

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

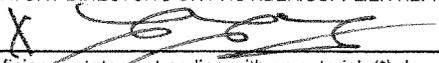
PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/07/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 000	INITIAL COMMENTS A Recertification Survey was initiated on 08/05/14 and concluded on 08/07/14 with deficiencies cited at the highest scope and severity of a "D".	F 000		9/2/14
F 279 SS=D	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 a comprehensive plan of care that included Range of Motion based on the restorative needs for one (1) of the eighteen (18) sampled residents (Resident #9).	F 279	F279 1. Resident #9's restorative program was discharged due to his progress and received orders from orthopedic MD for increase in weight bearing and was admitted to therapy on 8/8/14 2. All residents with restorative programs have the potential to be affected by the deficient practice. A review of all residents with restorative programs will be completed by 8/29/14 by DON or designee to ensure the program(s) are on the comprehensive and nurse aide care plans. 3. The facility will initiate the following practices to ensure the deficient practice does not recur:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE X Administrator X	(X6) DATE 9/4/14
--	-----------------------------------	----------------------------

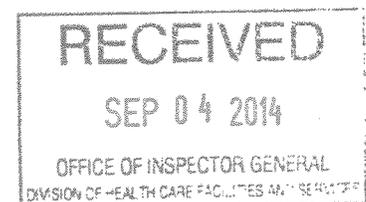
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

RECEIVED
SEP 04 2014
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE SERVICES

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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

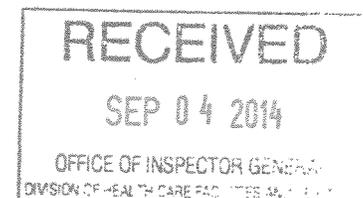
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 279	Continued From page 1 The findings include: The facility did not provide a policy for developing care plans. Observation and interview with Resident #9 during initial tour of the facility, on 08/05/14 at 8:20 AM, revealed the resident was sitting in a chair in his/her room. The resident revealed he/she was not receiving ROM everyday as ordered by the physician and was very concerned about losing ROM in the right shoulder. Observations of Resident #9, on 08/05/14 at 11:30 AM, 1:35 PM, and 3:00 PM, revealed the resident sitting in his/her room and no restorative therapy being done. Interview with the resident, on 08/07/14 at 9:29 AM, revealed he/she did not get restorative therapy for ROM on Tuesday 08/05/14. Review of the clinical record for Resident #9 revealed the facility admitted the resident on 05/30/14 with Amyotrophic Lateral Sclerosis (ALS) and a recent arm fracture from a fall at home. The facility assessed the resident as having impairment to both upper extremities and requiring assistance with all activities of daily living (ADL). Review of the physician's order, dated 07/01/14, revealed an order for Range of Motion (ROM) daily. Further review revealed another physician's order, dated 07/10/14, for gentle full ROM of elbow, wrist and digits frequently throughout the day, and gentle shoulder ROM passive and active assisted, but not forceful. Review of the comprehensive plan of care revealed the ordered ROM by the physician and	F 279	a. Education will be provided to RNAs by the DON by 8/29/14 on following the frequency of restorative care plans and communicating restorative programs not meeting frequency to nurse supervisor. b. The Performance Improvement Committee QA calendar will be updated to include an audit of ROM and Loss of ADLs to be completed monthly by DON or designee. 4. The facility plans to monitor the performance of the solution for sustainability by the following: a. The Performance Improvement		



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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

