

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

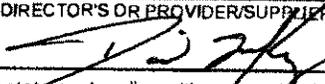
PRINTED: 03/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/22/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  J J JORDAN GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 270 E CLAYTON LN LOUISA, KY 41230
---	---

(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 Re-certification Survey was conducted from 02/19/13 through 02/22/13. Deficiencies were cited with the highest Scope and Severity level of an "E".	F 000	DISCLAIMER: THE COMPLETION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION THAT THE FACILITY AGREES WITH THE DEFICIENCIES AS STATED IN THE 1567. THE FACILITY IS COMPLETING THE PLAN OF CORRECTION BECAUSE IT IS REQUIRED BY STATE AND FEDERAL LAW. THE FACILITY RESERVES THE RIGHT TO TAKE FURTHER ACTION, INCLUDING ALL LEGAL MEANS NECESSARY, TO RESOLVE ANY DISPUTES ABOUT THE ACCURACY OF THIS INFORMATION.	
F 253 SS=E	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, interview and review of the facility's policy, it was determined the facility failed to provide and maintain effective sanitary housekeeping services to prevent the spread of disease-causing organisms by keeping the resident care equipment clean and property stored. The facility failed to properly store the residents' toothbrushes in a sanitary manner.  The findings include:  Review of the facility's policy, titled Standard Precautions, dated 01/05/13, revealed resident care equipment should be handled to prevent the contamination and transfer of other microorganisms to other residents and environment.  Observation during initial tour, on 02/19/13 at 11:30 AM, revealed toothbrushes hanging uncovered, mounted on the wall above the sink, near the faucet handles of the sink, in the resident rooms 206, 207, 216, 217, 218, 219.	F 253	The toothbrushes and toothbrush holders for rooms 200A-227B were removed and discarded by the Infection Control Coordinator and maintenance staff on 02/22/13. The Nursing Supervisors distributed new toothbrushes with containers and placed them inside the residents bedside table for rooms 200A-227B on 02/22/13.  The toothbrushes and toothbrush holders for all residents were removed and discarded and new toothbrushes with containers were distributed and placed inside the residents bedside tables by the Infection Control Coordinator, maintenance staff and Nursing Supervisors on 02/22/13.  The Infection Control Coordinator conducted in-services with all nursing and housekeeping staff on 02/22/13, 02/26/13, 03/11/13 and 03/14/13. The in-services reviewed keeping resident care equipment clean and properly stored in a sanitary manner.  The Nursing Supervisors will monitor to ensure resident care equipment is clean and properly stored during their shift. The Infection Control Coordinator will monitor resident care equipment cleanliness and storage during surveillance rounds monthly. Findings will be reported to the Performance Improvement Committee quarterly for six months.	3/18/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 3/18/13
--	------------------------	----------------------

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution's 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.

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

PRINTED: 03/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/22/2013
NAME OF PROVIDER OR SUPPLIER  J J JORDAN GERIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 270 E CLAYTON LN LOUISA, KY 41230		
(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 253	<p>Continued From page 1</p> <p>221, 222, 224, 225, 226 and 227. The toothbrushes were mounted uncovered in an area where staff, family, visitors, and patients could wash their hands and could spray water droplets from contaminated hands onto the uncovered toothbrushes.</p> <p>Observation, on 02/21/13 at 3:15 PM, revealed residents' toothbrushes hanging uncovered, mounted on the wall above the sink, near the faucet handles of the sink, for residents' rooms 201-A, 201-B, 203-A, 203-B, 204-A, 204-B, 205-A, 206-A, 206-B, 207-A, 207-B, 208-A, 208-B, 209-A, 209-B, 210-A, 210-B, 211-A, 211-B, 212-A, 212-B, 213, 214-A, 214-B, 216-A, 216-B, 217-A, 217-B, 218-A, 218-B, 219-A, 219-B, 221-A, 221-B, 222-B, 223-A, 223-B, 224-A, 225-A, 225-B, 226-A, 226-B, 227-A and 227-B. Additionally, rooms 214-A and 214-B's toothbrushes were touching. The toothbrushes were hung in an area where droplets from handwashing could be splashed onto the toothbrushes.</p> <p>Observation, on 02/22/13 at 9:30 AM, revealed State Registered Nursing Aide (SRNA) #1 assisting a resident with the urinal then washing his hands in the sink below the mounting for the toothbrushes in room 223. SRNA #1 shook his hands free of water, after completing the hand hygiene and prior to reaching for paper towels.</p> <p>Observation, on 02/22/13 at 9:35 AM, revealed SRNA #2 assisting a resident with perineal care then washing her hands in the sink below the mountings for the toothbrushes in room 224. SRNA #2 shook her hands free of water, after completing the hand hygiene and prior to</p>	F 253			

