Dysphagia, Chronic Low Back Pain, Insomnia, Secondary Generalized Weakness, and Compression Fracture of the Spine.</p> <p>Review of Resident #3's Minimum Data Set (MDS), Quarterly assessment dated 05/20/13, revealed the facility assessed Resident #3 with Brief Interview for Mental Status (BIMS) and determined a score of fifteen (15) which meant Resident #3 was interviewable.</p> <p>Observation of Resident #3's room, on 07/18/13 at 9:25 AM, revealed a bottle of Mountain Dew sitting on Resident #3's dresser.</p> <p>Interview with Resident #3, on 07/18/13 at 9:25 AM, revealed he/she had noticed a drink was sitting on her dresser that morning. Resident #3 stated that the Certified Nursing Assistants (CNA), left items in his/her room all the time. Resident #3 stated he/she had to always clean up behind the CNA's.</p> <p>Interview with CNA #7, on 07/18/13 at 9:55 AM, revealed she did not leave items in the residents rooms. CNA #7 stated when she came in to work that morning she noticed the drink sitting on Resident #3's dresser. CNA #7 stated staff should not leave personal items in the residents rooms. CNA #7 stated Resident #3 was interviewable and if he/she stated an item was left in his/her room, then an item was truly left.</p>	F 241	<p>no anxiety, anger, fear or other evidence of loss of self-esteem. The Director of Social Services develops a plan of care for residents who express concerns by 8-23-13. The Administrator develops a checklist on 7-30-13 to evaluate practices providing for resident dignity including knocking on resident doors prior to entering and associates not leaving personal items in resident rooms. The Staff Development Coordinator uses the checklist to identify other residents having the potential to be affected by the same deficient practice. The Staff Development Coordinator reeducates associates immediately regarding any deficient practices. She refers concerns to the Director of Social Services to assure she develops a plan of care to address the concerns the residents.</p> <p>*The Staff Development Coordinator reeducates all associates with contact with resident rooms and resident areas regarding dignity including knocking on resident doors prior to entering and associates not leaving personal items in resident rooms by</p>		



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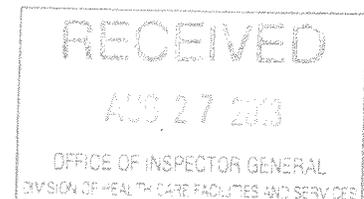
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F 241	Continued From page 2  Interview with Licensed Practical Nurse (LPN) #4, on 07/18/13 at 9:50 AM, revealed staff should not leave their drinks in resident rooms.  Interview with the Director of Nursing (DON), on 07/18/13 at 3:30 PM, revealed no staff should leave personal items in resident rooms. Staff were informed on orientation that there was a break room for personal use. Staff should not leave personal items in resident rooms because it's the resident's room, it can be an infection control concern and for safety reasons.  Interview with the Administrator, on 07/19/13 at 3:42 PM, revealed staff members should not leave their personal items in resident rooms. Staff were not permitted to drink in resident areas and the resident areas were the residents and not for staff personal use.  Observation of the 700 unit, on 07/17/13 at 12:30 PM, revealed Certified Nurse Aide (CNA) #1 opened the closed door to Resident #2 s room and entered without knocking or requesting permission to enter. Continued observation at 12:42 PM, revealed CNA #2 entered Resident #7's room without knocking or requesting permission to enter the room. Observation at 1:10 PM, revealed CNA #1 entered Resident #7's room, Unsampld Resident C's and Unsampld Resident D's rooms without knocking or requesting permission to enter.  Interview with Resident #2, on 07/17/13 at 2:45	F 241	8-27-13. Beginning 8-19-2013, the Staff Development Coordinator, the Unit Managers or the Weekend Supervisor observe the interaction of each associate assigned to work in resident areas this week to assure each associate is knocking on resident doors and not leaving personal items in resident rooms. The Administrator assigns a schedule for audits for the using the checklist to evaluate practices providing for resident dignity including knocking on resident doors prior to entering and associates not leaving personal items in resident rooms. The Administrator, Department Directors, Staff Development Coordinator and Weekend Supervisor alternate units to use the checklist to audit dignity weekly for four weeks and at least monthly thereafter. The person auditing discusses the results with the associates present immediately after the audit to evaluate the results and assure improvements. The Director of Social Services or her assistant will interview all residents during their quarterly assessments		



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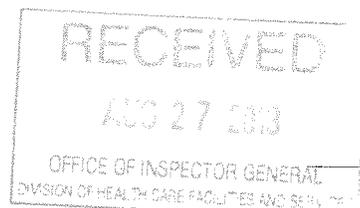
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F 241	<p>Continued From page 3</p> <p>PM, revealed the resident preferred staff to knock prior to entering the room, especially when the door was closed.</p> <p>Interview with Unsampled Resident C, on 07/17/13 at 2:50 PM, revealed the resident felt staff should knock prior to entering the room. The resident stated, at times, it was startling to awaken and have staff in the room.</p> <p>Interview with Unsampled Resident D, on 07/17/13 at 3:00 PM, revealed staff did enter the room without knocking at times. The resident stated this practice was not right.</p> <p>Interview with CNA #2, on 07/18/13 at 2:15 PM, revealed staff was trained to knock on resident doors prior to entering the room. She stated she forgot.</p> <p>Interview with CNA #1, on 07/18/13 at 2:28 PM, revealed she did not think about knocking on the resident doors every day. She stated she would not want someone to do that to her. She stated she had received training on knocking on resident's door prior to entering.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 07/18/13 at 2:40 PM, revealed the nurses supervised the CNAs. She stated she had not noticed staff entering rooms without knocking; however, all staff were trained to do so.</p> <p>Interview with Resident #1, on 07/18/13 at 4:50 PM, revealed dietary staff frequently do not knock on the resident's door before entering. The resident stated he/she self-catheterizes himself/herself and the resident did not feel it was right for the dietary staff to see that procedure</p>	F 241	<p>regarding whether they to ensure they express no anxiety, anger, fear or other evidence of loss of self-esteem. If a resident expresses any of these issues, the Director of Social Services develops a plan of care to address the concerns the residents. She will report the results to the Administrator, the Director of Nursing and the Unit Managers who will review results with associates.</p> <p>* The Staff Development Coordinator reports the results of the audits of checklist regarding dignity to the Quality Assurance committee each quarter for one year to ensure dignity solutions are sustained.</p>		



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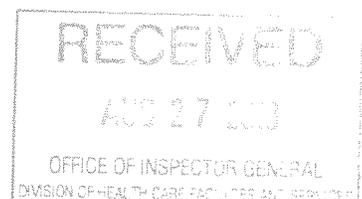
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F 241	Continued From page 4 done.  Review of Resident #1's clinical record revealed he/she had been assessed by the facility as having a cognition score of fifteen (15) which indicated he/she was cognitively intact. Review of the record further revealed Resident #1 had a diagnosis of Neurogenic Bladder (one which had to be catheterized to empty) and the resident was assessed by the facility to self-catheterize.  Interview with Dietary Aide #17, at 5:00 PM on 07/18/13, revealed she had been taught by the facility to always knock on a resident's door before entering, but she did not always knock because sometimes she forgot.  Interview with the Director of Nursing, on 07/18/13 at 5:10 PM, revealed all staff were trained to knock on residents' doors to respect their privacy and dignity.	F 241			
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to adequately assess two (2) of nineteen (19) sampled residents (Residents #2 and #10) in order to develop an ongoing program	F 248	*Resident #10 expires 8-4-13. The Director of Activities completes a reassessment of Resident #2 on 8-8-13 with an in-depth review to identify resident preferences, interests, life roles, and hobbies prior to admission. The Director of Activities develops a care plan 8-9-13 based on these resident preferences, interests, life roles, and hobbies prior to admission. The Director of Activities provides materials based on these	8-28-13	



