

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

PRINTED: 09/06/2011
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 C 08/26/2011
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NAME OF PROVIDER OR SUPPLIER J J JORDAN GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 270 E CLAYTON LN LOUISA, KY 41230
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS	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 2567. THE FACILITY IS COMPLETING THE PLAN OF CORRECTION BECAUSE IT IS REQUIRED BY STATE AND FEDERAL LAW. THE FACILITY DISAGREES AND DISPUTES THE DEFICIENCIES STATED IN THE 2567. ALSO THE FACILITY RESERVES THE RIGHT TO TAKE FURTHER ACTION, INCLUDING ALL LEGAL MEANS NECESSARY, TO RESOLVE ANY DISPUTES ABOUT THE ACCURACY OF THIS INFORMATION. (THE FACILITY IS PURSUING THE IDR PROCESS TO CONTEST SOME OF THE CITED DEFICIENCIES).	
F 223 SS=D	<p>483.13(b), 483.13(b)(1)(I) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy it was determined the facility failed to ensure a resident was protected from abuse during an investigation of an allegation of abuse by allowing the alleged perpetrator to continue to work during the investigation for one (1) of six (6) sampled residents. Resident #1 made an allegation a staff member had kissed the resident on the lips and the Administrator failed to remove this staff member from possible contact with the resident during the investigation time frame.</p> <p>The findings include:</p>	F 223	<p>Resident #1 is a 42-year old individual who is completely alert, oriented, and interviewable. Immediately upon learning of the statement that Resident #1 had been kissed on the lips by Housekeeper #1, the Facility Administrator initiated an investigation. As part of the investigation process, the Facility Administrator interviewed Resident #1. During the interview, Resident #1 stated that Housekeeper #1 was a family friend whom she had known for several years. Resident #1 further stated that Housekeeper #1's actions were innocent and she was not in any way troubled or upset by them.</p> <p>Interviewed multiple residents and staff throughout the Facility and there were no complaints or issues regarding Housekeeper #1.</p> <p>Administrator in-serviced by counsel Marian Hayden on needed policy clarifications. Clarified Facility policy and re-in-serviced staff regarding removal of alleged perpetrator from the building pending investigation.</p> <p>Staff Development Coordinator in-serviced all staff on 8/26/2011, 8/30/2011, 8/31/2011, 09/7/2011, 9/9/2011, and 9/15/2011 regarding abuse and neglect.</p> <p>Social Worker will perform random checks (3) regarding removal of staff after any allegations of abuse, neglect or exploitation. Results will be reported quarterly to the Performance Improvement Committee to verify and ensure compliance with policy and regulations.</p>	9/21/2011

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OCT 17 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X8) DATE 10/6/11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	Continued From page 1 Review of the facility's policy titled "Abuse/Neglect", not dated, revealed employees involved in an incident reported as neglect or abuse are immediately relieved of responsibilities that involve direct care, and are assured that their payroll check will include all scheduled hours during the period of investigation. Review of the resident's medical record revealed the facility admitted the resident on 07/22/10 with diagnoses which included Dwarfism, Convulsions and Depressive Disorder. Interview, on 08/24/11 at 5:30 PM, with Resident #1 revealed the resident knew Housekeeper #1 was still working after he/she made the allegation. Interview, on 08/26/11 at 9:15 AM, with the Administrator revealed he did not remove Housekeeper #1 from her duties, as per the facility's policy. Interview, on 08/26/11 at 12:10 PM with Housekeeper #1 revealed the Administrator was going to suspend her and then Resident #1 began to change his/her story.	F 223		
F 225 SS=D	483.13(c)(1)(II)-(III), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would	F 225	Resident #1 is a 42-year old individual who is completely alert, oriented, and interviewable. Immediately upon learning of the statement that Resident #1 had been kissed on the lips by Housekeeper #1, the Facility Administrator initiated an investigation. As part of the investigation process, the Facility Administrator interviewed Resident #1. During the interview, Resident #1 stated that Housekeeper #1 was a family friend whom she had known for several years. Resident #1 further stated that Housekeeper #1's actions were innocent and she was in no way troubled or upset by them.	9/21/2011