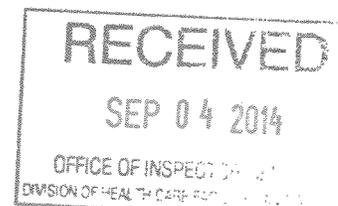
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 279	<p>Continued From page 2</p> <p>therapy based on Resident #9's assessed restorative needs was not reflected on the care plan.</p> <p>Interview with the Occupational Therapist (OT), on 08/07/14 at 1:54 PM, revealed Resident #9 required passive range of motion (PROM) daily to prevent loss of the quality of motion in his/her arm. The OT revealed he trained the restorative therapy assistants in the proper technique and discharged the resident to restorative therapy to continue with the daily PROM.</p> <p>Interview with the Physical Therapist (PT), on 08/07/14 at 11:31 AM, revealed therapy completed the restorative assessment, filled out the referral form, and trained the Restorative Nursing Assistants on the resident's assessed needs and techniques to be used. The PT stated the Nursing Department was responsible for restorative and they would be responsible for developing a plan of care.</p> <p>Interview with Restorative Nursing Assistant (RNA) #1, on 08/07/14 at 1:25 PM, revealed she used the referral form and did not know if Resident #9's ROM was care planned. The RNA stated care plans were normally completed by the Minimum Data Set (MDS) Nurse #1.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 08/07/14 at 3:15 PM, revealed she did not know if Resident #9's restorative therapy was care planned. The LPN revealed the purpose of the care plan was to provide direction on how to meet an assessed goal. The LPN revealed the residents restorative therapy should be care planned and she did not know why it was not done and she did not ensure it was done.</p>	F 279	<p>Committee will review the audits performed monthly and make needed recommendations to the Quality Assurance and Performance Improvement Committee (QAPI).</p> <p>b. The QAPI Committee will review the submitted reports/audits monthly to ensure compliance. Recommendations will be made based on the outcomes of these reports/audits as to needed revisions of the plan of correction.</p>		



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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

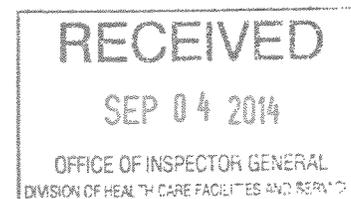
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 279	Continued From page 3 Interview with MDS Nurse #1, on 08/07/14 at 2:50 PM, revealed she did complete Resident #9's assessment, but did not pick up on the fact the resident had been transferred to restorative therapy. The MDS nurse revealed the care plan determined the resident goals and there was a potential for the resident to decline if interventions were not completed to meet that goal. The MDS nurse revealed the ROM should have been care planned. Interview with the Director of Nursing (DON), on 08/07/14 at 3:45 PM, revealed the care plan was used to notify nursing what services the resident received or required. The DON stated ROM was used to maintain a resident's function. The DON further stated ROM did not have to be specifically written on a resident's care plan and could just say restorative therapy. The DON indicated she did not know Resident #9's care plan did not include either ROM or restorative and revealed the facility did not have to provide restorative therapy either. The DON revealed any nurse could develop a care plan, but MDS was responsible to monitor. The DON did not provide information as to how she monitored to ensure care plans were developed to meet the comprehensive needs of the residents.	F 279			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	F282 1. Resident #12 Certified Nursing Assistant (CNA) care plan and comprehensive care plan where reviewed by MDS and updated to include not leaving resident unattended during toileting (8/10/14).	9/2/14	



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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

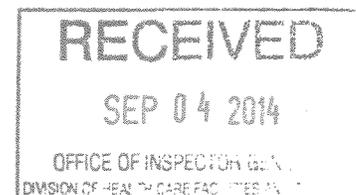
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 282	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined the facility failed to follow the comprehensive care plan for Resident #12. The facility care planned Resident #12 to have assist of two (2) staff when toileting and sustained an unwitnessed fall from the bedside commode in his/her bedroom.</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding following resident care plans.</p> <p>Observation of Resident #12, on 08/06/14 at 12:30 PM, revealed the resident was in a wheelchair in the unit dining room with his/her family member assisting with the lunch meal. Resident #12 displayed a left arm hemiparesis (one sided weakness).</p> <p>Review of Resident #12's clinical record revealed the facility admitted the resident on 07/06/14 with diagnoses of Status Post Cerebrovascular Accident (Stroke), Atrial Fibrillation, and Left Hemiparesis (Left Sided Weakness). The facility completed a Minimum Data Set (MDS) assessment of the resident on 07/13/14 which revealed the resident had a Brief Interview for Mental Status with a score of four (4) indicating a severe cognitive loss. The MDS also indicated the resident required the assistance of two (2) staff when toileting. Review of the initial nursing care plan and the initial nurse aide care plan, each dated 07/06/14, the comprehensive nursing care plan, dated 07/17/14, and therapy notes, dated 07/17/14, revealed Resident #12 was a high falls risk and required assist of two (2) staff</p>	F 282	<p>2. All residents have the potential to be affected by the deficient practice. MDS staff performed an audit on all resident comprehensive care plans and CNA care plans to ensure accuracy and corrected as needed (8/20/14).</p> <p>a. The facility utilizes the guidelines in the RAI manual as its policy for care planning</p> <p>3. The facility will initiate the following practices to ensure the deficient practice does not recur:</p> <p>a. CNA care plans were revised by Medical Records to allow for accessibility of each residents care plan in the resident's room by CNA's carrying the resident care plan on their person (8/20/14).</p>		