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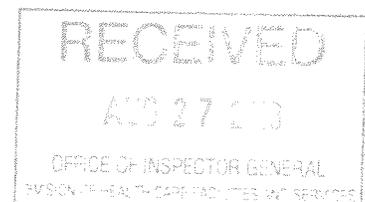
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F 248	<p>Continued From page 5</p> <p>of activities to meet the residents' needs. The facility failed to develop an activity care plan for Residents #2 and #10.</p> <p>The findings include:</p> <p>The facility provided a policy for One To One (1:1) Programs, undated, which revealed residents are scheduled one to one programs by the Activity Director. This program would meet and identify residents' socialization needs while using their abilities and interests to enhance their recreational/leisure opportunities. These visits would last for 15 to 30 minutes and would be documented as to the response of the resident and what activity was provided for the resident.</p> <p>The facility did not provide any policies for group activities.</p> <p>1. Observation of Resident #2, on 07/17/13 at 9:43 AM, 10:20 AM, 1:50 PM, and 3:00 PM, revealed the resident sleeping in the hallway in a geri-chair.</p> <p>Review of the clinical record for Resident #2, revealed the facility admitted the resident with diagnoses of Dementia, Depression, Immobility and Chronic Diarrhea. The facility completed a Quarterly Minimum Data Set (MDS) assessment on 06/27/13 which revealed the resident was cognitively intact, required limited assistance with daily activities and was frequently incontinent of bowel and bladder. The activity section of the MDS indicated the resident enjoyed being outdoors and liked music and reading.</p> <p>Review of the activity assessment, dated 06/27/13, for Resident #2, revealed the resident</p>	F 248	<p>assessments 8-9-13.</p> <p>*The Director of Activities and her assistant review the comprehensive assessment and care plans for all other residents by 8-27-13 to assure that care plans are based on resident preferences, interests, life roles, and hobbies prior to admission. The Director of Activities provides materials based on these assessments.</p> <p>*The company's clinical consultant for Activities and Social Services on 8-15-13 and 8-16-13 provides reeducation for the Director of Activities and her assistant regarding the completion of in-depth reviews to identify resident preferences, interests, life roles, and hobbies prior to admission in order to develop care plans and provide materials. Each month for 3 months, the Administrator will review 5 activity assessments and care plans. The Administrator will verify that the care plans are developed based on comprehensive activity assessments. The Administrator will continue the audits on a quarterly basis as an ongoing practice.</p>		



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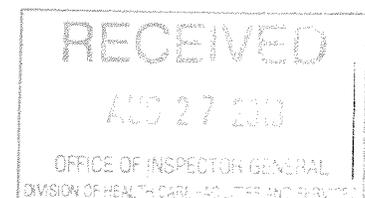
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F 248	<p>Continued From page 6</p> <p>needed large print reading materials. There was no documentation to determine if the facility provided the resident with large print reading materials. The resident received one to one (1:1) visits for conversation. A progress note on 07/02/13 stated the Activity Director would remind the resident regarding activities of possible interest, however, those interests were not identified. There was no documentation of any group activities.</p> <p>Review of the comprehensive care plan, dated 06/27/13, for Resident #2 revealed no activity care plan.</p> <p>Interview with the resident, on 07/18/13 at 10:15 AM, revealed the resident enjoyed listening to talking books, having the newspaper read, listening to music especially live music, liked exercises and was active in the community prior to admission to the facility. The resident stated small print was difficult to read and the resident preferred large print. The resident indicated no large print books or magazines were provided and no one read the newspaper to the resident.</p> <p>Interview with the Activity Director, on 07/19/13 at 2:38 PM, revealed the resident had health concerns and stayed in the room much of the time. She stated the resident did not have a care plan as the resident could make choices and attend any activity of interest. She stated the resident received one to one (1:1) visits for conversation; however, she had not provided the resident with materials or activities based on a resident assessment. She stated the assessment she completed did not require an indepth review of the resident's preferences, interests, life roles or hobbies prior to admission</p>	F 248	*The Director of Activities will present the reports of audits to the Quality Assurance committee each quarter to assure ongoing activity compliance with the regulation.		



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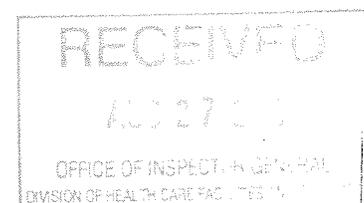
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F 248	<p>Continued From page 7 to the facility. She stated she did not document activities as this would take time away from her work.</p> <p>2. Observation of Resident #10, on 07/17/13 at 8:30 AM, 9:40 AM, 10:15 AM, 11:30 AM, 2:30 PM and 3:15 PM, revealed the resident sitting in a geri-chair in the hallway next to the common area with eyes closed.</p> <p>Review of the clinical record for Resident #10, revealed the facility admitted the resident with diagnoses of Dementia, Psychosis and Alzheimer's Disease. The Activity Profile completed on 04/09/13, revealed the resident liked some pets and watched television in the day room. The facility completed a Significant Change MDS assessment on the resident on 05/15/13 which revealed the resident had a severe cognitive impairment, required extensive assistance with daily living tasks and was incontinent of bowel and bladder. The resident was able to communicate simply at times.</p> <p>Review of the activity progress notes, dated 07/02/13, revealed Resident #10 sat in the dining room during the day and liked to watch television. No other information regarding the resident's past hobbies, interests and preferences was located.</p> <p>Review of the physician's notes for 07/16/13, revealed the resident had a rapidly progressing dementia and decline with terminal restlessness and to continue Haldol and Ambien.</p> <p>Interview with the Activity Director, on 07/19/13 at 2:38 PM, revealed Resident #10 was confused and not involved in activities prior to admission to the facility. She stated since the resident was</p>	F 248			



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F 248	Continued From page 8 doing nothing at home, the resident would be able to do nothing at the facility. She stated she did not develop a care plan based on the resident's interests, preferences, hobbies or life roles.	F 248			
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure resident areas were maintained in good repair for one (1) of three (3) dining rooms. The facility failed to make repairs in the Green Unit including missing baseboard, a torn window screen, missing caulk around the sink and chipped paint on the chair rail.  The findings include:  The facility did not provide a policy regarding maintenance and up keep of the facility.  Observation of the Dining Room on the Green Unit, on 07/19/13 at 11:15 AM, revealed missing base board under the counter, caulking around the sink was missing, a window screen was torn, and the chair rail was missing paint and a small piece was loose.  Interview with the Maintenance Director, on 07/19/13 at 5:10 PM, revealed he was aware of	F 253	*The Director of Maintenance or his assistant replaces the missing base board under the counter in the Dining Room on the Green Unit by 8-8-13. The Director of Maintenance or his assistant replaces the caulking around the sink by 8-8-13. The Director of Maintenance or his assistant removes the torn window screen 7-22-13. Without the screen, the Director of Maintenance adjusts to window to prevent it from opening. The Director of Maintenance paints the area above the chair rail with missing paint 8-8-2013 and fastens the small piece of chair rail below it by 8-8-13.  *The Department Directors complete an audit on 7-23-13 of maintenance and housekeeping concerns and use the company's Are You Ready for Company? form to ensure that resident areas are maintained in good repair. The Director of Maintenance addresses areas identified with concerns.	8-9-13	



\*The Department Directors will complete the Are You Ready for Company? audit each month to assure that maintenance and housekeeping concerns are addressed. The Department Director responsible for concerns will address those concerns and report to the Director of Admissions to assure completion.

\*The Director of Admissions will report the results of the audits to the Quality Assurance Committee each quarter for 1 year to assure activity compliance with the regulation.

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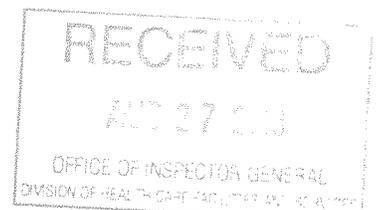
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OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES LICENSURE

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

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F 253	Continued From page 9 the missing baseboard and it should have been repaired. He stated he made rounds in the facility on a weekly basis to identify needed repairs. He stated staff notified him of any emergency repairs that were needed.	F 253			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Contenance; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and	F 272	*Resident #10 expires 8-4-13 while the Director of Resident Assessment is in the process of completing a comprehensive reassessment of Resident #10's needs including behaviors and antipsychotics. *The Director of Resident Assessment and Care Planning, the Director of Activities and the Director of Social Services review the comprehensive assessments for all residents currently receiving palliative care or antipsychotic medications to assure that behaviors, antipsychotic medications, psycho social needs and activity needs are addressed. *The Director of Resident Assessment and Care Planning reviews the RAI Manual on 7-23-13 and 8-6-13 with the Resident Assessment Coordinators, the Director of Activities and the Director of Social Services regarding the completion of a	8-28-13	



