

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

PRINTED: 06/02/2010
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 05/27/2010
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE			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	F 000	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	6-22-10
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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

TITLE

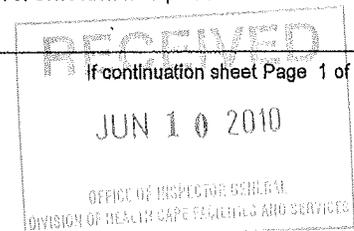
(X6) DATE

Wendy Biddle

Administrator

6-10-2010

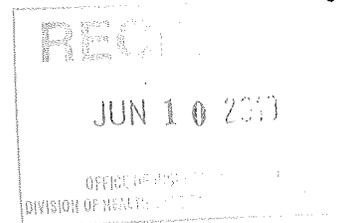
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable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



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

PRINTED: 06/02/2010
FORM APPROVED
OMB NO. 0938-0391

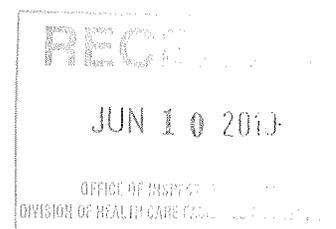
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/27/2010
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 441	<p>Continued From page 1</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to follow standards of practice regarding infection control during the dressing change for one (1) of thirteen (13) sampled residents, (Resident #5).</p> <p>The findings include:</p> <p>Record review of Resident #5, admitted on 03/19/10, revealed the resident was admitted with a Fractured Right Ankle, and a pressure area located on the outer aspect of the right ankle. According to the physician's note on 05/20/10 the wound along the incision site was exposing the metal plate which was inserted during surgery to repair the fractured ankle. Yellow slough was noted and the resident was placed on Keflex 500mg four times a day. Betadine wet to dry dressing changes were ordered to be done twice a day.</p> <p>Interview with the daughter of Resident #5 on 05/25/10 at 3:15pm revealed the surgical wound looked infected approximately two (2) weeks prior. The resident was seen by the physician and he stated the skin did not always heal over the metal plate. The resident was seen by the physician again a week earlier and was put on an antibiotic with instructions to return 05/27/10 to consider options to close the wound.</p>	F 441	<p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice,</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>*The Director of Nursing immediately reeducated LPN #1 regarding the proper technique for clean or sterile dressing changes. Education has addressed the following... frequency and timing of washing hands, use and choice of gloves, setting up a sterile field, preparing the area for</p>	



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

PRINTED: 06/02/2010
FORM APPROVED
OMB NO. 0938-0391

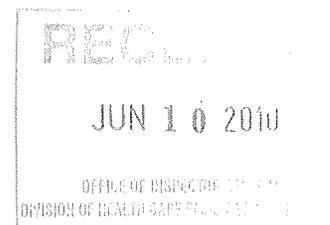
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/27/2010
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE 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 441	<p>Continued From page 2</p> <p>Observation of the dressing change on 05/27/10 at 8:10am revealed Licensed Practical Nurse (LPN) #1 washed her hands and put on non-sterile gloves. She proceeded to remove the old dressing by cutting the Kerlix with her own scissors. The dressing was removed and discarded in the trash can. The dressing supplies were placed on the bedside table with no cleaning or prepping of the area. Then LPN #1 placed a dry 4x4 gauze on the outer wrapper of the gauze and then placed two (2) Betadine wipes on top of the 4x4 gauze. She then irrigated the wound with normal saline and applied the 4x4 gauze that contained the Betadine swipes. She measured the wound as 1.8cm x 1cm with a depth of 0.3cm with the metal plate exposed. The ankle was then wrapped in Kerlix. The dressing supplies were removed from the bedside table. No cleaning of the bedside table was observed. LPN #1 washed her hands and returned her scissors to her pocket. Observation of the dressing change revealed LPN #1 did not follow proper technique for clean or sterile dressing changes.</p> <p>Interview with LPN #1 on 05/27/10 at 8:30am revealed she should have cleaned her scissors before returning them to her pocket. LPN #1 admitted she should have changed gloves between removing the old dressing and applying a new dressing. She did not feel the dressing required sterile technique.</p> <p>Interview with the Director of Nursing (DON) on 05/27/10 at 8:40am revealed the LPN did not follow standards of practice for dressing changes. The DON stated her expectation would be that the LPN should use sterile technique including sterile gloves for the dressing change on Resident #5. The DON stated LPN #1 should</p>	F 441	<p>supplies, preparing tools, glove changing, rewashing of hands, bagging and disposal of soiled dressings.</p> <p>*On or before June 22, the Director of Nursing or her designee has reeducated all licensed associates responsible for dressing changes regarding the proper technique for clean or sterile dressing changes. Education has addressed the following... frequency and timing of washing hands, use and choice of gloves, setting up a sterile field, preparing the area for supplies, preparing tools, glove changing, rewashing of hands, bagging and disposal of soiled dressings.</p> <p>*The Director of Nursing or her designee will monitor each licensed associate responsible for dressing changes for proper technique during dressing changes to ensure demonstration of the proper practice.</p>	



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

PRINTED: 06/02/2010
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 05/27/2010
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE			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 441	Continued From page 3 disinfect the scissors prior to and after a dressing change. She also stated the nurse should change gloves and wash her hands between the removal of the old dressing and application of the new dressing. The DON stated sterile technique is not required for dressing changes for Stage I and Stage II pressure. According to the DON the facility uses the Springfield Nursing Procedures for the standards of nursing practice. The Springfield Nursing Procedures states the nurse should change gloves between removing the old dressing and applying the new dressing for pressure ulcers. The standards for surgical wound dressings include sterile technique. The nurse should wash hands, don gloves, remove the old dressing and discard. The nurse should proceed to wash his/her hands and set up a sterile field, don sterile gloves and proceed with the dressing change. All soiled dressings should be bagged and discarded according to facility policy.	F 441	*The Director of Nursing or her designee will monitor each licensed associate responsible for dressing changes at least once each quarter. The Director of Nursing will report the results of these audits to the Quality Assurance Committee each quarter.		



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

PRINTED: 06/14/2010
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 06/09/2010
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE	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	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 06/09/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	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.