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

INSPECTOR GENERAL
PRINTED: 07/23/2014
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 C 06/10/2014
NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR HEALTH & REHABILITATION CENTER			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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	"The preparation and execution of the Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement Of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law."	
F 226 SS=D	<p>AMENDED SOD 07/23/14 - An Abbreviated Survey was initiated on 06/09/14 and concluded on 06/10/14 to investigate KY21807. The Division of Health Care unsubstantiated the allegation with related deficiencies cited.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to follow the Abuse Policy when an allegation of abuse was reported for one (1) of four sampled residents (Resident #2) by notifying the appropriate agencies and protecting residents from potential abuse during an investigation.</p> <p>The findings include: Review of the facility's Abuse Policy, dated 02/05/03 revealed page four (4) of seven (7) section D, item #3 revealed any individual suspected of causing abuse would be removed from direct patient care. Item #5 stated, an incidence could be determined initially to be suspected abuse per the policy. In addition item #5 stated the alleged incident was to be reported to Adult Protective Services (APS) and the Office of the Inspector General (OIG) by phone call or</p>	F 226	<p>Resident #2 has a diagnosis of senile dementia and was unable to provide any information regarding the allegation. This resident is very hard of hearing and did not have hearing aids in at time of reported suspected abuse.</p> <p>Resident #2 was reassessed by the Administrator and Assistant Unit Manager on 5/15/14, on 6/10/14 & 6/25/14 by the Assistant Unit Manager and there were no changes in behavior or demeanor noted.</p> <p>On 6/11/14 the Administrator, DON, ADON, Unit Managers and Assistant Unit Managers reviewed the facility abuse policy including the education process and protecting residents from potential abuse during an investigation.</p> <p>Employees were re- educated on the abuse policy and reporting process by Staff Development Coordinator, DON,</p>	7/5/14

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

Queen Adour

TITLE

Administrator

(X6) DATE

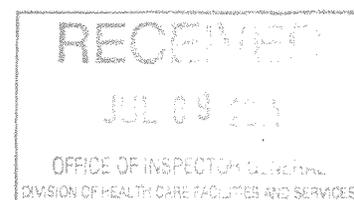
7/9/14

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

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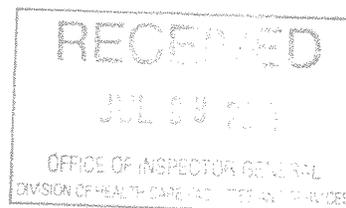
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F 226	Continued From page 1 fax. Item # 6 stated verbal reports were to be reported. Review of the facility's investigation, dated 05/16/14, revealed the facility had no evidence they had followed their policy to report the alleged incident to APS and OIG. In addition, the facility had no evidence the alleged perpetrator was removed from patient care as their policy dictated. Interview with the Administrator, on 06/10/14 at 11:20 AM, revealed when the allegation was reported to her an investigation was initiated with interviews with the staff present at the time the alleged incident was reported. The Administrator did not notify APS, OIG, the family, or the physician as policy dictated. She did not suspend the staff member per policy. Interview with the Director of Nursing (DON), on 06/10/14 at 1:25 PM, revealed the incident of alleged abuse was reported to her and she in turn reported the incident to the Administrator. She did not suspend the staff member as policy dictated. Interview with the Nurse Manager of the Green Unit, on 06/10/14 at 2:05 PM, revealed when the alleged incident of abuse was reported to her by the staff member, she did not follow the facility's policy to protect residents from potential abuse by suspending the alleged perpetrator per policy.	F 226	and Administrator. This was completed by 7/4/14. The Social Services Director, DON and SDC will interview residents and employees to ensure that there have been no new allegations of abuse or neglect that have not been reported. No less than 5 residents and employees will be interviewed weekly times 4 weeks and then no less than 10 residents and employees every month for 2 months. Then no less than 10 residents and employees quarterly. All allegations of abuse or neglect will be reviewed by the facility QA Committee no less than quarterly to ensure the facility policy was followed including reporting, investigation, and protection of the resident during investigation.		
F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest	F 490	Resident #2 has a diagnosis of senile dementia and was unable to provide any information regarding the allegation. This resident is very hard of hearing		



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F 490	<p>Continued From page 2</p> <p>practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to follow their abuse policy which stated the facility was to notify appropriate agencies, suspend the alleged perpetrator, and ensure the safety of residents.</p> <p>The findings include:</p> <p>Review of the facility's Abuse Policy, dated 02/05/03, revealed the facility was to suspend the alleged perpetrator, report the incident to the appropriate agencies which were Adult Protective Services (APS) and Office of the Inspector General (OIG), notify the family and the physician.</p> <p>Review of the investigation, dated 05/16/14, revealed the facility initiated an investigation, but the facility did not suspend the alleged perpetrator nor did they report the alleged incident to the appropriate agencies, APS and OIG.</p> <p>Interview with the Activity Assistant, on 06/10/14 at 10:45 AM, revealed she reported the incident to the manger of the Green Unit and the Director of Nursing (DON) on 05/16/14.</p> <p>Interviews with the Manager of the Green Unit and the Director of Nursing (DON), on 06/10/14 at 1:25 PM, revealed they both had been notified and neither took action to suspend the alleged perpetrator per the facility Abuse Policy.</p>	F 490	<p>and did not have hearing aids in at time of reported suspected abuse.</p> <p>Resident #2 was reassessed by the Administrator and Assistant Unit Manager on 5/15/14, on 6/10/14 & 6/25/14 by the Assistant Unit Manager and there were no changes in behavior or demeanor noted.</p> <p>An Elmcroft clinical consultant re-educated Administrator, DON, Assistant DON, Activity Director, Social Service Director, Dietary Director, Housekeeping and Laundry Director, and Maintenance Director on the facility Abuse Policy this was completed by 7/4/14. A pre and post test was administered to ensure understanding of policy including reporting, investigation, and protection of residents during the investigation. Employees will be re-educated on the abuse policy and reporting process by Staff Development Coordinator, DON, and Administrator. This was completed by 7/4/14. To ensure competency, employees will complete a post test administered by the SDC, DON, Unit Mangers and Department Directors. Any employee that does not pass the post test will be immediately reeducated by their supervisor. This re-education will be repeated monthly for 3 months. New employees are educated on the abuse policy during general orientation and all staff are re-educated no less than annually on the abuse policy.</p>	<p>7/4/14 7-5-14 eng D PB 7-16-14</p>



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F 490	Continued From page 3 Interview with the Administrator, on 06/10/14 at 11:20 PM, revealed when she was notified of the alleged abuse incident she took no action to protect the residents from potential abuse during an investigation by suspending the alleged perpetrator as stated by the policy.	F 490	The Social Services Director, DON and SDC will interview residents and employees to ensure that there have been no new allegations of abuse or neglect that have not been reported. No less than 5 residents and employees will be interviewed weekly times 4 weeks and then no less than 10 residents and employees every month for 2 months. Then no less than 10 residents and employees quarterly. All allegations of abuse or neglect will be reviewed by the facility QA Committee no less than quarterly to ensure the facility policy was followed including reporting, investigation, and protection of the resident during investigation.		