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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

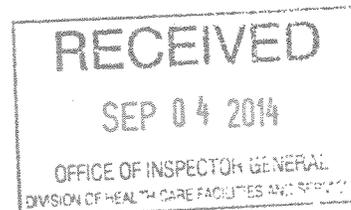
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 282	<p>Continued From page 5 when toileting.</p> <p>Interview with the Minimum Data Set (MDS) Nurse #1, on 08/07/14 at 1:20 PM, revealed the MDS nurses followed the Resident Assessment Instrument of the Minimum Data Set assessment tool to create the comprehensive nursing care plan and the CNA care plan for each resident of the facility. She stated it was very important for all of the nursing staff to follow the nursing care plans as they were based on the comprehensive assessment of each residents' needs.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, on 08/07/14 at 3:30 PM, revealed she was assigned to Resident #12 on the evening of 07/28/14 when the resident fell from the bedside commode. She stated she and another CNA left the resident alone on the bedside commode around 5:00 PM and left the room to give him/her privacy. She further stated she was gone from the room approximately five (5) minutes and upon returning found the resident on the floor. CNA #2 indicated she did not think the resident would fall from the bedside commode. CNA #2 also stated she knew the resident was an assist of two (2) staff when toileting from the CNA care plan and based on the verbal report she received at the beginning of each shift she worked. She stated she had been trained by the facility to follow the guidance from the CNA care plan and from the verbal reports she received and she knew the resident had a Left Sided Weakness and was a high risk for falls.</p> <p>Interview with the Licensed Practical Nurse (LPN) Unit Manager, on 08/07/14 at 3:30 PM, revealed she was aware Resident #12 was an assist of two (2) staff when toileting and she knew the CNA's</p>	F 282	<p>b. Education will be provided to nursing staff by the Staff Development Coordinator on following care plans and new location of care plans (8/29/14).</p> <p>c. The Performance Improvement Committee QA calendar will be updated to include a care plan audit developed by the Administrator and Director of Nursing (DON) to monitor care plan adherence to be performed monthly by the Unit Managers or designee.</p> <p>4. The facility plans to monitor the performance of the solution for sustainability by the following:</p> <p>a. The Performance Improvement Committee will review the care plan audit performed monthly and make needed</p>	



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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

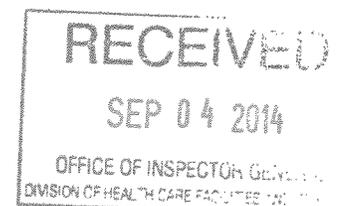
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 282	Continued From page 6 assigned to Resident #12 were aware of that from the reports given to them. She stated the CNA's had access to a CNA Care Plan which was created from the nursing comprehensive care plan and both of those care plans for Resident #12 indicated the resident was an assist of two (2) staff during toileting. The LPN Unit Manager revealed any resident assessed as being a high risk for falls who was not assisted per the care plans could fall and be injured. Interview with the Director of Nursing, on 08/07/14 at 3:40 PM, revealed Resident #12 was assessed as being at high risk for falls by the facility upon admission and the care plans for Resident #12 indicated he/she was to be assisted by two (2) staff when toileting. The DON stated Resident #12 did not have two (2) staff with him/her when the fall from the bedside commode occurred on 07/28/14 and the staff were not following the resident's comprehensive or CNA care plans. The DON further stated she relied on the Unit Managers to monitor the work of the CNA's, but they did not document their monitoring or give her any written reports regarding that monitoring.	F 282	recommendations to the Quality Assurance and Performance Improvement Committee (QAPI). b. The QAPI Committee will review the submitted reports/audits monthly to ensure compliance. Recommendations will be made based on the outcomes of these reports/audits as to needed revisions of the plan of correction.		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318	F318 1. Resident #9's restorative program was discharged due to his progress and received orders from orthopedic MD for increase in weight bearing and was admitted to therapy on 8/8/14	9/2/14	



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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