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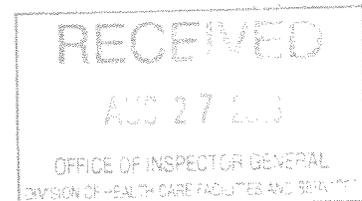
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F 272	Continued From page 10 Documentation of participation in assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure a comprehensive, accurate, standardized reproducible assessment for one (1) of nineteen (19) sampled residents (Resident #10). The facility failed to make a comprehensive assessment of Resident #10's needs with documentation of additional assessment information using the utilization guidelines triggered by the Minimum Data Set (MDS) to include behaviors and antipsychotic medications. In addition, the facility failed to assess concerns not triggered by the MDS to include activities.  The findings include:  Review of the facility's policy for the RAI Process and Care Planning, undated, revealed the RAI (Resident Assessment Instrument) Coordinator would oversee the completion of an interdisciplinary and comprehensive resident assessment using the MDS and Care Area Assessments. All staff will use the RAI Manual guidelines to complete the RAI process.  Review of the clinical record for Resident #10, revealed the facility admitted the resident with diagnoses of Dementia, Psychosis and	F 272	comprehensive, accurate, standardized reproducible assessment using the utilization guidelines triggered by the MDS to include behaviors and antipsychotic medications and to address psychosocial and activity needs. The company's clinical consultant for Activities and Social Services provides reeducation for the Director of Social Services, the Director of Activities and their assistants 8-15-13 and 8-16-13 regarding psychosocial needs and activity needs especially for residents receiving palliative care and/or antipsychotic medications. Beginning 8-9-13, the Resident Assessment Coordinators, the Director of Activities and the Director of Social Services audit all assessments by 8-23-13 for newly admitted residents, residents with significant change assessments and annual assessments to assure the completion of a comprehensive, accurate, standardized reproducible assessment using the utilization guidelines triggered by the MDS to include behaviors and antipsychotic medications and to address		



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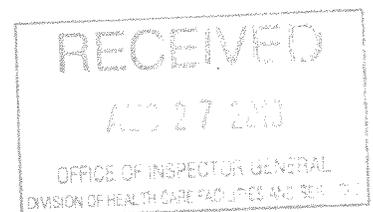
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F 272	<p>Continued From page 11</p> <p>Alzheimer's Disease. On 04/29/13, the physician's note indicated the resident was likely dying. Hospice was ordered on 05/10/13 and no information regarding Hospice care was addressed in the CAA's. The facility completed a Significant Change MDS assessment on the resident on 05/15/13 which revealed the resident had severe cognitive impairments, required extensive assistance with daily living tasks and was incontinent of bowel and bladder. The resident received Hospice services and received psychotropic medication. The MDS did not trigger behaviors or activities and the Care Area Assessments (CAA) did not include information regarding the resident's behaviors or psychotropic medications during the time period from admission on 04/09/13 to the re-assessment date of 05/15/13 or how this affected the resident. In addition, there was no information located in the CAA's regarding the resident's psychosocial needs or activity needs.</p> <p>Review of the comprehensive care plan, dated 07/01/13, for Resident #10, revealed activities were not addressed and social service needs for a terminal resident were not addressed.</p> <p>Interview with the MDS Coordinator, on 07/19/13 at 10:08 AM, revealed all care plans were based on information gathered for completion of the MDS and CAA's. She stated the CAA's for Resident #10 did not include information on Hospice, psychosocial needs or activities. She stated a care plan should have been developed for Hospice care and psychosocial needs; however, she was not responsible for the activity care plan although she was responsible for the oversight of care planning. She stated Social Services completed the section of the MDS</p>	F 272	<p>psychosocial and activity needs. Each month for 3 months and ongoing each quarter thereafter, the Director of Nursing will review 5 comprehensive assessments. The Director of Nursing will audit to assure the completion of a comprehensive, accurate, standardized reproducible assessment using the utilization guidelines triggered by the MDS to include behaviors and antipsychotic medications. Each month for 3 months and ongoing each quarter thereafter, the Administrator will audit assessments for residents to assure that they address psychosocial and activity needs. The Director of Nursing and the Administrator will report any concerns to the Director of Resident Assessment and Care Planning who will assure compliance and reeducate as needed.</p> <p>*The Director of Resident Assessment and Care Planning, the Director of Activities and the Director of Social Services report the results of the audits to the Quality Assurance committee each quarter for one year to ensure</p>		



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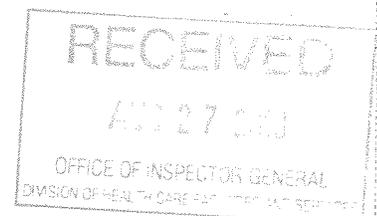
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F 272	Continued From page 12 dealing with customary routines; however, the social worker could have added to the care plan based on the assessments completed since admission.  Interview with the Activity Director, on 07/19/13 at 2:38 PM, revealed she completed an admission assessment for Resident #10; however, the assessment did not include detailed information on the resident's past interests and preferences. She stated she did not use the assessment information to identify resident needs. She stated writing care plans for residents would take time away from the residents.  Interview with the Social Services Director, on 07/19/13 at 10:50 AM, revealed she did not complete an assessment for Resident #10's behaviors, psychotropic medications or Hospice. She stated the social assessment form, utilized by the facility, did not require information regarding these issues. She stated she did not use any information obtained by assessment to identify what problems should be addressed on the care plan.  Interview with the Director of Nursing, on 07/19/13 at 3:40 PM, revealed the facility utilized the RAI Manual for assessment of the resident and the triggered areas were further addressed in the CAA's. She stated the assessment was the basis for resident care planning.	F 272	assessment solutions are sustained.	
F 279 SS=E	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.	F 279	*The Director of Resident Assessment and Care Planning develops a care plan for refusal of care for Resident #1 on 8-6-2013. The Director of Resident	8-28-13



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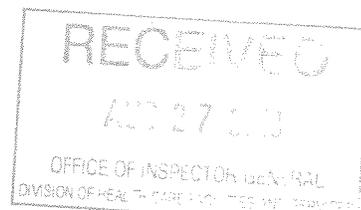
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F 279	Continued From page 13  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the 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, record review and review of the facility's Care Plan Guidelines, it was determined the facility failed to develop a comprehensive plan of care based on resident assessment for four (4) of the sixteen (16) sampled residents (Residents #1, 2, 6, and 10). The facility failed to care plan Resident #1 for his/her refusal of care. The facility failed develop a care plan to address palliative care and activities for Resident #2. The facility failed to develop an individualized care plan for the use of psychotropic medications for Resident #6. In addition the facility failed to develop a care plan to address coordination of care with Hospice, activities, and psychotropic medications for Resident #10.  The findings include:	F 279	Assessment and Care Planning develops a care plan to address palliative care for Resident #2 on 8-6-2013, and the Director of Activities develops a care plan to address activities for Resident #2 on 8-6-2013. Resident #6 discharges from the facility 7-23-13. Resident #10 expires 8-4-2013. * The Director of Resident Assessment and Care Planning reviews the RAI Manual with the Resident Assessment Coordinators, the Director of Activities and the Director of Social Services on 7-23-13 and 8-6-13 regarding the development of comprehensive care plans based on comprehensive assessments. The company's clinical consultant for Activities and Social Services provides reeducation on 8-15-13 and 8-16-13 for the Director of Social Services, the Director of Activities and their assistants regarding assessment and care planning for psychosocial needs and activity needs especially for residents receiving palliative care and/or antipsychotic medications and those refusing care. The Director of Resident	



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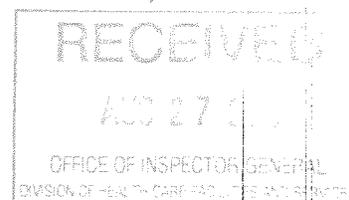
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F 279	<p>Continued From page 14</p> <p>Review of the facility's Care Plan Guidelines, not dated, revealed an initial care plan should be completed within 24 hours of admission and updated upon identification of a problem. Care plans should include medical problems and consist of a problem statement, one clear goal and three to five approaches for that goal. Care plans should be individualized with specific approaches only applicable to that resident. Care plans are interdisciplinary and look at the person as a whole to include spiritual, social, and activity needs.</p> <p>1. Review of the clinical record for Resident #6 revealed the facility admitted the resident with diagnoses of Status Post Right Knee Replacement, Peripheral Neuropathy, Irritable Bowel Syndrome, Breast and Bladder Cancer, and Dementia with Paranoid Delusions. The residents psychoactive medication Zyprexa was continued upon admission. Review of the comprehensive plan of care, dated 07/15/13, revealed a pharmacy sticker that stated a potential for complications related to the Zyprexa, but did not include the actual reason the resident was on the medication or a clear goal for use of the medication. Interventions did not include potential behaviors, individualized nonpharmacologic approaches, or signs and symptoms of exacerbation or improvement.</p> <p>Observations of Resident #6, on 07/17/13 at 10:04 AM and 11:02 AM, revealed the resident was sitting in the his/her room reading a book, with a calm, pleasant mood and affect.</p> <p>Interview with Registered Nurse (RN) #1, on 07/19/13 at 2:24 PM, revealed she had not noted</p>	F 279	<p>Assessment and Care Planning, the Assistant Director of Nursing and the Unit Manager identify residents receiving palliative care and antipsychotic medications as well as residents who have been refusing care recommendations by 8-22-13. By 8-22-13, the Director of Resident Assessment, the Director of Activities and the Director of Social Services audit to assure plans of care for these residents are in place. Care plans for antipsychotic medications reflect individualized components such as the actual reason for the antipsychotic medication or a clear goal for the use of the medication, behavior triggers, behavior interventions, nonpharmacologic approaches, signs and symptoms of exacerbation or improvement, symptoms to be monitored to determine improvement or decline, and individualized information such as a medication reduction plan. Care plans for palliative care include individualized interventions to address needs and behaviors such as restlessness. Care plans for Hospice will include interventions</p>		