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

PRINTED: 03/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/22/2013
NAME OF PROVIDER OR SUPPLIER  J J JORDAN GERIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 270 E CLAYTON LN LOUISA, KY 41230		
(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 253	Continued From page 2 reaching for paper towels.  Interview with SRNA #1, on 02/22/13 at 9:40 AM, revealed it could be an infection control issue for the water droplets to contact the toothbrushes. Interview further revealed the toothbrushes have been removed from the wall at the sink and are now placed in a basin in the resident's night stand.  Interview with SRNA #2, on 02/22/13 at 9:45 AM, revealed it would contaminated the toothbrushes if the water from the hand hygiene were to fall on the toothbrushes. Further interview revealed the toothbrushes have been removed and are now placed in a basin in the resident's night stand.  Interview with the Infection Control Nurse, on 02/22/13 at 10:07 AM, revealed the water from hand hygiene could contaminate the resident's toothbrushes and this would be an infection control issue. Further interview revealed the toothbrushes had been placed in a basin in the resident's night stand and the toothbrush mounts were being removed from the walls.  Interview with the Director of Nursing, on 02/22/13 at 1:10 PM, revealed the water could contaminate the toothbrushes and this would be an infection control issue.	F 253			
F 431 SS=D	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	F 431	The expired sterile water and abdominal pad were removed from the emergency crash cart by the medication nurse on 02/22/13. The medication nurse replaced the items on 02/22/13.  The medication nurse inspected the expiration dates on all items in the emergency crash cart for expired items on 02/22/13.		

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

PRINTED: 03/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/22/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  J J JORDAN GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 270 E CLAYTON LN LOUISA, KY 41230
---	---

(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	<p>Continued From page 3</p> <p>records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and the expiration date when applicable. The facility failed to remove expired items from the facility's</p>	F 431	<p>The Staff Development Coordinator in-serviced the nursing staff on monitoring for proper labeling and expiration dates on all drugs and biologicals on 03/08/13, 03/11/13 and 03/14/13.</p> <p>The medication nurse will inspect for proper labeling and expiration dates on items in the emergency crash cart daily. The Staff Development Coordinator will monitor for proper labeling and expiration dates on drugs and biologicals during monthly surveillance rounds. Findings will be reported to the Performance Improvement Committee quarterly for six months.</p>	3/18/13

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

PRINTED: 03/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/22/2013
NAME OF PROVIDER OR SUPPLIER  J J JORDAN GERIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 270 E CLAYTON LN LOUISA, KY 41230		
(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	<p>Continued From page 4 emergency crash cart.</p> <p>The findings include:</p> <p>Review of the facility's policy, titled Storage of Medications, undated, revealed the facility's policy was there should be no discontinued, outdated, or deteriorated drugs or biologicals available for use in the facility.</p> <p>Observation of the facility's crash cart, on 02/22/13 at 11:05 AM, revealed an abdominal pad with the expiration date of April 2010 and a one hundred and ten (110) milliliter container of sterile water with an expiration date of June 2010.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 revealed that the crash cart was checked at 6:00 AM and 6:00 PM on each day by the LPNs. LPN #1 further states that she was one of the LPNs responsible for checking the crash cart for accuracy. Further interview revealed the items were just missed during the check.</p> <p>Interview with the Director of Nursing, on 02/22/13 at 1:10 PM, revealed the items should have been removed from the crash cart and not available for resident use.</p>	F 431			