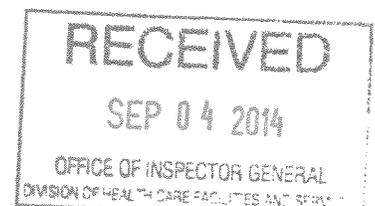
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/07/2014	
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 318	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's Resident Restorative Binder, it was determined the facility failed to provide one (1) of the eighteen (18) sampled residents range of motion (ROM) that was ordered by the physician. (Resident #9).</p> <p>The findings include:</p> <p>The facility did not provide a policy for restorative therapy or ROM.</p> <p>Observation and interview with Resident #9 during initial tour of the facility, on 08/05/14 at 8:20 AM, revealed the resident was sitting in a chair in his/her room. The resident stated he/she was not receiving ROM everyday as ordered by the physician. The resident indicated he/she never received restorative therapy on the weekends and was very concerned about losing ROM in the right shoulder.</p> <p>Review of the clinical record for Resident #9 revealed the facility admitted the resident on 05/30/14 with Amyotrophic Lateral Sclerosis (ALS) and a recent arm fracture from a fall at home. The facility assessed the resident as having impairment to both upper extremities and required assistance with all activities of daily living (ADL). Review of the physician's order, dated 07/01/14, revealed an order for forty (40) to fifty (50) repetitions of motion at elbow to full extension daily, move shoulder to ninety (90) degrees passively forty (40) to fifty (50) repetitions per day, reach across the abdomen to neutral and progress slowly inward, and ROM daily. Further review revealed another</p>	F 318	<p>2. All residents with restorative programs have the potential to be affected by the deficient practice. Review of all residents with active restorative programs to verify both program and care plans state the frequency of the program, to be completed by 8/29/14 by DON and RNAs.</p> <p>a. The facility utilizes the guidelines in the RAI manual as its policy for care planning</p> <p>3. The facility will initiate the following practices to ensure the deficient practice does not recur:</p> <p>a. Education of RNAs to communicate to nurse supervisor when restorative programs are not completed given by DON by 8/29/14.</p> <p>b. DON or designee will monitor "Restorative <6 Occurances" report in</p>	



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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

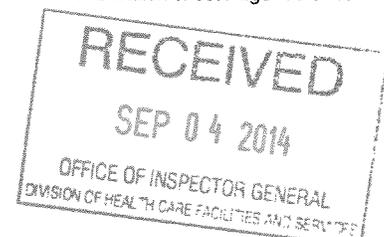
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 318	<p>Continued From page 8</p> <p>physician's order, dated 07/10/14, for gentle, full ROM of elbow, wrist and digits frequently throughout the day, and gentle shoulder ROM passive and active assisted, but not forceful. Review of the Occupational Therapy notes, dated 07/03/14, revealed the resident required skilled services to engage in a passive range of motion (PROM) program to prevent contractures with the right shoulder and to establish a modified Restorative Nursing Program.</p> <p>Interview with the Occupational Therapist (OT), on 08/07/14 at 1:54 PM, revealed he worked with Resident #9 and developed the restorative program. The OT revealed the resident required PROM daily of at least forty (40) repetitions to prevent loss of the quality of motion in his/her arm. The OT revealed he trained the Restorative Nursing Assistants and discharged the resident to restorative to continue with the daily PROM.</p> <p>Continued review of Resident #9's clinical record revealed a physician's progress note, dated 07/17/14, stating therapy transitioned the resident to restorative until the resident could do more and bear weight with his/her arm to prevent all of the insurance benefit money from being used. The note revealed a plan to transition the resident to restorative therapy seven (7) days per week, and then for therapy to pick back up once orders were less restrictive. Review of the physician's progress notes, dated 07/29/14, revealed the resident had voiced a concern that he/she was not consistently receiving ROM.</p> <p>Observations of Resident #9, on 08/05/14 at 11:30 AM, 1:35 PM, and 3:00 PM, revealed the resident sitting in the room and no restorative therapy being done.</p>	F 318	<p>Caretracker daily, address concerns immediately, and report findings to the PI committee</p> <p>4. The facility plans to monitor the performance of the solution for sustainability by the following:</p> <p>c. The Performance Improvement Committee will review the audits performed monthly and make needed recommendations to the Quality Assurance and Performance Improvement Committee (QAPI).</p> <p>d. The QAPI Committee will review the submitted reports/audits monthly to ensure compliance. Recommendations will be made based on the outcomes of these reports/audits as to</p>		



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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