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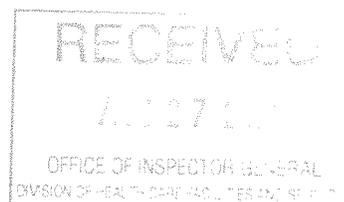
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F 279	<p>Continued From page 15</p> <p>any behaviors with Resident #6 and was not aware of what behaviors or symptoms she should be monitoring. RN #1 revealed she did not know why the resident was on an antipsychotic medication. She further revealed the resident's baseline and desirable outcomes should be listed on the care plan. However, RN #1 did not feel the care plan addressed the resident as an individual.</p> <p>Interview with the ADON, on 07/19/13 at 2:57 PM, revealed the facility admitted the resident on Zyprexa and the dose had already been reduced. However, the ADON revealed she did not know what individualized symptoms of the resident's illness should be monitored to determine improvement or decline. The ADON revealed this information should be incorporated into the plan of care. The ADON revealed the Minimum Data Set (MDS) coordinator was responsible to create the plan of care, however, the nursing staff were responsible to obtain the information necessary to individualize the plan of care.</p> <p>Interview with the MDS Coordinator, on 07/19/13 at 3:55 PM, revealed she was not aware the care plan should contain individualized information such as a psychotropic medication reduction plan and behavior triggers.</p> <p>2. Review of the clinical record for Resident #2, revealed the facility admitted the resident with diagnoses of Dementia, Depression, Immobility and Chronic Diarrhea. The facility completed a Quarterly Minimum Data Set (MDS) assessment which revealed the resident was cognitively intact, required limited assistance with daily activities</p>	F 279	<p>developed for services Hospice provides. The Interdisciplinary Team including the Director of Resident Assessment and Care Planning, the Director of Activities, the Director of Social Services and the Director of Food Services review all care plans to assure they reflect current and accurate needs, goals and interventions by 8-27-13.</p> <p>* Beginning 8-9-13, the Resident Assessment Coordinators, the Director of Activities and the Director of Social Services audit all assessments for newly admitted residents, residents with significant change assessments and annual assessments to assure the completion of comprehensive care plans based on comprehensive assessments. Each month for 3 months and each quarter thereafter, the Director of Nursing will review 5 comprehensive care plans. The Director of Nursing will audit to assure the completion of comprehensive care plans based on comprehensive assessments. Each month for 3 months and each quarter thereafter, the Administrator will audit care plans</p>	



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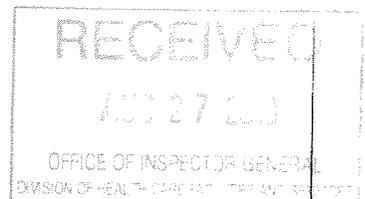
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F 279	<p>Continued From page 16</p> <p>and was frequently incontinent of bowel and bladder. The resident enjoyed being outdoors, liked music and the news. The resident had physician orders for palliative care, Do Not Resuscitate and No Hospital.</p> <p>Review of the activity assessment for Resident #2, revealed the resident needed large print reading materials. There was no documentation to determine if the facility provided the resident with large print reading materials. The resident received visits for conversation. A progress note on 07/02/13 stated the activity director would remind the resident regarding activities of possible interest; however, those interests were not identified.</p> <p>Review of the comprehensive care plan, dated 06/27/13, for Resident #2, revealed no care plan was located by the facility for activities or the palliative care the resident was receiving.</p> <p>Interview with Resident #2, on 07/17/13 at 2:45 PM, revealed the facility had not talked with the resident regarding an activity program related to her interests. The resident stated no reading materials in large print were offered.</p> <p>Interview with the MDS Coordinator, on 07/19/13 at 10:08 AM, revealed no care plan was developed for Resident #2 for palliative care or activities. She stated a care plan should have been developed for palliative care; however, she was not responsible for the activity care plan although she was responsible for the oversight of care planning.</p> <p>Interview with the Activity Director, on 07/19/13 at 2:38 PM, revealed residents that were alert could</p>	F 279	<p>for residents to assure that they address psychosocial and activity needs. The Director of Nursing and the Administrator will report any concerns to the Director of Resident Assessment and Care Planning who will assure compliance and reeducate as needed.</p> <p>*The Director of Resident Assessment and Care Planning, the Director of Activities and the Director of Social Services report the results of the audits to the Quality Assurance committee each quarter to ensure care plan solutions are sustained.</p>		



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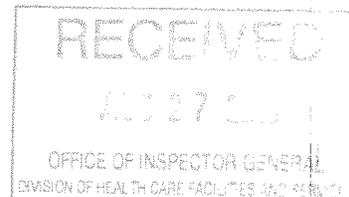
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F 279	<p>Continued From page 17</p> <p>decide which activity they wanted to attend so no activity care plan was developed for those residents' interests, hobbies or preferences. She stated Resident #2 had talking books and so large print reading materials were not provided. She stated writing care plans for residents would take time away from the residents. She stated she did have assistance with activities and some volunteers.</p> <p>Interview with the Director of Nursing, on 07/19/13 at 3:40 PM, revealed care plans should have been developed for activities and palliative care to ensure residents received appropriate care.</p> <p>3. Review of the clinical record for Resident #10, revealed the facility admitted the resident with diagnoses of Dementia, Psychosis and Alzheimer's Disease. The facility completed a Significant Change MDS assessment on the resident on 05/15/13 which revealed the resident had severe cognitive impairments, required extensive assistance with daily living tasks and was incontinent of bowel and bladder. The resident received Hospice services and received psychotropic medication. The resident was not interviewable.</p> <p>Review of the comprehensive care plan, dated 07/01/13, for Resident #10, revealed the facility addressed Hospice; however, no interventions were developed for the services Hospice provided. The facility addressed a fall risk and interventions to prevent falls although the resident's behavior of restlessness contributing to the falls was not identified on the care plan. In addition, the facility provided no activity care plan for the resident.</p>	F 279			



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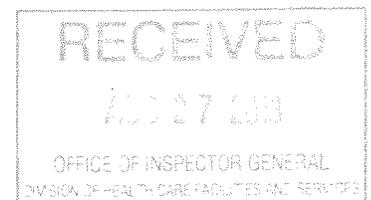
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F 279	<p>Continued From page 18</p> <p>Observation of Resident #10, on 07/17/13 at 9:43 AM, 10:20 AM, 1:50 PM, and 3:00 PM, revealed the resident in the hallway sleeping in a geri-chair.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 07/18/13 at 2:40 PM, revealed the comprehensive care plan was developed by the MDS nurses after the MDS assessment was completed. She stated Resident #10 had behaviors of restlessness, combativeness and verbal outbursts. She stated the restlessness could be because the resident wanted to get up and walk. She stated the resident was ambulated approximately 15 feet a week ago, however, there was no care plan to ambulate the resident on an as needed or routine basis. She stated the resident used a geri-chair or a wheelchair. She stated the specific behaviors were not addressed on the care plan. She revealed the resident's behaviors should have been addressed so specific non-pharmaceutical interventions could guide the staff when the behaviors occurred.</p> <p>Interview with the Activity Director, on 07/19/13 at 2:38 PM, revealed Resident #10 was not social prior to coming to the facility so no care plan was developed for activities. She stated she spoke with the resident daily. She stated if a care plan was required it would take time away from the residents. She stated she was never told about care planning, however, she was certified as an Activity Director.</p> <p>Interview with the MDS Coordinator, on 07/19/13 at 10:08 AM, revealed she was responsible for oversight of the MDS process and the care plan team did meet to review the residents' care plans.</p>	F 279		



