

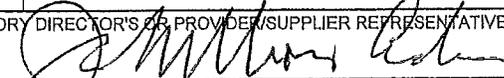
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185169	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/14/2010
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NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted 10/12/10 through 10/14/10 and a Life Safety Code survey on 10/13/10. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. An abbreviated survey was initiated on 10/12/10 and concluded on 10/14/10 investigating KY00015234, KY00014974 and KY00015034. KY00015234, KY00014974 and KY00015034 were unsubstantiated with no deficiencies cited.	F 000		
F 205 SS=B	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced	F 205	At the time of transfer of a resident for hospitalization or therapeutic leave, Jefferson Manor will provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy. On 10/13/10 the Unit Mangers were in serviced on sending Jefferson Manors bed-hold policy with residents upon transfer. All nursing staff will be in serviced on sending the bed-hold policy out with each resident. The Unit Managers will audit all residents that have been transferred to ensure that Jefferson Manors bed-hold policy was sent with them on a weekly basis for 3 months, if not deficient practice is noted a monthly audit will be performed quarterly. Findings will be reported to the Quality Assurance Meeting.	11/26/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Administrator (X6) DATE 11/5/2010

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

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F 205	<p>Continued From page 1</p> <p>by: Based on interview and record review, it was determined the facility failed to provide residents being transferred to acute care facilities with a copy of the facility's bedhold policy for four (4) of twenty-four (24) sampled residents (#2, #3, #4, and #14).</p> <p>The findings include:</p> <p>Review of policies revealed the facility did not have a policy for bedhold while residents were out of the facility for acute care or therapeutic leaves. The facility did present a bedhold policy that was just written and the policy failed to state that a copy of the facility's bedhold policy would be provided to residents when leaving the facility for a medical or therapeutic leave.</p> <p>Review of the clinical record for Resident #3 revealed the resident was admitted with diagnoses of; Dysphagia, Hypertension, and a History of a Cerebral Vascular Accident. The facility completed a quarterly Minimum Data Set (MDS) assessment on 08/23/10 which indicated the resident had a fall within the last thirty (30) days. Nursing notes for 09/29/10 revealed the resident rolled out of bed and was transferred to acute care for evaluation. The facility failed to send a Bedhold Policy with the resident.</p> <p>Review of the clinical record for Resident #2 revealed the resident was admitted with diagnoses of Cellulitis, Congestive Heart Failure, Hypertension and Pernicious Anemia. The facility completed an admission MDS assessment on 07/14/10 which revealed the resident was independent in decision making and required extensive assistance from staff for all care. The</p>	F 205		

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OFFICE OF INSPECTION AND EVALUATION

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 205	<p>Continued From page 2</p> <p>resident sustained a fall with a minor head injury and was transferred to the hospital for evaluation. The facility did not provide the resident with a copy of the facility bedhold policy.</p> <p>Review of the clinical record for Resident #4 revealed the resident was admitted with diagnoses of Failure to Thrive, Hyponatremia and Dehydration. The facility completed an annual MDS on 10/23/10 which revealed the resident to be alert and oriented and independent in decision making. The resident sustained a fall on 10/10/10 and was transferred to the emergency room for evaluation. The resident was not provided a copy of the facility's bedhold policy.</p> <p>Review of the clinical record for Resident #14 revealed an admission date of 09/22/10 with diagnoses of; Subdural Hematoma, Senile Dementia, Anxiety, Depression and GI Hemorrhage. The facility completed an Admission MDS on 09/30/10 which indicated the resident had short and long term memory deficits. The resident was transferred to the emergency room for evaluation due to a urinary tract infection on 09/23/10. The facility failed to provide the resident/responsible party with a copy of the facility's bedhold policy.</p> <p>Interview with Licensed Practical Nurse (LPN) #5 on 10/13/10 at 11:45am revealed she had no knowledge of a bedhold policy or that residents needed to receive this notice when leaving the facility to go to acute care or on therapeutic leave.</p> <p>Interview with the Blue Unit Manager 10/13/10 at 3:00pm revealed the facility did not provide residents with a bedhold policy when leaving for acute care or a therapeutic leave because the</p>	F 205		

