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OFFICE OF INSPECTOR GENERAL
HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185169	A. BUILDING _____ B. WING _____	C 07/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE AT JEFFERSON MANOR REHAB & WE	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)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY# 31910 and a COVID-19 Focused Infection Control Survey was initiated 07/02/2020 and concluded on 07/10/2020. KY# 31910 was unsubstantiated however, related deficiencies were cited. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 72.	F 000	Preparation and execution of this allegation of compliance does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in alleged deficiencies. This allegation of compliance is prepared and/or executed solely because it is required by the provisions of Federal and State law.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656	How correction action will be accomplished for those residents found to have been affected by the deficient practice; The care plan has been updated on Resident #3 and #4 to reflect their adaptive equipment being utilized on 7/15/20 by Special Projects, Clinical Reimbursement Specialist. How the facility will identify other residents having the potential to be affected by the same deficient practice; All physician's orders were reviewed by the Administrator to verify those residents with adaptive equipment orders on 7/13/20. The Special Projects, Clinical Reimbursement Specialist reviewed all care plans of those residents with adaptive equipment orders and implemented care plans on 7/15/20.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 7-29-20

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 656	Continued From page 1 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to implement the care plan for two (2) residents, Residents #3 and #4. Observations revealed facility-provided meal trays did not contain the care planned adaptive utensils or equipment. The findings include: Review of facility policy Comprehensive Care Plans (CCP), revised 07/19/18, revealed the person-centered Comprehensive Care Plan included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs and was developed for each	F 656	What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur; MDS Coordinator's, Licensed staff and Unit Managers were educated on 7/15/20, 7/16/20 7/17/20, 7/20/20, 7/24/20, 7/25/20, 7/26/20 and 7/27/20. to implement care plans to include adaptive equipment ordered for residents. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and The DON, Unit Managers and/or Administrator are auditing for implementation of care plans related to adaptive equipment in their daily clinical meeting. These audits began on 7/17/20 and are ongoing as part of clinical meeting. Any issued identified will be corrected immediately and staff will be counseled as necessary. Results from audits will be reviewed by the QAPI committee monthly for further review and recommendations. Completion Date – 7/30/2020	

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F 656	Continued From page 2	F 656		

resident. Additionally, the CCP included how the facility assisted the resident to meet their needs, goals and preferences and included specialized services.

Review of facility policy Adaptive Equipment - Feeding Devices, revised 08/30/19, revealed adaptive feeding equipment was used by residents who needed to improve their ability to feed themselves.

Review of facility record revealed the facility re-admitted Resident #3 on 01/23/2020 with diagnoses including Diabetes Type 2, Iron Deficiency Anemia, Muscle Weakness, and Vitamin Deficiency, Unspecified.

Review of the Physician Orders for Resident #3 revealed an order dated 05/21/2020 that specified Diet: regular consistency CCHO (consistent carbohydrate) no salt packets, no bananas, no oranges/OJ (orange juice), no fresh potatoes. Divided plate and a ninety (90) degree spoon.

Review of the CCP revealed the problem resident has a potential for nutritional risks, secondary to the following conditions: Diabetes Mellitus Type 2, Dementia, and High BMI (body mass index). An approach for this problem listed to provide diet as ordered.

Observation during lunch service, on 07/02/2020 at 12:20 PM, revealed Resident #3's tray contained no ninety (90) degree spoon and the resident was utilizing a regular teaspoon to eat. Review of the tray card specified the tray required a ninety (90) degree spoon.

Review of facility record revealed the facility

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F 656	Continued From page 3 re-admitted Resident #4 on 02/13/19 with diagnoses including Multiple Sclerosis, Muscle Weakness, and Dysphagia, Oropharyngeal Phase. Review of the Physician Orders for Resident #4 revealed an order in the section, Dietary Flow Sheet, dated 03/02/2020 that specified sippy cup for liquids at meals. Review of the CCP revealed a problem nutritionally at risk related to therapeutic diet and noncompliance with diet. Risk for alterations in fluid maintenance related to heart failure with diuretic use. Approaches for the Problem included diet as ordered. Observation during lunch service, on 07/02/2020 at 12:37 PM, revealed Resident #4's tray contained a cup of water and a cup containing a light yellow liquid. Interview with Certified Nursing Assistant (CNA) #1, on 07/02/2020 at 1:00 PM, revealed CNA's were responsible to insure resident meal trays included the correct adaptive equipment. CNA #1 stated adaptive equipment was necessary to enable a resident to eat better and prevent potential choking. Interview with Licensed Practical Nurse (LPN) #2, on 07/08/2020 at 1:19 PM, revealed all staff were responsible to insure the resident's meal trays contained the ordered and care planned adaptive utensils. LPN #2 stated adaptive utensils were necessary to insure a resident did not potentially lose nutrition. LPN #2 stated the care plan was not implemented if staff did not provide the ordered and care planned adaptive equipment.	F 656		

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F 656	Continued From page 4	F 656		

Interview with LPN #4, on 07/09/2020 at 3:25 PM, revealed staff developed resident care plans with goals and guidelines to meet the goals and if staff did not provide care planned adaptive equipment then staff did not implement the care plan.