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F 225	<p>Continued From page 2</p> <p>Indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review it was determined the facility failed to ensure an allegation of abuse was reported to the State Survey and Certification Agency for one (1) of six (6) sampled residents, Resident #1. Resident #1 reported an allegation a staff member had kissed the resident on the lips to a State Registered Nursing Assistant (SRNA) who</p>	F 225	<p>Interviewed multiple residents and staff throughout the Facility and there were no complaints or issues regarding Housekeeper #1.</p> <p>Administrator is serviced by counsel Marian Hayden on needed policy clarifications. Administrator clarified Facility policy and re-inserviced staff regarding reporting allegations of potential abuse, neglect or exploitation to the state agency.</p> <p>Social Worker will perform random checks (3) regarding reporting allegations of potential abuse, neglect or exploitation every three months. Results will be report quarterly to the Performance Improvement Committee.</p>		

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F 225	<p>Continued From page 3</p> <p>then reported the allegation to the Nurse taking care of the resident. The Nurse reported the allegation to the Administrator who failed to report the allegation to the State Survey and Certification Agency, per the facility's policy.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Abuse/Neglect", not dated, revealed observations that indicate possible neglect or abuse must be reported without delay to the first line of supervision available, who will in turn communicate the problem through lines of authority to the Administrator. It further stated reports which are considered valid must be reported to the responsible party, physician, and regulatory agencies....without delay. The investigative report must be issued within five (5) working days unless more time is required and negotiated with regulatory agencies. The report must be made available to all persons involved or agencies receiving the original report.</p> <p>Review of the resident's medical record revealed the facility admitted the resident on 07/22/10 with diagnoses which included Dwarfism, convulsions and depressive disorder.</p> <p>Interview, on 08/24/11 at 5:30 PM, with Resident #1 revealed the resident stated he/she had been told an investigation would be done because Housekeeper #1 had kissed her on the lips. The resident further stated he/she had retracted his/her statement because staff had told him/her, he/she was lying. Resident #1 further stated he/she had been friends with Housekeeper #1 and felt bad because he/she had lost a friend.</p>	F 225		

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F 225	Continued From page 4 Interview, on 08/26/11 at 9:15 AM, with the Administrator revealed Resident #1 initially told him when he interviewed him/her it was not a problem and Housekeeper #1 had not kissed him/her in a sexual manner. He indicated the resident had stated he/she did not know where he got his information from. He further stated he did not report the incident to the State Survey and Certification Agency because when the resident was interviewed he/she stated the incident did not occur.	F 225		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review it was determined the facility failed to ensure residents received services in the facility with reasonable accommodations for three (3) unsampled residents and one (1) sampled resident, Resident #6. Unsampled Residents A, C and D where observed to be in their rooms and their call lights were not in reach. Interviews with staff revealed the call lights should always be in reach of the resident because if they needed something they would not be able to notify the staff.	F 246	The call lights for sampled resident #6 and un sampled residents A, C, & D were immediately placed with in easy reach on August 26, 2011 by nursing staff. The call lights of all other residents were checked by nursing supervisors to make sure they were with in easy reach of all residents on August 26, 2011. The staff development coordinator in-serviced all nursing staff on proper placement of call lights including ensuring all call lights are with in easy reach of the residents. The in-services were conducted on the following dates: August 26, 2011, September 07, 2011, and September 09, 2011. The nursing supervisors will monitor each staff to be sure call lights are with in easy reach of all residents. The staff development coordinator will monitor call lights for all residents during monthly surveillance rounds for six months to ensure call lights are properly placed and with in easy reach. Findings will be reported to the Performance Improvement Committee quarterly.	9/21/2011

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F 246	<p>Continued From page 5</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Call Light, Answering", not dated, revealed when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.</p> <p>1. Observation, on 08/24/11 at 9:30 AM, revealed Unsampld Resident A was lying in bed and his/her call light was noted to be lying in the floor. The resident stated, on 08/24/11 at 9:32 AM, he/she was unable to reach the all light.</p> <p>interview with Certified Medication Aide (CMA) #1, on 08/24/11 at 9:40 AM, revealed Unsampld Resident A's call light was not in reach and it should be because if the resident could not get help if he/she needed help. She further indicated the staff knew this.</p> <p>Continued observation, on 08/25/11 at 12:20 PM, revealed Unsampld Resident A was sitting in his/her chair eating lunch and his/her call light was noted to be lying on the bed. The resident stated he/she could not reach the call light and stated he/she needed to go to the bathroom.</p> <p>Interview, on 08/25/11 at 12:20 PM, with State Registered Nursing Assistant (SRNA) #1 revealed the resident could not reach the call light and if he/she needed assistance the resident would not be able to call for assistance.</p> <p>2. Observation, on 08/24/11 at 9:42 AM, revealed Resident #6 was sitting up to a wheelchair towards the end of the bed and the residents call light was laying on the bed near the</p>	F 246		