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OFFICE OF INSPECTOR GENERAL

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F 205	Continued From page 3 facility would automatically hold the bed. She stated there was no bedhold policy at the facility.	F 205		
F 279 SS=E	Interview with the Admissions Director on 10/13/10 at 3:30pm revealed she was not aware of a bedhold policy other than the one advising residents regarding payment. She stated she did not review a bedhold policy during admission. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to develop comprehensive care plans for five (5) of twenty-four (24) sampled residents (#2, #13, #14,	F 279	Jefferson Manor will continue to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's highest practicable physical, mental, and psychosocial well-being. On 11/2/10 the care plans for Residents #13 and #15 were revised to include individualized isolation and precaution needs. Resident #2 and #16 have been removed from contact precautions. Resident # 14 was discharged home on 10/22/10. The care plan of resident #16 was also revised to include the resident and physicians desire to have no hospitalizations, lab testing, weights or x-rays due to their condition. On 11/2/10 all residents requiring transmission based precautions were reviewed to ensure that isolation needs were addressed on the care plan. All residents care plans will be reviewed and revised as needed to ensure that interventions are addressed as needed. This will be accomplished by reviewing each residents nursing assessments, most recent RAI assessments, physician orders and interventions that are in place for the resident.	11/26/10



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F 279	<p>Continued From page 4</p> <p>#15, and #16) based on the results of the comprehensive assessment. Residents #2, #13, #14, #15, and #16 did not have care plans developed to address isolation needs.</p> <p>The findings include:</p> <p>1. Review of the facility's care planning policy revealed the facility used the Resident Assessment Instrument (RAI) as their policy which required care plans to be developed based on the Minimum Data Set (MDS) assessment and other assessments of the resident.</p> <p>Observation of Resident #16 on 10/13/10 at 2:40pm, 3:40pm and on 10/14/10 at 8:00am revealed a sign on the door indicating the resident was on isolation. There was no personal protective equipment present.</p> <p>Review of the clinical record for Resident #16 revealed the resident was admitted with diagnoses of; Clostridium Difficiles in the Stool, Dementia, Failure to Thrive, and Renal Failure. The facility completed an admission MDS assessment on 08/27/10 which revealed the resident had a moderate impairment in the ability to make daily care decisions and required extensive assistance for care and was incontinent of bowel and bladder. The resident was placed in contact precautions due to the infection in the bowel.</p> <p>Review of the Physician's orders for 08/24/10 revealed the resident was to have comfort measures only and there were to be no hospitalizations, laboratory tests, weights or x-rays.</p>	F 279	<p>All nursing staff will be in serviced on the updated Infection Control Policy, including the care planning process for residents in transmission based precautions.</p> <p>A meeting was held on 11/2/10 with the DON, Unit Managers, Assistant Unit Managers, MDS Coordinators and full time 3-11 management nurses to discuss the updated Infection Control Policy, including the care planning process for residents in transmission based precautions.</p> <p>The DON or Unit Manager will review the daily 24 Hour Reports to ensure that changes in residents interventions including transmission based precautions are followed through on the care plan. Audits will be performed weekly for 3 months and then monthly for 3 months or until the deficient practice is resolved. Findings will be reported to the Quality Assurance Committee.</p>	11/26/10

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F 279	<p>Continued From page 5</p> <p>Review of the comprehensive care plan dated 08/23/10 revealed the facility failed to develop a care plan for the infection in the resident's bowel and the contact precautions put in place for the resident. In addition, the facility failed to develop a care plan for the resident's failure to thrive and address the physician's orders for no hospitalization, no laboratory tests, no weights, no x-rays, and comfort care only.</p> <p>2. Review of the clinical record for Resident #2 revealed the resident was admitted with the diagnoses of; Cellulitis of the Legs and a Urinary Tract Infection. The facility completed an admission MDS assessment on 07/14/10 which revealed the resident was able to make daily care decisions and required extensive assistance with care. The resident was placed in contact isolation and laboratory testing of the resident's urine on 08/27/10 and 09/14/10 revealed the resident continued to have multiple drug resistant Eschericia Coli in the urine.</p> <p>Review of the comprehensive care plan revealed the facility failed to develop a care plan to address the resident's contact precautions.</p> <p>Interview with the MDS Coordinator on 10/14/10 at 2:00pm revealed the contact precautions and comfort measures for Resident #16 and the contact precautions for Resident #2 should have been addressed on the care plan to communicate the needed interventions.</p> <p>Interview with the Director of Nursing (DON) on 10/14/10 at 1:30pm revealed she was surprised the concerns were not on the care plans but should have been.</p>	F 279		