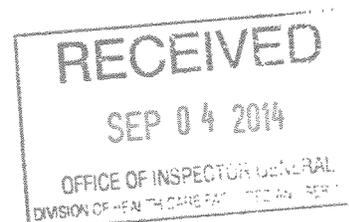
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 318	Continued From page 9 Interview with Resident #9, on 08/07/14 at 9:29 AM, revealed he/she did not get restorative therapy for ROM on Tuesday 08/05/14. The resident revealed no one told him/her it was not going to be done until he/she went to the therapy room and was then told the Restorative Nurse Aide (RNA) was again pulled to work the floor. Review of the Resident Restorative Binder, used by the RNA to document restorative programs provided to residents, revealed Resident #9 had only been active with the Restorative Program for nineteen (19) days and had not received the ordered ROM for six (6) of the nineteen (19) days. Interview with RNA #1, on 08/07/14 at 1:25 PM, revealed she was Resident #9's normally assigned RNA and had eighteen (18) people on her case load. The RNA stated the resident did not get the ordered ROM because she was pulled to work the floor. The RNA continued that she was pulled frequently to work the floor. The RNA indicated there were two people (2) who worked in Restorative, Tuesday thru Friday, and one person on Saturday and Sunday. The RNA stated the weekend people were frequently pulled to work the floor leaving no one to do the Restorative programs. The RNA stated there were thirty-two (32) residents receiving Restorative programs and if one person was pulled it was nearly impossible to get all the residents completed. The RNA further stated she was not aware of how often the resident was to receive ROM as it was not written on the Restorative Referral form; however, therapy was aware of how often the restorative team was pulled, so they trained the second shift nursing	F 318	needed revisions of the plan of correction.		



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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

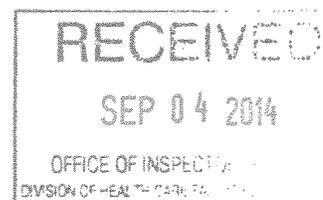
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 318	Continued From page 10 staff to ensure it was done. The RNA revealed the resident had the potential to become stiff in the shoulder and not maintain the strength that was established with therapy if not receiving the ordered ROM. Review of the Restorative Referral, dated 07/17/14, revealed Resident #9 was referred for PROM forty (40) to (50) repetitions of the right shoulder, extension rotation across the abdomen to neutral, and elbow flexion and extension. Interview with the OT, on 08/07/14 at 2:35 PM, revealed he assisted with creating the referral to restorative and did not notice there was no frequency. However, the OT stated he did one on one training with several staff members, including the RNAs, on techniques and that it needed to be done every day. The OT stated the frequency of the physician's orders never changed and the resident should have received ROM every day. Interview with RNA #2, on 08/07/14 at 2:15 PM, revealed she was pulled to work the floor most of the day on 08/06/14 and did not get most of her restorative case load completed. The RNA stated Restorative was assigned to obtain the monthly weights on the first Tuesday of the month which was 08/05/14. The RNA indicated the other restorative person was pulled which left her with over one hundred weights to obtain and she was not able to do the Restorative programs. The RNA further stated Resident #9 was ordered to receive ROM every day, but did not know if that was being done. The RNA revealed she did not tell the nursing staff Resident #9 would not receive their restorative program as everyone knew the other RNA was pulled and weights had to be done.	F 318		



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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

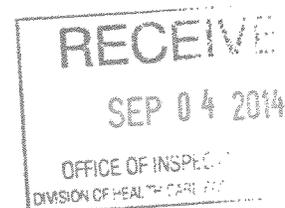
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 318	Continued From page 11 Interview with Certified Nursing Assistant (CNA) #4, on 08/07/14 at 1:45 PM, revealed sometimes she was told by Restorative that they would not be able to complete Resident 9's ROM. However, the CNA stated she was never trained on how to perform the resident's ROM. Interview with RNA #3, on 08/07/14 at 2:04 PM, revealed she did the Restorative programs on Sundays and sometimes helped on Mondays. The RNA stated she was frequently pulled to work the floor, but tried to get some of the Restorative programs completed. However, the RNA indicated she did not do PROM on Resident #9 because she did not have time. The RNA further stated the floor staff was trained by therapy to perform the PROM and should have been completing the Restorative programs if the RNAs could not. Review of the Restorative Therapy schedule revealed RNA #1 worked Monday thru Friday, RNA #2 worked Tuesday thru Saturday, and RNA #3 worked on Sunday which covered the seven (7) days of the week. Interview with CNA #5, on 08/07/14 at 1:52 PM, revealed she did not do any of the Restorative programs if RNA's were pulled to work the floor. Interview with CNA #3, on 08/07/14 at 3:10 PM, revealed she was never trained by therapy to perform Resident #9's PROM. The CNA revealed she was the resident's assigned CNA and had never performed nor been asked to perform the resident's PROM. Interview with the Rehab Department Manager,	F 318		