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F 246	<p>Continued From page 6</p> <p>head of the bed. The resident indicated he/she could not reach the call light while sitting in the wheelchair related to "one side of me is paralyzed".</p> <p>Interview with Registered Nurse (RN) #1, on 08/24/11 at 9:42 AM, revealed the resident could not reach the call light related to paralysis on one side of the resident.</p> <p>3. Observation, on 08/25/11 at 12:35 PM, revealed Unsamped Resident C was sitting in his/her Geri chair eating lunch and the call light was noted to be lying on the bed. The resident stated he/she could not reach the call light and wanted to sit in the recliner now instead of the Geri chair.</p> <p>Interview on 08/25/11 at 12:35 PM with CMA #1 revealed Unsamped Resident C could not reach his/her call light so he/she would be unable to call for assistance.</p> <p>4. Observation, on 08/25/11 at 12:39 PM, revealed Unsamped Resident D was lying in bed and his/her call light was wrapped around the bedside rail and the button portion of the call light was between the mattress and rail near the bottom of the mattress. The resident was unable to reach the call light when asked if he/she could.</p> <p>Interview with SRNA #2, on 08/25/11 at 12:39 PM, revealed call lights should always be in reach no matter what and this resident was unable to reach his/her call light.</p> <p>Continued observation, on 08/25/11 at 8:09 PM, revealed Unsamped Resident D was lying in the</p>	F 246		

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F 246	Continued From page 7 bed and his/her call light was noted to be between the mattress and the side rail. The resident stated he/she was unable to reach the call light. Interview with SRNA #4, on 08/25/11 at 8:09 PM, revealed the resident could not call for assistance if he/she needed it because the call light was not in reach.	F 246		
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review it was determined the facility failed to distribute food under sanitary conditions related to temperatures were not measured for all food items prior to the food being served to residents. The findings include: Review of the facility's policy titled "Food Temperatures", dated 2010, revealed the temperatures of the food items will be taken and properly recorded for each meal.	F 371	On 08/24/2011 cook #1 was in-serviced by Dietary Manager on taking and recording of all food items on the tray line. Dietary Manager also in-serviced the rest of the dietary staff on taking and recording the temperatures of all food items on the tray line prior to meals service, beginning and approximately midway through the meal service per department policy. Dietary staff was also in-serviced on the correct procedure for reheating foods in the microwave per department policy. Tray line food temperatures are completed by the cooks for each meal and recorded on a temperature log. Microwave temperature logs are completed with each food item that is reheated in the microwave by dietary staff. Temperature logs are reviewed by Dietary Manager for completion and accuracy daily Monday through Friday with weekend logs reviewed on Monday mornings with completion of temperature log monitoring form. Beginning on September 14, 2011, the registered dietitian will observe lunch and dinner tray line temperatures being taken by cook prior to meal service and approximately midway through meal service when in the facility. Registered dietitian will submit a written report regarding her observation. All tray line food and microwave temperature monitoring logs and Registered Dietitian reports will be reviewed by the Performance Improvement Committee quarterly.	9/21/2011

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F 371	<p>Continued From page 8</p> <p>Review of the "Resident Census and Resident Condition", completed by the facility on 08/24/11 revealed fifty-four (54) residents of ninety-six (96) received mechanically altered diets including pureed and all chopped food (not only meat).</p> <p>Observation, on 08/24/11 at 11:24 AM, revealed Cook #1 did not measure temperatures of the ground turkey, chopped turkey, gravy or noodles.</p> <p>Observation, on 08/24/11 at 11:58 AM, revealed a bowl of tomato soup was heated in the microwave and sent out to a resident without having the temperature taken prior to being sent out to a resident.</p> <p>Observation, on 08/24/11 at 12:04 PM, revealed a bowl of hot cereal was heated in the microwave and sent out to a resident without having the temperature measured first.</p> <p>Interview with the Dietary Manager, on 08/24/11 at 12:30 PM, revealed temperatures should be measured for all foods before they were served to residents.</p>	F 371		
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