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F 279	<p>Continued From page 6</p> <p>3. Observation of Resident #13 on 10/13/10 at 3:15pm revealed a table outside the room in the hall with toilet paper, wipes, masks, gloves, gowns and sign on the wall stating Isolation precautions: use gloves, mask and wash hands. The door to the room was closed; however, the resident was not in the room. Resident #13 was with a visitor on the porch and the resident had a face mask on.</p> <p>Record review for Resident 13 revealed an admission date of 07/04/10 with diagnoses of; Functional Disorder, Anemia, MRSA (Methicillin Resistant Staph Aureus). The Quarterly MDS dated 09/24/10 did not indicate the resident was in isolation or had an infection. The physician orders stated the resident may be out of the room with a mask on and a follow up sputum culture was to be done on 10/04/10. Review of the labs revealed results of a follow up sputum culture dated 10/07/10 and heavy growth of MRSA. Review of the comprehensive plan of care revealed the resident's isolation was not addressed.</p> <p>4. Observation of Resident #14 on 10/13/10 at 3:15pm revealed the resident was sitting in a chair in the room asleep. The door was open and a sign on the door indicated isolation precautions: gloves for providing direct patient contact and toileting, wash hands before leaving the room, use barrels in room for disposal of trash and linens.</p> <p>Record review for Resident #14 revealed an admission date of 09/22/10 with diagnoses of; Senile Dementia, Subdural Hematoma, Anxiety and Depression. Review of the Admission MDS dated 09/30/10 revealed the resident was in</p>	F 279		

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F 279	<p>Continued From page 7</p> <p>isolation. Review of the physician orders did not reveal an order for isolation precautions. Review of the labs indicated the resident was placed in isolation on 09/27/10 due to VRE (Vancomycin Resistant Enterococcus) in the urine that was diagnosed on 09/23/10 in the emergency room. A repeat urinalysis on 09/28/10 indicated the resident continued with VRE. Review of the comprehensive plan of care did not reveal isolation precautions for Resident #14.</p> <p>Interview with the Director of Nursing on 10/14/10 at 1:30pm revealed the MDS Coordinators would be responsible for addressing Isolation on the plan of care. In addition, the nursing management team audits to ensure isolation is addressed on the plan of care. The DON was surprised to hear isolation had not been addressed on the plan of care and was not sure how it got missed in the audits.</p> <p>Interview with the MDS Coordinators for the Blue and Green units on 10/14/10 at 2:00pm revealed they retrieve information from the telephone orders and the RAPs to identify issues for the residents. The Coordinators stated you should see the issues on the plan of care. Neither MDS Coordinator was sure if isolation should be on the plan of care; however, they decided at this time isolation should be placed on the plan of care to address the reason for being in isolation and to communicate to others.</p> <p>5. Observation of Resident #15 on 10/13/10 at 3:00pm revealed a yellow cart outside the room in the hall with gloves, gowns, mask and a sign on the wall stating isolation precautions: use gloves for direct patient contact and toileting, wash hands before leaving the room, use barrels in the</p>	F 279		

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F 279	Continued From page 8 room for disposal of trash and linens. Record review for Resident #15 revealed an admission date on 03/27/02 with diagnoses of; Hyper-natremia, syncope, PVD (peripheral vascular disease). On 09/24/10 the resident was treated for a UTI. The Quarterly MDS dated 08/27/10 did not indicate the resident was in isolation or had an infection. Review of the physician orders did not reveal an order for isolation precautions. Interview with the MDS Coordinator on 10/14/10 at 2:00pm revealed the contact precautions for Resident #15 should have been addressed on the care plan to communicate the needed interventions. Interview with the DON on 10/14/10 at 1:30pm revealed the care plan should address the isolation. The DON further revealed she was surprised that the care plan was not addressing isolation.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280	Jefferson Manor will continue to develop a comprehensive care plan 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.	