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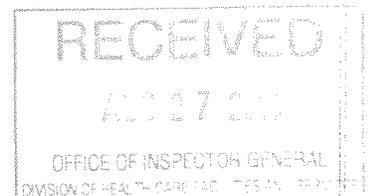
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F 279	<p>Continued From page 19</p> <p>She stated she was not aware the comprehensive care plan needed to include the Hospice interventions. She stated the resident's behaviors were not on the care plan and should have been included.</p> <p>Interview with the Social Services Director, on 07/19/13 at 10:50 AM, revealed she did not complete an assessment for Resident #10's behaviors, psychotropic medications or Hospice. She stated the social assessment form, utilized by the facility, did not require information regarding these issues. She stated she obtained demographic information. She indicated she did not develop or contribute to the resident's care plan with interventions regarding behaviors, Hospice or psychotropic medications.</p> <p>Interview with the Director of Nursing, on 07/19/13 at 4:40 PM, revealed the facility should obtain sufficient information to develop a comprehensive care plan to address all the residents' problems, even if they were not triggered. She further stated the goal was to provide each resident with appropriate care.</p> <p>4. Review of the comprehensive plan of care, dated 05/28/13, for Resident #1 revealed no problem/need, no goal date and no approaches provided to address Resident #1's refusal (to include the resident's right to refuse) to turn in bed or get out of bed to maintain his/her highest physical well-being. Review of Resident #1's record revealed the resident had a Stage 3 pressure ulcer on his/her coccyx. Review of Resident #1's Minimum Data Set cognition score (a tool used to determine nursing facility residents' cognition) revealed Resident #1 had a</p>	F 279			



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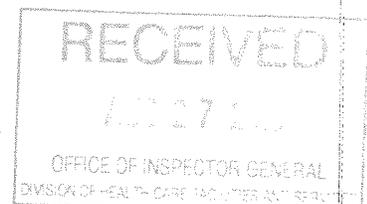
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F 279	<p>Continued From page 20</p> <p>score of fifteen (15) which indicated the resident was cognitively intact and could make decisions for himself/herself. Further review of Resident #1's nursing notes for the past two (2) months revealed no documentation of approaches taken with Resident #1 to address refusal to turn and get out of bed.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/16/13 at 3:30 PM, during initial tour revealed Resident #1 refused to get out of bed (except for showers) or turn in bed to relieve pressure from the coccyx and aid in healing of a Stage 3 pressure ulcer on his/her coccyx. She stated there was no plan of care to address that need. She further stated it was every nurses responsibility to create and/or revise a resident's comprehensive plan of care based on his/her needs to include the resident's right to refuse. LPN #1 indicated it appeared the nursing staff were informing the resident of the consequences of not turning and getting out of bed, however, they were not documenting that resident education.</p> <p>Interview with the Director of Nursing (DON), on 07/19/13 at 2:10 PM, revealed she knew nursing had a responsibility to educate all residents in ways to maintain their highest physical well-being and she was aware the nurses did not document any resident education for Resident #1's refusal of care to turn and get out of bed. She stated she was aware there was no comprehensive plan of care to address Resident #1's refusal of care and there should have been one with approaches to address that need as a guidance for the nursing staff. She further stated she did not know why there was no care plan for Resident #1's refusal of care to turn and get out of bed.</p>	F 279			



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F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>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 one (1) of sixteen (16) sample residents. Resident #8. The facility failed to revise the care plan when the Registered Dietician (RD) recommended Resident #8 be placed on the Nutritionally At Risk (NAR) program.</p> <p>The findings include:</p>	F 280	<p>*The Director of Food Services revises the care plan to reinstate Resident # 8 on the Nutritionally at Risk (NAR) program 8-6-13.</p> <p>*The Director of Food Services audits the Registered Dietician (RD) recommendations for all current residents 8-9-13 to assure that residents she recommends for the Nutritionally at Risk (NAR) program have revisions to care plans to reflect nutritional concerns. The Director of Food Services reviews the list of current residents who trigger for Nutritional Status in the Care Area Assessment Summary Section 8-9-13 to assure revisions to care plans reflect nutritional concerns.</p> <p>*The Director of Food Services audits the Registered Dietician (RD) recommendations and the residents who trigger for Nutritional Status in the Care Area Assessment Summary Section to assure revisions to care plans reflect nutritional concerns each month as an ongoing practice. The Director of Food Services oversees a weekly review of care plans for all residents on the Nutritionally at</p>	8-10-13



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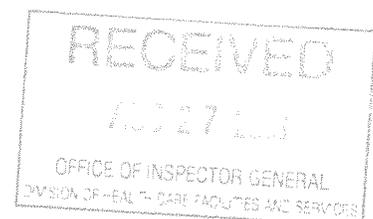
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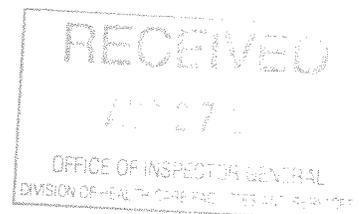
F 280	<p>Continued From page 22</p> <p>Review of the RAI Process and Care Planning Policy, not dated, revealed resident care plans would be continuously updated. Care plans were to be used by all staff and updated as necessary to reflect care provided. All disciplines together would review the plan of care and make additional changes as necessary.</p> <p>Review of the Nutritionally at Risk Residents Policy 3.12, revised 2011, revealed Nutritionally at Risk (NAR) residents were identified in a timely manner and monitored frequently. In addition, the staff person identifying a resident to be added to NAR monitoring was responsible for adding the resident to the nursing unit's master NAR list, and adding NAR to the resident's care plan.</p> <p>Review of the clinical record for Resident #8 revealed the facility admitted the resident on 01/31/13 with diagnoses of Anemia, Hypertension, Atrial Fibrillation, and an episode of Gastrointestinal Bleeding just prior to admission. The Admission MDS, dated 02/07/13, for Resident #8, revealed the facility triggered the resident for Nutritional Status in the Care Area Assessment (CAA) Summary Section. The clinical record revealed Resident #8 was diagnosed with Pneumonia on 02/19/13 and was treated with Levaquin 750 mg for five (5) days. Further review of the clinical record revealed Resident #8 was placed on the NAR program on 03/08/13 until the morning of 04/05/13 for an identified Stage 2 pressure ulcer .</p> <p>Review of the recorded weights for resident #8, revealed a gradual, continuous weight loss from 02/19/13 to 04/09/13, and this was documented by the RD as a 7.8% decline over a two month</p>	F 280	<p>Risk master list to assure that specific individual interventions are reflected based on the NAR review.</p> <p>*The Director of Food Services reports the results of the audits each quarter to assure care plans are revised to reflect nutritional concerns.</p>	
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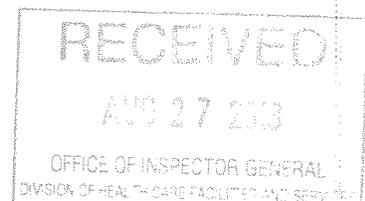
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F 280	<p>Continued From page 23</p> <p>period. The NAR committee meeting notes and the NAR Resident Worksheet for Resident #8 revealed his/her NAR monitoring was discontinued on the morning of 04/05/13 due to healing of the stage 2 pressure ulcer and average meal intakes of 64%; however, the NAR committee meeting notes from 04/05/13 and thereafter through 04/26/13 did not reveal Resident #8 was re-instated to NAR monitoring as recommended by the RD.</p> <p>Review of Resident #8's Comprehensive Care Plan, dated 02/08/13, revealed only one (1) intervention (vanilla milkshakes at 3:15 PM and 7:15 PM) was added on 03/29/13 to an identified problem titled Resident at Risk for Unplanned Weight Loss D/T Poor Intakes.</p> <p>Observation, on 07/17/13 at 8:10 AM, revealed Resident #8 was seated in a wheelchair at a table in the Audubon Dining Room. Resident #8 was fed his/her breakfast by a Certified Nursing Assistant (CNA).</p> <p>Interview, on 07/17/13 at 10:00 AM, with CNA# 5 revealed Resident #8 ate 75% of his/her breakfast meal earlier that morning. CNA #5 stated Resident #8 was able to eat some finger foods such as toast or a sandwich on his/her own, but for the most part, he/she needed to be fed and monitored by staff at every meal. CNA #5 stated she recorded Resident #8's intake on the meal sheets at the nurses' station and also in the care tracker.</p> <p>Interview, on 07/19/13 at 3:05 PM, with the Director of Nursing (DON) revealed the comprehensive care plan was a tool for communication and coordination of care across</p>	F 280		