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

PRINTED: 03/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/20/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  J J JORDAN GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 270 E CLAYTON LN LOUISA, KY 41230
---	---

(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: 1974</p> <p>Survey under: NFPA 101 (2000 Edition) Chapter 19 (existing health care)</p> <p>Facility type: SNF/NF</p> <p>Smoke Compartment: 7</p> <p>Fire Alarm: Complete fire alarm with smoke detectors in corridors</p> <p>Sprinkler System: Complete automatic sprinkler system</p> <p>Generator: Type II, Natural Gas</p> <p>A standard Life Safety Code survey was conducted on 02/20/13. JJ Jordan Geriatric Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was ninety five (95). The facility is licensed for one hundred four (104) beds.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (life Safety from Fire).</p>	K 000	<p>DISCLAIMER: THE COMPLETION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION THAT THE FACILITY AGREES WITH THE DEFICIENCIES AS STATED IN THE 1567. THE FACILITY IS COMPLETING THE PLAN OF CORRECTION BECAUSE IT IS REQUIRED BY STATE AND FEDERAL LAW. THE FACILITY RESERVES THE RIGHT TO TAKE FURTHER ACTION, INCLUDING ALL LEGAL MEANS NECESSARY, TO RESOLVE ANY DISPUTES ABOUT THE ACCURACY OF THIS INFORMATION.</p> <p style="text-align: center;">RECEIVED MAR 18 2013 BY _____</p>	
K 056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard</p>	K 056		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE ADMINISTRATOR DATE 3/18/13

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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.

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

PRINTED: 03/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/20/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  J J JORDAN GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 270 E CLAYTON LN LOUISA, KY 41230
---	---

(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 056 Continued From page 1  
for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5

K 056  
A sprinkler was installed in the ICF linen closet by Air Gas on 03/11/13.  
  
All other smoke compartments were inspected on 03/12/13 by the Environmental Director to ensure adequate sprinkler coverage throughout the facility.  
  
All smoke compartments will be checked by the Environmental Director during monthly surveillance rounds.  
  
The Environmental Director will report surveillance rounds findings to the Performance Improvement Committee quarterly.

3/19/13

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure complete sprinkler coverage was ensured, according to National Fire Protection Association (NFPA). The deficiency had the potential to affect one (1) smoke compartment, thirty six (36) residents, staff and visitors.

The findings include:

Observations on 02/20/2013 at 1:51 PM, revealed the ICF linen closet was not provided with sprinkler coverage. All areas must be provided with sprinkler protection to ensure protection from fire. The observation was confirmed with the Maintenance Director. Interview on 02/20/2013 at 1:51 PM, with the Maintenance Director, revealed she was unaware the ICF linen closet was not provided with Sprinkler Coverage.

Reference: NFPA 101 (2000 edition)

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

PRINTED: 03/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/20/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  J J JORDAN GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 270 E CLAYTON LN LOUISA, KY 41230
---	---

(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 056 Continued From page 2  
19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.)  
Exception:\* Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met:  
(a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings.  
(b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill.  
(c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.

K 056

Table 19.1.6.2 Construction Type Limitations

Construction Type	Stories			
	1	2	3	4
I(443)	X	X	X	X
I(332)	X	X	X	X
II(222)	X	X	X	X
II(111)	X	X*	X*	NP
II(000)	X*	X*	NP	NP
III(211)	X*	X*	NP	NP
III(200)	X*	NP	NP	NP
IV(2HH)	X*	X*	NP	NP
V(111)	X*	X*	NP	NP
V(000)	X*	NP	NP	NP

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

PRINTED: 03/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/20/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  J J JORDAN GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 270 E CLAYTON LN LOUISA, KY 41230
---	---