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F 280	<p>Continued From page 9 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 and record review, it was determined the facility failed to periodically revise the comprehensive care plan for one (1) of twenty-four (24) sampled residents (#6). The resident's physician ordered Hosparus on 05/03/10 and Isolation on 05/25/10; however, the facility failed to revise the care plan with interventions to address these changes.</p> <p>The findings include:</p> <p>Review of the facility's care planning policy revealed the facility used the Resident Assessment Instrument (RAI) as their policy which required care plan revisions to address the resident's care needs.</p> <p>Review of the clinical record for Resident #6 revealed the resident was admitted with diagnoses of; Dysphagia and End-Stage Alzheimer's Disease. The facility completed a quarterly Minimum Data Set (MDS) assessment on 09/08/10 which assessed the resident as moderately impaired in the ability to make daily care decisions. The resident required extensive assistance with all care and was incontinent of bowel and bladder.</p>	F 280	<p>On 11/2/10 the care plan for Resident #6 was revised to include isolation precautions.</p> <p>Hosparus was discontinued on Resident #6 on 10/13/10 per family request.</p> <p>On 11/3/10 all care plans for residents receiving Hosparus services were audited to ensure that appropriate interventions were addressed.</p> <p>Nurses will be in serviced on the revision and updating of care plans.</p> <p>Social Services will audit care plans of all residents receiving Hosparus services to ensure that the interventions have been incorporated weekly for a month and if no deficient practice is noted quarterly audits will be performed. Findings will be reported to the Quality Assurance Committee.</p> <p>The DON or Unit Manager will review the daily 24 Hour Reports to ensure that changes in residents interventions including transmission based precautions are followed through on the care plan. Audits will be performed weekly for 3 months and then monthly for 3 months or until the deficient practice is resolved. Findings will be reported to the Quality Assurance Committee</p>	11/26/10

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F 280	<p>Continued From page 10</p> <p>Physician's orders indicated a Hosparus consultation was ordered for Resident #6 on 05/03/10. Review of the comprehensive care plan, dated 09/03/10, revealed the facility failed to revise the care plan or provide any evidence that the facility incorporated the Hosparus interventions into the resident's care plan.</p> <p>Review of the facility's policy for contact precautions revealed the Office of Inspector General, Long Term Care Infection Control Seminar, dated 05/04/10, was utilized. The policy revealed residents in contact precautions required gowns and gloves be donned prior to entry into the room.</p> <p>Review of physician orders for 05/25/10, revealed the physician wrote an order for isolation. Review of the laboratory results for urine samples obtained on 06/12/10 and 07/30/10 revealed Resident #6 had a multiple drug resistant form of Eschericia Coli in the urine and the facility placed the resident on contact precautions.</p> <p>Review of the comprehensive care plan revealed the facility had failed to revise the care plan to include precautions, including the type of precautions and interventions to carry out the isolation of the resident after the completion of a comprehensive assessment.</p> <p>Interview with Certified Nurse Aide (CNA) #4 on 10/13/10 at 12:00pm, revealed she was not aware of the type of Isolation Resident #6 was receiving; that a gown should be worn when changing the resident's brief; or that personal protective equipment should be donned before entering the room especially when providing perineal care.</p>	F 280		

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NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222	
(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 280	Continued From page 11 Interview with the MDS Coordinator on 10/14/10 at 2:00pm, revealed new orders were reviewed daily; however, since the facility did not obtain orders for isolation, it was not added to the care plan as it should have been. Interview with the Director of Nursing on 10/14/10 at 1:20pm, revealed isolation should be included in the care plan and she was not aware of the omission. She stated she did occasionally audit clinical records.	F 280		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure equipment was maintained in a sanitary manner. The plate warmer containing plates during meal time was dirty. The findings include: Observation of the plate warmer on 10/12/10 at 11:30am and on 10/12/10 at 3:50pm revealed the plate warmer containing clean plates had a build	F 371	Jefferson Manor will continue to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions. The Plate warmer in the dietary department was cleaned immediately when brought to the dietary managers attention. An in-service will be conducted and all dietary employees will be in-serviced on the proper cleaning of all equipment. The Dietary manager or her designee will inspect all equipment on a weekly basis and schedule deep cleaning on a monthly basis. A record of cleaning will be kept and employees will sign to acknowledge when cleaning takes place. The findings will be reported to the Quality Assurance Committee, which meets quarterly.	11/26/2010