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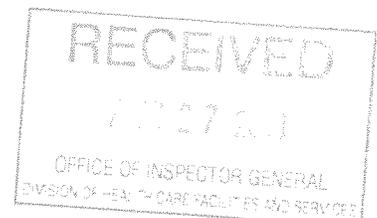
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F 280	Continued From page 24 the interdisciplinary team which would ultimately ensure each resident's needs were consistently met. The DON stated Resident #8's care plan for nutrition should be more specific to his/her nutritional status and should have included interventions that addressed the unplanned weight loss such as NAR monitoring, snacks and supplements as ordered, assistance with feeding, and meal intake documentation per the direct care staff.	F 280		
F 323 SS=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 adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review , and review of the facility's procedure Hot Packs, it was determined the facility failed to monitor water temperatures of the hydrocolator (hot pack machine) stored in one (1) of the two (2) medication rooms (Maroon Unit).  The findings include:  Review of the facility's procedures for Hot Packs, not dated, revealed the hot pack machine should have water of about 170 degrees Fahrenheit (F)	F 323	*The Director of Maintenance removes the hydrocolator (hot pack machine) from the Maroon Unit medication room 7-24-13 so that it is no longer available. *The Director of Nursing reviews the event reports for the previous 3 months 7-19-13 to ascertain that no residents have received burns. *The Director of Maintenance double checks the hydrocolator temperatures weekly to assure the temperatures are in the correct range. The Director of Maintenance reviews the log of temperatures weekly to assure it is complete beginning 8-6-13. The members of the Safety Committee who complete monthly environmental rounds audit the hydrocolator logs and report to the safety committee which includes	8-7-13



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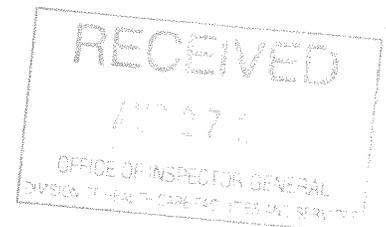
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F 323	<p>Continued From page 25 and a thermometer should be used to monitor the temperature of the water.</p> <p>Observation of the Maroon Unit medication room, on 07/19/13 at 10:20 AM, revealed a hot pack machine to the left of the door entrance, plugged into the wall outlet, with four (4) packs inside. No thermometer was noted built into or on the machine. There were no temperature logs noted around the hot pack machine.</p> <p>Interview with Certified Medication Technicon (CMT) #2, on 07/19/13 at 10:20 AM, revealed she was not aware if water temperatures were monitored for the hydrocolator or who was responsible to monitor the water temperatures.</p> <p>Interview with the Rehabilitation Technician, on 07/19/13 at 11:50 AM, revealed he was responsible to only monitor the water temperature of the hydrocolator in the therapy department. The Rehabilitation Technician revealed he was not responsible for any machines on the nursing units, as they would not have access to the machine when it was locked up in the nursing medication room.</p> <p>Interview with Registered Nurse (RN) #2, on 07/19/13 at 12:00 PM, revealed she had seen nurses and therapy use the hydrocolator in the medication room; however, it was not used very often. The RN revealed she did not know who was responsible for monitoring the water temperature and had never checked the water temperature herself.</p> <p>Interview with CMT #2, on 07/19/13 at 12:02 PM, revealed she last used the hydrocolator to obtain a hot pack for Unsampled Resident B for</p>	F 323	<p>the Administrator.</p> <p>*The Director of Maintenance reports the results of the audits to the Quality Assurance Committee for review to assure compliance each quarter ongoing.</p>		



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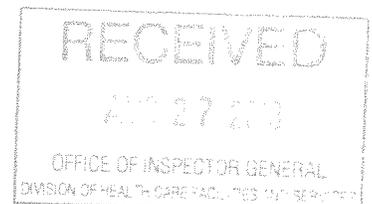
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F 323	<p>Continued From page 26</p> <p>complaints of arthritic pain. The CMT revealed she did not check the temperature of the water prior to administering the hot pack.</p> <p>Interview with Unsampled Resident B, 07/19/13 at 12:40 PM, revealed he/she did not feel the hot pack was too warm or hot to touch and had never had concerns with the temperature of the hot packs.</p> <p>Interview with the Maroon Unit Charge Nurse, on 07/19/13 at 12:05 PM, revealed she thought the hydrocolator temperature was monitored by the night shift nurse. After reviewing the night shift logs, the charge nurse revealed she could not find any indication the hydrocolator had ever been monitored for temperature, and revealed a potential for a resident to sustain a burn if it was too hot. The charge nurse revealed she did not know the appropriate temperature range for the hydrocolator.</p> <p>Interview with the Rehab Manager, on 07/19/13 at 12:10 PM, revealed the hydrocolator water temperature should be between 160-165 degree (F). The Rehab Manager revealed she was not aware the Maroon Unit even had a hydrocolator, but stated regardless, the Therapy Department would use their own machine that they were responsible for monitoring.</p> <p>Observation of the Rehab Manager, on 07/19/13 at 12:10 PM, revealed the manager checking a thermometer for accuracy with ice water then checking the hydrocolator temperature with a reading of 166 degree (F).</p> <p>Interview with the Director of Nursing, on 07/19/13 at 3:58 PM, revealed she was aware of</p>	F 323		



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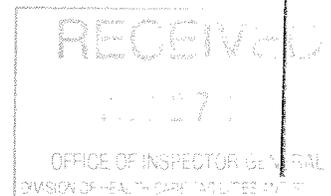
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F 323	Continued From page 27 the hydrocolator in the Maroon Unit medication room, but thought the Therapy Department was responsible to monitor the temperatures. The DON revealed she was not monitoring to ensure the temperatures were being monitored.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to maintain adequate nutrition to prevent an unexplained weight loss for one (1) of sixteen (16) sampled residents, Resident #8. The Nutrition At Risk (NAR) program was not reinstated when recommended by the Registered Dietician (RD).  The findings include:	F 325	*The Director of Food Services revises the care plan to reinstate Resident # 8 on the Nutritionally at Risk (NAR) program 8-6-13. *The Director of Food Services audits the Registered Dietician (RD) recommendations for all current residents 8-9-13 to assure that residents she recommends for the Nutritionally at Risk (NAR) program have revisions to care plans to reflect nutritional concerns. The Director of Food Services reviews the list of current residents who trigger for Nutritional Status in the Care Area Assessment Summary Section 8-9-13 to assure revisions to care plans reflect nutritional concerns. * The Assistant Director of Nursing, the Director of Food Services and the Unit Manager develop a uniform system for obtaining resident weights on 8-5-13. The Nurse Supervisor on each Unit is responsible to monitor	8-28-13



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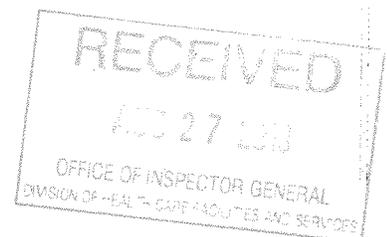
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F 325	<p>Continued From page 28</p> <p>Review of the facility's Nutritionally at Risk Residents Policy 3.12, revised 2011, revealed Nutritionally at Risk (NAR) residents were identified in a timely manner and monitored frequently. NAR residents included those who exhibited a significant unplanned weight loss of 5% or more in one (1) month; residents who have lost 10% or more of their body weight over a six (6) month period that is unplanned/undesired or eats 50% or less of their meals for seven (7) consecutive days; residents with pressure ulcers of Stage II or higher, or other residents of serious nutritional concern who may not fit in the above criteria. In addition, the staff person identifying a resident to be added to NAR monitoring was responsible for adding the resident to the nursing unit's master NAR list, adding NAR to the resident's care plan, and notifying the Registered Dietician (RD) that a new resident had been added to the program.</p> <p>Review of the clinical record for Resident #8 revealed the facility admitted the resident on 01/31/13 from the hospital with diagnoses of Anemia, Hypertension, Atrial Fibrillation, and an episode of Gastrointestinal Bleeding just prior to admission.</p> <p>Review of the Care Area Assessment Summary as part of the Admission Resident Assessment Instrument (RAI), dated 02/07/13, revealed the facility triggered Resident #8 for Nutritional Status. Further review of the Admission RAI revealed the facility scored Resident #8 at a three (3) on the Brief Interview for Mental Status (BIMS) and needed supervision as well as one person physical assist for eating.</p>	F 325	<p>resident weights for discrepancies of weight gain or weight loss. The Nurse Supervisor will direct a reweight if a weight fluctuates more than 5 pounds from the previous weight. The Staff Development Coordinator reeducates and evaluates all Certified Nurse Assistants and all Nurses to assure they demonstrate the appropriate method for obtaining resident weight by 8-27-13. The Director of Food Services audits the Registered Dietician (RD) recommendations and the residents who trigger for Nutritional Status in the Care Area Assessment Summary Section to assure revisions to care plans reflect nutritional concerns ongoing each month. The Director of Food Services oversees an ongoing weekly review of care plans for all residents on the Nutritionally at Risk master list to assure that specific individual interventions are reflected based on the NAR review. *The Director of Food Services reports the results of the audits each quarter to assure care plans are revised to reflect nutritional concerns.</p>		