(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 056	Continued From page 3 X: Permitted type of construction. NP: Not permitted. *Building requires automatic sprinkler protection. (See 19.3.5.1.) 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5.	K 056		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the emergency generator was maintained according to National Fire Protection Association (NFPA). The deficiency had the potential to affect seven (7) smoke compartments, one hundred four (104) residents, staff and visitors.  The findings include:  Observation, on 02/20/2013 at 2:29 PM, revealed the generator's battery charger was hooked directly to the generator battery. Battery	K 144	The generator battery charger was disconnected from the generator battery by a certified electrician on 03/18/2013. It now has a dedicated circuit. The battery charger is fully hardwired into the generator.  The weekly emergency generator inspection was performed and recorded on the maintenance record by the Environmental Director on 02/22/2013.  The Environmental Director in-serviced maintenance staff about weekly generator inspection and recording the inspection on 02/22/2013.  The maintenance staff will perform and document weekly generator inspections. The Environmental Director will monitor inspection documentation during monthly surveillance rounds and report findings to the Performance Improvement Committee quarterly.	3/18/13

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

PRINTED: 03/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185131</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/20/2013</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>J J JORDAN GERIATRIC CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>270 E CLAYTON LN LOUISA, KY 41230</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 144	<p>Continued From page 4</p> <p>chargers cannot be hooked directly to the generator battery due to increased risk of fire. The observation was confirmed with the Maintenance Director.</p> <p>Interview, on 02/20/2013 at 2:29 PM, with the Maintenance Director, revealed the facility was not aware of the battery charger being hooked directly to the generator battery.</p> <p>Review of the facility's maintenance records for the emergency generator, on 02/20/2013 at 3:47 PM, revealed the facility had not documented weekly inspections for the generator during the dates of 02/22/2013, 02/08/2013, 01/25/2013, 01/10/2013, 11/30/2012, and 11/23/2012. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 02/20/2013 at 3:47 PM, revealed maintenance staff had not completed the proper documentation and she was not aware the documentation had not been completed. Reference: NFPA 110 (1999 Edition), 5-12.6</p> <p>The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturer's recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.</p> <p>Reference: NFPA 110 (1999 edition) 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p>	K 144		
-------	--	-------	--	--

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

PRINTED: 03/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/20/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  J J JORDAN GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 270 E CLAYTON LN LOUISA, KY 41230
---	---

(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 144	Continued From page 5 Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded.	K 144		
K 154 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure a fire watch was put into place while the sprinkler system had been affected by construction, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) smoke compartment, thirty six (36) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 02/20/2013 at 2:01 PM, revealed the male and female bathrooms were being remodeled. Further observation revealed the sprinkler heads for both rooms had been removed. A fire watch must be performed to</p>	K 154	<p>A fire watch was initiated on 02/21/13 for the male and female bathroom area being remodeled by housekeeping staff at the beginning and end of each shift.</p> <p>The sprinkler heads were replaced in the male and female bathrooms on 03/11/13 by Air Gas.</p> <p>All sprinkler heads were inspected throughout the facility by the Environmental Director on 02/25/13.</p> <p>The Staff Development Coordinator and Environmental Director in-serviced all staff on 03/15/2013 and 03/17/2013 about implementing a fire watch in the event the sprinkler system is out of service.</p> <p>The Environmental Director will inspect sprinkler heads monthly during surveillance rounds with findings reported to the Performance Improvement Committee quarterly.</p>	3/18/13

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

PRINTED: 03/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185131</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/20/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>J J JORDAN GERIATRIC CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>270 E CLAYTON LN LOUISA, KY 41230</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 154	<p>Continued From page 6</p> <p>prevent the spread of fire due to lack of sprinkler protection while the system is affected. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 02/20/2013 at 2:01 PM, with the Maintenance Director, revealed a fire watch had done been performed since construction had started on the area three (3) weeks prior. Further interview revealed the facility did have a policy stating a fire watch would be performed when the sprinkler system was not working.</p> <p>Reference: NFPA 101 (2000 edition) 9.7.6.1 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service.</p>	K 154		
-------	--	-------	--	--