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F 371	Continued From page 12 up sticky yellow substance around the edges and down the inside of the warmer where the plates sit. Interview with the Dietary Manager (DM) on 10/12/10 at 3:50pm revealed the yellow sticky substance was a buildup of grease. The DM stated the staff wipe around the edges but do not wipe the sides. In addition, the warmer needed to be scrubbed; the greasy substance could make the residents ill if the dirt got into their food. The Dietary Manager further stated the plate warmer is cleaned every three months. There was no policy provided by the facility.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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 prevent the spread of infection, the facility must isolate the resident.	F 441	Jefferson Manor has established and maintains an Infection Control Program designated to provide a safe and sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The previous Infection Control Manual that was updated in 2001 was being used along with information from the CDC regarding specific organisms. . The Infection Control Manual was updated on 11/2/10 to include the <u>2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings</u> . The Infection Control Manual was approved by the Medical Director. A system has been implemented to track infections.	

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F 441	Continued From page 13 (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation it was determined the facility failed to ensure an approved updated infection control policy and procedure manual was available for use to staff and failed to have a system in place to track infections. In addition, the facility delivered ice to residents that were contaminated by the staff; nursing staff left unidentified bars of soap in the shower rooms, and failed to wash their hands when leaving isolation rooms. The findings include: 1. Observation of the breakfast meal on 10/13/10 at 8:05am revealed Certified Nursing Assistant (CNA) #3 carried a tray into an isolation room and then proceeded to touch the resident's equipment without gloves on. The CNA set up the breakfast tray and left the room to carry another tray into another resident's room. In addition, the CNA did not wash or sanitize his/her hands after leaving	F 441	Ice containers are no longer being brought up on the meal carts. Dietary staff is filling the glasses with ice before the meal carts are brought to the units. On 10/14/10 all bars of soap were removed from the shower rooms and all towels were removed from the sinks. Appropriate Personal Protective Equipment was placed outside the room of any resident in transmission based precautions. All staff will be in serviced on the updated Infection Control Policy including not to leave bar soap in the shower room, not leaving clean towels in the sink and what measures to take with residents on transmission based precautions and the use of soap and water with residents who have C Diff. The Staff Development Coordinator will conduct annual education on infection control. The Staff Development Coordinator or Nursing Supervisor will perform weekly audits of staff members who care for residents in transmission based precautions for 4 weeks, then monthly to ensure that staff are and using appropriate PPE and performing hand hygiene. Findings will be reported to the Quality Assurance Meeting. The Assistant Unit Managers or Unit Secretaries will perform audits twice a week for a month to ensure that bar soap is not left in the shower room and that towels are	11/26/10

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F 441	<p>Continued From page 14 the isolation room.</p> <p>Interview with CNA #3 on 10/13/10 at 8:10am revealed the staff should wear gloves to deliver the tray and wash hands before leaving the room. The CNA stated the other resident could have gotten the same infection from the isolation room. The CNA stated they were worried about getting food to the residents.</p> <p>Interview with CNA #5 on 10/13/10 at 8:15am revealed the nursing assistants should wear gloves in the isolation rooms and wash hands before leaving the room to prevent cross contamination.</p> <p>2. Observation of staff passing meal trays on 10/12/10 at 12:45pm, revealed CNAs #6, #7 and #8 filling drinking glasses with ice and delivering the glasses to residents. The staff were observed to consistently place the ice scoop back in the container of ice after using the scoop.</p> <p>Interview with CNA #6 on 10/12/10 at 1:10pm, revealed there was no policy on using the ice scoop and everyone placed the ice scoop back in the ice container after filling a glass and she did not have any concerns with this practice. In addition, the CNA stated she had received training on infection control practices.</p> <p>Interview with CNA #7 on 10/12/10 at 1:15pm, revealed she had received training on infection control; however, she could see no concern with placing the ice scoop down in the container of ice after using the scoop.</p> <p>Interview with CNA #8 on 10/12/10 at 1:18pm, revealed the ice scoop should not be placed</p>	F 441	<p>not left in the sink. If no deficient practice is noted the audits will be performed on a weekly basis for 3 months then quarterly. Findings will be reported to the Quality Assurance Committee.</p>	