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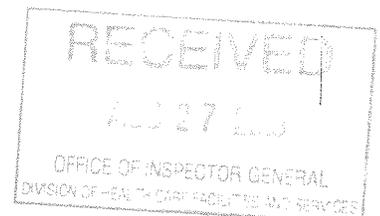
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F 325	<p>Continued From page 29</p> <p>Observation, on 07/17/13 at 8:10 AM, revealed Resident #8 was seated in a wheelchair at a table in the Audubon Dining Room within the Green Unit of the facility. Resident #8 was being fed by the Certified Nursing Assistant (CNA).</p> <p>Interview, on 07/17/13 at 10:00 AM, with CNA #5 revealed Resident #8 ate 75% of his/her breakfast meal earlier that morning. CNA #5 stated Resident #8 was able to eat some finger foods such as toast or a sandwich on his/her own, but for the most part, he/she needed to be fed and monitored by staff at every meal. CNA #5 stated she recorded Resident #8's intake on the meal sheets at the nurses' station and also in the care tracker.</p> <p>Review of the weight book kept at the Green Unit nurses' station revealed a recorded admission weight for Resident #8 of 203.3 pounds on 01/31/13. Three additional weights over approximately a month's time were recorded as 206.4 on 02/19/13, 197.0 on 02/26/13, and 195.8 on 03/05/13. Additional weights recorded for Resident #8 were: 171.2 (04/09/13); 174.8 (04/16/13); 213.6 minus the wheel chair (04/23/13); 167.4 (05/01/13); 171.8 (06/2013); and 167.0 (07/2013).</p> <p>Review of the Cardiovascular Consult performed on 01/30/13 at the hospital revealed Resident #8's weight was recorded as 180 pounds. This was one day prior to his/her admission to the facility on 01/31/13. Continued review of the</p>	F 325			



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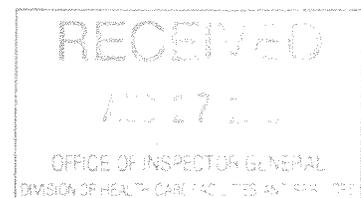
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F 325	<p>Continued From page 30</p> <p>clinical record revealed Resident #8 was diagnosed with Left Lower Lobe pneumonia on 02/19/13 and was treated with Levaquin 750 mg daily for five (5) days.</p> <p>Review of the average meal intakes for Resident #8 during the weeks of 02/19/13 -02/26/13 revealed the intake average was 72.3%, 02/27/13-03/05/13, 69.0%, 03/06/13-03/12/13, 55%; 03/13/13-03/19/13, 55.7%; 03/20/13-03/26/13, 61.3%; and 03/27/13-04/02/13, 63.3%.</p> <p>Review of the RD's Nutrition Services Progress Notes revealed the initial assessment was completed on 02/08/13, and an entry on 03/08/13 documented a recommendation for a multivitamin (MVI) daily related to a Stage 2 wound on Resident #8's coccyx. Further review of the Nutrition Progress Notes revealed the Dietary Manager visited Resident #8 on 03/29/13 regarding poor meal intakes and vanilla milkshakes, twice daily, were added to Resident #8's diet. An RD note dated 04/05/13, 2:00 PM revealed Resident #8 had a 7.8% weight loss in two (2) months with shakes added and an average intake of 64%. The RD recommended monitoring the resident on NAR with continued follow up for weight loss.</p> <p>Interview, on 07/18/13 at 2:30 PM, with the Unit Manager (UM) and the Assistant Director of Nursing (ADON) for the Green Unit, revealed Resident #8 was placed on the NAR program on 03/08/13 related to a Stage 2 wound on his/her coccyx, and poor oral intake. At the NAR</p>	F 325			



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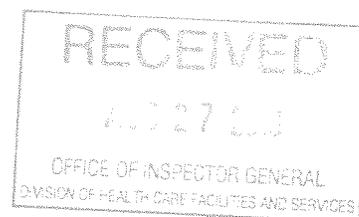
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F 325	<p>Continued From page 31</p> <p>committee meeting on the morning of 04/05/13, Resident #8's NAR monitoring was discontinued because his/her pressure ulcer had healed and his/her oral intake was improving. The UM could not explain Resident #8's documented 25.8 pound weight loss from 02/26/13 to 04/09/13, but she stated it seemed to occur after Resident #8's Pneumonia diagnosis in February.</p> <p>Interview, on 07/19/13 at 9:20 AM, with Registered Nurse (RN) #1 revealed the weight book at the nurses' station was used to record weights for residents who were NAR, and for residents with other health issues that necessitated frequent weight monitoring. The CNA's were responsible to weigh residents and the unit's nurses were responsible for recording the residents' weights into a weight book. The ADON, the unit's nurses, and the RD were responsible for monitoring the results, and for reporting any significant weight changes to a resident's physician.</p> <p>Review of the NAR Committee Meeting Minutes revealed Resident #8 was added to the NAR program on 03/08/13, and discontinued from NAR on 04/05/13.</p> <p>Interview, on 07/19/13 at 9:45 AM, with the Registered Dietician (RD) revealed she attended the NAR meeting once per month as one of the components of following the residents' progress. Resident #8 was on the NAR program from 03/08/13 to 04/05/13 because of the presence of a stage 2 pressure ulcer on his/her coccyx. The RD stated she recommended the NAR program</p>	F 325		



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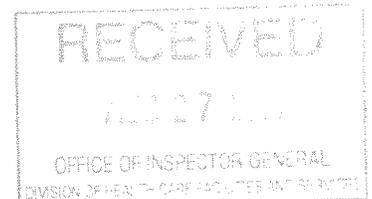
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F 325	<p>Continued From page 32</p> <p>on the afternoon of 04/05/13 after she calculated a 7.8% weight decline over (2) months for Resident #8. The RD stated she assumed Resident #8 had been re-added to NAR after her note of 04/05/13, but this must have been an oversight.</p> <p>Interview, on 07/19/13 at 3:05 PM, with the Director of Nursing (DON) revealed the facility's admitting nurse was responsible for reviewing all medical documents provided by other entities such as hospitals upon a resident's admission, with emphasis on identification of discrepancies between that documentation and data collected upon admission to the facility. In addition, within one week of a resident's admission to the facility, the RD was supposed to review any admission documents sent with a resident and admission data ( including labs, weights and other vital signs, etc.) collected by the facility. However, in Resident #8's case, there was a failure to identify the discrepancy in Resident #8's weight on 01/30/13 at the hospital, and his/her weight on admission to the facility on 01/31/13. The DON stated the ADON, the Unit's nurses and ultimately she was responsible for ensuring such discrepancies were caught and addressed as soon as they were identified. The DON stated the NAR committee decided to discontinue Resident #8's NAR program on the morning of 04/05/13, when it was determined his/her pressure ulcer had healed. The RD's recommendation on the afternoon of 04/05/13 for the re-admitting Resident #8 to the NAR program should have been copied to the DON, the Administrator, the ADON, and the Dietary Manager. However, the DON stated she did not remember reviewing that recommendation. The</p>	F 325			



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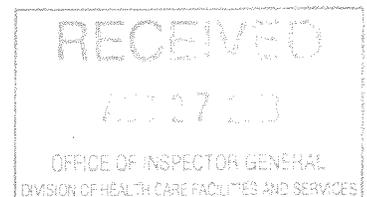
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F 325	Continued From page 33 DON further stated, the NAR program should have been re-instated for Resident #8 on 04/05/13, but it was not reinstated due to a miscommunication.	F 325			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	*The Unit Managers remove all medications previously stored in the same refrigerator with food for storage in new refrigerators on each unit designated for medications only 8-7-13. * The Unit Managers remove all medications previously stored in the same refrigerator with food for storage in new refrigerators on each unit designated for medications only 8-7-13. *The Unit Managers notify all nurses verbally about the storage of medications in the new refrigerators designated for medications only 8-7-13. The Unit Managers audit the refrigerators weekly to assure that medications are being stored in the new refrigerators designated for medications only. The members of the Safety Committee who complete monthly environmental rounds audit of the refrigerators and report to the safety committee. *The Assistant Director of Nursing will report the results of the	8-8-13	