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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

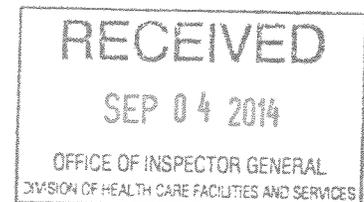
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/07/2014	
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 318	<p>Continued From page 12</p> <p>on 08/07/14 at 4:50 PM, revealed she trained the Restorative Nursing Assistants on the proper techniques for ROM. The Manager stated Resident #9 should have received PROM daily as ordered and the resident's CNA's, Nurses, and Nurse Supervisor were trained to ensure it was done seven (7) days a week.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 08/07/14 at 3:15 PM, revealed she watched the therapy training on Resident #9's PROM. The LPN stated she was aware that restorative was frequently pulled to work the floor, but had never been told the resident's PROM was not completed. The LPN indicated she did not know RNA #1 was pulled to work the floor on 08/05/14. The LPN stated someone should have notified her the resident's PROM was not going to be done. The LPN further stated she was not normally told by Restorative when they would not be able to complete someone's therapy.</p> <p>Interview with the Director of Nursing (DON), on 08/07/14 at 3:45 PM, revealed the physician talked to her about Resident #9 not receiving the ordered PROM and the Physician was told the facility did not provide Restorative Programs seven (7) days a week. The DON stated Restorative programs was just one of the benefits and not something that had to be provided. The DON indicated a potential for the resident to have limited mobility by not receiving the ordered ROM. However, the DON voiced ROM was completed by Restorative, and Restorative was not something that had to be done. The DON stated both therapy and the physician were aware the facility did not have to provide the resident's with ROM.</p>	F 318		



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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

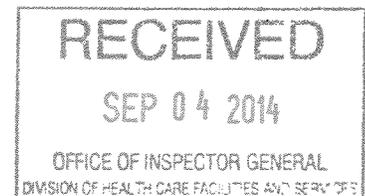
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 318	Continued From page 13 Interview with Resident #9's Physician, on 08/07/14 at 4:35 PM, revealed she talked to both the Unit Manager and the DON regarding Resident #9 not receiving the ROM daily as ordered. The physician stated she was assured by both the Unit Manager and the DON that it would be completed and had never been told that the facility would not be able to provide the ordered Restorative program.	F 318			
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 policy Falls Management, it was determined the facility failed to ensure one (1) of eighteen (18) sampled residents, (Resident #12) received adequate supervision with toileting to prevent an avoidable fall. The facility staff left Resident #12 on the bedside commode unsupervised, and the resident subsequently sustained a fall. The findings include: Review of the facility's policy regarding Falls Management, dated 01/01/10, revealed it was the policy of the facility to screen all residents to	F 323	F323 1. Resident #12 Certified Nursing Assistant (CNA) care plan and comprehensive care plan where reviewed by MDS and updated to include not leaving resident unattended during toileting (8/10/14). 2. All residents have the potential to be affected by the deficient practice. MDS staff performed an audit on all resident comprehensive care plans and CNA care plans to ensure accuracy and corrected as needed (8/20/14). 3. The facility will initiate the following practices to ensure the deficient practice does not recur:	9/2/14	



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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