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F 441	<p>Continued From page 15</p> <p>down in the ice container and should have been stored in a closed separate container between uses. The CNA stated the ice scoop could have a handle contaminated with bacteria.</p> <p>Interview with the Blue Unit Manager on 10/12/10 at 1:20pm revealed the ice scoop was to be placed in a dated zip-lock bag between uses and not placed in the ice container. She stated staff were trained during orientation and during meetings on the unit.</p> <p>3. Observations of the Blue and Green Unit Shower Rooms on 10/12/10 at 9:00am and on 10/13/10 at 9:10am revealed opened bars of soap stored in the shower stalls. One shower stall on the Green Unit had three (3) bars of soap stacked on top of each other. In addition, clean folded linen, towels and wash cloths, were observed to be stored in the sinks in both Green Unit bathrooms.</p> <p>Interview with CNA #4 on 10/13/10 at 11:30am revealed the facility provided liquid bath soap; however, some residents liked to use bar soap when showering. She stated the bar soap was stored in the residents' rooms and was not to be left in the shower room for other residents to use. She stated clean linen could not be placed in the sink due to possible contamination.</p> <p>Interview with the Blue Unit Manager on 10/13/10 at 3:00pm revealed bar soap could be used by residents with a preference; however, liquid bath soap was available in each shower stall. She stated bar soap should be used only by one resident and then taken back to the resident's room after the showers completed. She stated the bar soap was not to be left in the shower and</p>	F 441			

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F 441	<p>Continued From page 16</p> <p>CNAs had received training on this. She stated clean linen was not to be stored in the sink in the shower room due to possible contamination.</p> <p>Review of the Infection Control Manual provided by the facility as current revealed it had not been reviewed by the Medical Director or revised to meet the new CDC (Centers for Disease Control) guidelines since 1995.</p> <p>Interview with the Director of Nurses (DON) on 10/14/10 at 1:30pm revealed she had been looking at infection control for about the last two weeks because she noticed there was not a system in place to track infections in the building, and recognized a problem of when to take residents out of isolation, when colonized or not, the policy manual did not address new recommendations and had not been approved by the Medical Director. The DON further indicated all PPE (personal protective equipment) should be outside the door of the isolation room. Isolation should be on the plan of care to address the psychosocial needs of the resident, following physician orders for treatment, one on one activities and Social Services assessments. Nursing Staff are taught to wash their hands when they enter, leave, or touch anything in the isolation room. Hand sanitizer is used for all isolations. The staff are not educated on non-use of hand sanitizer for C-Diff isolations. The DON further stated the facility did not utilize eye protection for droplet transmitted infections. The nursing staff are not to use bar soap in the shower rooms and should be kept in a container in the resident's rooms.</p> <p>Interview with the Administrator on 10/14/10 at 2:20pm revealed the policy and procedure</p>	F 441		

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F 441	Continued From page 17 manuals had been reviewed in Quality Assurance meetings; however, the infection control policy and procedure manual had not been reviewed because it had been sufficient in the past. In addition, it was the DON's responsibility and she should have been talking to the Medical Director.	F 441			

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NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222	
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K 000	INITIAL COMMENTS	K 000		
K 027 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview on 10/13/10, it was determined the facility failed to ensure fire/smoke corridor doors are functioning properly to resist the passage of smoke, according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 10/13/10 at 1:45pm, with the Maintenance Director, revealed one of the fire/smoke corridor doors on the 500 Hallway between resident rooms numbered 502 and 504 would not close during the alarm test.</p> <p>Interview with the Maintenance Director, on</p>	K 027	<p>Inspection of the fire doors on the 500 hall revealed that there was a loose wire nut in the wiring harness and some dust on the electromagnetic closer gear. The wire nuts were tightened and wrapped with electrical tape. The gear was dusted with compressed air and sprayed with lubricant (WD-40). On 11/3/10 the doors were then tested ten times consecutively. The doors operated correctly in every trial.</p> <p>To ensure proper operation all fire doors shall be inspected for proper closing and latching at every monthly fire drill. The findings will be reported to the Quality Assurance Committee, which meet quarterly.</p>	11/3/10

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

TITLE

(X6) DATE

[Signature] Administrator x 11/5/2010

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

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K 027	Continued From page 1 10/13/10 at 1:45pm, indicated that he was not aware the door was not releasing properly. NFPA 80 (1999 Edltion) 15-1.4 Repairs Repairs shall be made and defects that would interfere with the operation shall be corrected immediately. 15-2.1.1 Hardware shall be examined frequently and any parts found to be inopertive shall be replaced immediately. 15-2.4.1 Self closing devices shall be kept in proper working condition at all times.	K 027		

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