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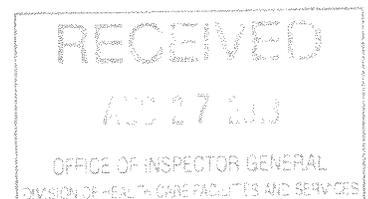
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F 431	Continued From page 34  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy Medication Storage in the Facility, it was determined the facility failed to ensure refrigerated medications were stored separately from food and beverages in two (2) of the two (2) medication rooms.  The findings include:  Review of the facility's policy Medication Storage in the Facility, dated 02/01/10, revealed refrigerated medications are kept in closed and labeled containers, with internal and external medications separated and separate from fruit juices, applesauce, and other foods used in administering medications. Other foods such as employee lunches and activity department refreshments are not stored in this refrigerator.  Observation of the Green Unit medication room, on 07/19/13 at 9:50 AM, with Licensed Practical Nurse (LPN) #1 revealed only one refrigerator in the medication room with medications mixed in with food and beverages. A blue box containing three (3) insulin pens belonging to residents, three (3) vials of PPD serum, fifty-four (54) Bisacodyl Suppositories, Cubcin 400 mg/100 ml IV, and a one (1) gm opened vial of Vancomycin was sitting on the second shelf. The blue medication box was situated next to a carton of thickened water, a carton of orange juice, and a carton of prune juice. The shelf above the medication had number (1) can of tomato juice, fourteen (14) 4 oz cartons of Activia yogurt, four	F 431	refrigerator audits quarterly to the Quality Assurance Committee for ongoing review.		



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F 431	<p>Continued From page 35</p> <p>(4) 5.3 oz containers of Activia yogurt, ten (10) cans of Glucerna, two (2) cartons of applesauce, and four (4) peach Upstate Farm yogurts. In the refrigerator door were eight (8) cartons of milk and three (3) cartons of pudding. On the bottom shelf was the pharmacy locked emergency box and ten (10) cans of Premier protein drinks.</p> <p>Interview with LPN #1, during the observation revealed medications had been stored together with food and beverages since she started. The LPN revealed there had been talk several times about not keeping the food and medications in the same refrigerator due to the risk for cross contamination. However, nothing had ever been done about it. The LPN revealed she had worked at several other facility's and had never seen medications stored with food before.</p> <p>Observation of the Green Unit medication room, on 07/11/13 at 1:30 PM, revealed a plastic Glad brand container sitting on the second shelf with a hole in the corner and a prefilled syringe with the plunger end sticking out of container through the hole. The container was sandwiched between two (2) cartons of juice.</p> <p>Observation of the Maroon Unit, on 07/19/13 at 10:15 AM, with Certified Medication Technician (CMT) #1 and CMT #2 revealed the medication room refrigerator contained a metal tray stored on the top shelf above the locked drawer containing the emergency medications box. The emergency medications drawer had large cut out slots/openings in the top. A cup of fruit cocktail, and two (2) cups of applesauce were sitting on the metal tray over the drawer with the cutout areas. Next to the tray were two (2) bottles of thickened water and two (2) cartons of milk. On</p>	F 431			



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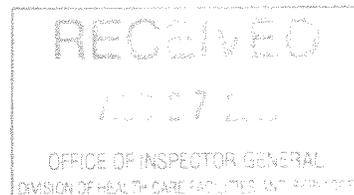
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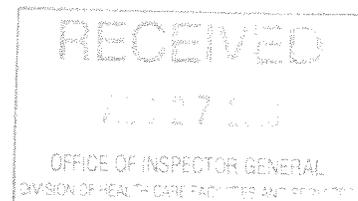
F 431	<p>Continued From page 36</p> <p>the shelf below were fourteen (14) cans of Glucerna and six (6) cans of Ensure. In the refrigerator door were two (2) cans of tomato juice, three (3) cans of Ensure, and two (2) cans of Shasta soda .</p> <p>Interview with CMT #1, on 07/19/13 at 10:15 AM, revealed storage of foods and medications were a potential for cross-contamination. The CMT revealed she was not aware if pharmacy checked the refrigerator for storage of medications.</p> <p>Interview with a PCA Pharmacist (pharmacy for the facility), on 07/19/13 at 1:18 PM, revealed a PCA Quality Assurance LPN monitored the medication carts and storage of medications monthly. The Pharmacist revealed medications should be kept in a refrigerator separate from food because the food could contaminate the medications.</p> <p>Interview with the PCA Quality Assurance LPN, on 07/19/13 at 2:30 PM, revealed she was the person responsible for monitoring the storage of medications at the facility. The Quality Assurance LPN revealed medications could be kept in the same refrigerator as food and beverages as long as they were kept on a different shelf. When asked what standards were being used for the storage of medications the Quality Assurance LPN did not respond. No information was provided in regards to pharmacy standards.</p> <p>Review of the Pharmacy Drug Storage Inspection, dated 05/28/13, revealed storage of refrigerated medications were not checked with a notation that resident foods and wines were stored in the medication refrigerator.</p>	F 431		
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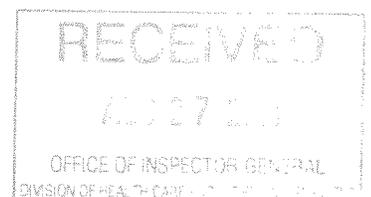
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185349</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/19/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>JEFFERSON PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1705 HERR LANE LOUISVILLE, KY 40222</b>		
(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 431	Continued From page 37 Interview with the Director of Nursing (DON), on 07/19/13 at 3:58 PM, revealed a potential for contamination for both food and medications when they were stored together. The DON revealed the policy eluded to the employee food which should not be kept in the refrigerator, but the observations made by the surveyor did not meet the the criteria for separate and separated as outlined in the facility policy. The DON revealed separate but separated meant keeping the food on different shelves. The DON reveled she was responsible for monitoring and ensuring food and medications were not stored on the same shelf, and she felt limiting access to medications to those only licensed or authorized to do so was sufficient.	F 431			
F 441 SS=D	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441	*The Therapy Manager moves the linen in the therapy room to a shelf within closed cabinet 7-19-13. * The Director of Housekeeping audits all resident areas including the therapy gym, whirlpool room and shower room to assure proper storage of linens 7-19-13. *The Staff Development Coordinator reeducates all therapists, nurse aides and housekeepers about the handling, storage, processing and transportation of linens to prevent the spread of infection by 8-27-13. The Director of Housekeeping audits all resident areas including the therapy gym, whirlpool room	8-28-13	



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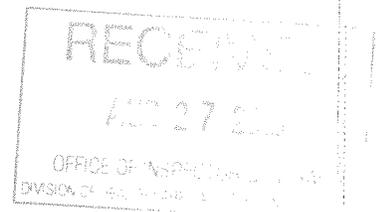
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185349</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/19/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>JEFFERSON PLACE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1705 HERR LANE LOUISVILLE, KY 40222</b>		
(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 441	<p>Continued From page 38</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure clean linen in the Therapy Room was covered.</p> <p>The findings include:</p> <p>The facility did not have a policy for storing clean linen in the therapy treatment area.</p> <p>Observation of the therapy treatment area, on 07/19/13 at 12:10 PM, revealed shelves stocked with clean linen for use with residents during therapy. The linen was not covered. Staff was noted to remove the clean linen and take it to residents.</p> <p>Interview with the Occupational Therapist, on 07/19/13 at 12:20 PM, revealed the storage shelves were not equipped with a door or a cover.</p>	F 441	<p>and shower room to assure proper storage of linens weekly for 4 weeks. The Director of Housekeeping audits all resident areas including the therapy gym, whirlpool room and shower room to assure proper storage of linens monthly.</p> <p>*The Director of Housekeeping reports the results of the audits quarterly to the Quality Assurance Committee quarterly for ongoing review.</p>	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185349</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/19/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>JEFFERSON PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1705 HERR LANE LOUISVILLE, KY 40222</b>		
(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 441	Continued From page 39 She stated the linen should be covered to prevent contamination.	F 441			



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185349</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/17/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>JEFFERSON PLACE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1705 HERR LANE LOUISVILLE, KY 40222</b>		
(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: 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, 150 KW generator; fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 07/17/13. Jefferson Place was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance 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

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.