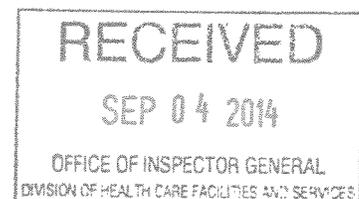
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 323	<p>Continued From page 14</p> <p>identify possible risk factors which would place the resident at risk for falls, to evaluate those risks, to implement interventions to reduce fall risks and to monitor those interventions and modify them when necessary.</p> <p>Observation of Resident #12, on 08/06/14 at 12:30 PM, revealed the resident's family member was assisting with the lunch meal as the resident sat in a wheelchair in the dining room. Resident #12 displayed a left arm hemiparesis (weakness).</p> <p>Review of Resident #12's clinical record revealed the facility admitted the resident on 07/06/14 with diagnoses of Status Post Cerebrovascular Accident (Stroke), Atrial Fibrillation, and Left Hemiparesis (Left Sided Weakness). The facility completed a Minimum Data Set (MDS) assessment of the resident on 07/13/14 which revealed the resident had a Brief Interview for Mental Status with a score of four (4) indicating a severe cognitive loss. The MDS also indicated the resident required the assistance of two (2) staff when toileting. Review of the initial nursing care plan and the initial nurse aide care plan, each dated 07/06/14, the comprehensive nursing care plan, dated 07/17/14, and therapy notes, dated 07/17/14, revealed Resident #12 was a high falls risk and required assist of two (2) staff when toileting.</p> <p>Review of the falls investigation completed for a fall on 07/28/14 at 5:00 PM revealed Resident #12 was found on the floor of his/her bedroom after an unwitnessed fall from the bedside commode. Resident #12 was assessed by the unit nurse as being without injury after the fall.</p> <p>Interview with Certified Nursing Assistant (CNA)</p>	F 323	<p>a. CNA care plans were revised by Medical Records to allow for accessibility of each residents care plan in the resident's room by CNA's carrying the resident care plan on their person (8/20/14).</p> <p>b. Education will be provided to nursing staff by the Staff Development Coordinator on following care plans and location of care plans (8/29/14).</p> <p>c. The Performance Improvement Committee QA calendar will be updated to include an observation audit related to falls management which will be performed by the administrator, DON, Dietary Manager, Housekeeping Supervisor, Social Services Director, Bookkeeper, Activities</p>



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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

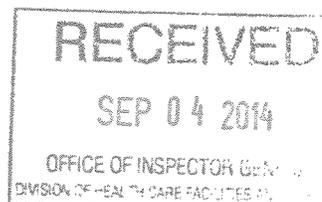
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 323	<p>Continued From page 15</p> <p>#2, on 08/07/14 at 3:30 PM, revealed she was assigned to Resident #12 on the evening of 7/28/14 when the resident fell from the bedside commode. She stated she had assistance getting Resident #12 onto the bedside commode but she and the other CNA left the resident alone on the bedside commode and left the room to give him/her privacy. She further stated she was gone from the room approximately five (5) minutes and upon returning found the resident on the floor. CNA #2 indicated she was aware the resident was an assist of two (2) staff, but she did not think the resident would fall from the bedside commode.</p> <p>Interview with the Licensed Practical Nurse (LPN) Unit Manager, on 08/07/14 at 3:30 PM, revealed she was aware Resident #12 was an assist of two (2) staff when toileting and she knew the CNA's assigned to Resident #12 were aware of that from the reports given to them. She stated the CNA's had access to a CNA Care Plan which was created from the nursing comprehensive care plan and both of those care plans for Resident #12 indicated the resident was an assist of two (2) staff during toileting. She further stated she did spot checks of the CNAs' work but she did not document those checks. The LPN Unit Manager revealed any resident assessed as being a high risk for falls who was not assisted per the care plans could fall and be injured and Resident #12's fall from the bedside commode was probably avoidable.</p> <p>Interview with the Director of Nursing, on 08/07/14 at 3:40 PM, revealed Resident #12 was assessed as being at high risk for falls by the facility upon admission and the care plans for Resident #12 indicated he/she was to be assisted</p>	F 323	<p>Director, ADON, Admissions Director, and Maintenance Director developed by the Administrator and Director of Nursing (DON) to monitor all residents for falls management adherence through visual observation to be performed monthly by the for mentioned individuals.</p> <p>4. The facility plans to monitor the performance of the solution for sustainability by the following:</p> <p>a. The Performance Improvement Committee will review the falls management audit performed monthly and make needed recommendations to the Quality Assurance and Performance Improvement Committee (QAPI).</p>		



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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 323	Continued From page 16 by two (2) staff when toileting. The DON stated Resident #12 did not have two (2) staff with him/her when the fall from the bedside commode occurred on 07/28/14 and if the staff had been present the fall would most likely have been prevented. The DON further stated she relied on the Unit Managers to monitor the work of the CNA's, but they did not document their monitoring or give her any written reports regarding that monitoring.	F 323	b. The QAPI Committee will review the submitted reports/audits monthly to ensure compliance. Recommendations will be made based on the outcomes of these reports/audits as to needed revisions of the plan of correction.		



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

PRINTED: 08/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/05/2014
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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	
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 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 Recertification Life Safety Code Survey was conducted on 08/05/14. The facility 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.