Interview with Green Unit Manager (Green UM), on 07/08/2020 at 4:04 PM, revealed resident care plans directed staff on the care necessary for the resident and staff implemented the care plan to provide good and necessary care. The Green UM stated staff individualized resident care plans to meet the care needs of the resident and all staff were responsible to insure meal trays contained the ordered adaptive equipment.

Interview with the Blue Unit Manager (Blue UM), on 07/09/2020 at 2:55 PM, revealed staff individualized care plans to each resident to address the resident's medical needs. The Blue UM stated CNA's were responsible to insure adaptive equipment was included on resident meal trays.

Interview with the Dietary Manager (DM), on 07/09/2020 at 2:01 PM, revealed dietary staff initially prepare resident trays, including providing adaptive equipment as ordered. The DM stated adaptive equipment was necessary to help the resident eat and failure to provide adaptive equipment may hinder a resident from eating or drinking properly.

Interview with the Director of Nursing (DON), on 07/10/2020 at 8:45 AM, revealed all staff were responsible to insure resident meal trays contained adaptive equipment as ordered.

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F 656 Continued From page 5

Interview with the Administrator, on 07/10/2020 at 9:42 AM, revealed she was unaware of any issue with residents receiving adaptive equipment with meal trays. The Administrator stated the facility audited orders to meal tray cards but did not specify if the facility audited meal tray cards to the meal tray provided to residents.

F 761 Label/Store Drugs and Biologicals
SS=D CFR(s): 483.45(g)(h)(1)(2)

§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

F 656

F 761

How corrective action will be accomplished for those residents found to have been affected by deficient practice;
No residents were affected by the cited deficiency.
The expired normal saline solution, sterile saline solution, oxygen tubing and IV start kits were removed from emergency cart on 7/2/20 by Central Supply Clerk.

How the facility will identify other residents having the potential to be affected by the same deficient practice;
The Central Supply Clerk audited the two emergency carts on 7/2/20 to verify no another expired items were on the emergency carts.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
Licensed nursing staff were educated on the addition of expiration dates to be

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F 761	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure drugs and biologicals were stored in a professional standard to prevent the presence of expired items. Observations revealed expired normal saline solution and sterile saline solution present in the emergency carts. In addition, continued observation revealed expired medical supplies including oxygen tubing and intravenous (IV) start kits. The findings include: Review of facility policy Emergency Carts, reviewed 07/24/18, revealed the facility insured emergency equipment was readily available and the emergency cart and staff audited the carts daily and restocked as indicated. Observation of the emergency cart on Blue Unit, on 07/02/2020 at 1:49 PM, revealed a one (1) liter bag of normal saline with an expired date, a one hundred (100) milliliter container of sterile saline with an expiration date of 03/08/19. Additional observations revealed an IV start kit with an expiration date of 05/31/19, and an IV tubing administration set with an expiration date of 09/2019. Observation of the emergency cart on the Green Unit, on 07/02/2020 at 2:40 PM, revealed a one hundred (100) milliliter container of sterile saline solution with an expiration date of 03/08/19 and an IV start kit with an expiration date of 05/31/2020.	F 761	included on the audit of emergency carts by the Staff Development Coordinator on 7/15/20, 7/16/20, 7/17/20, 7/20/20, a7/24/20, 7/25/20, 7/26/20 & 7/27/20. Any staff not educated by 7/29/20 will not work until education has been completed. How the facility will monitor its corrective actions(s) to ensure that the deficient practice is being correction and will not recur, and The Unit Manager(s) will audit the emergency cart(s) weekly for any expired medications. These audits began on 7/24/20. Any issues identified will be corrected immediately and staff will be counseled as necessary. Results from the audits will be reviewed by the QAPI committee monthly for further review and recommendations. Completion Date – 7/30/20	

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F 761	Continued From page 7	F 761		

Interview with Blue Unit Manager (Blue UM), 07/02/2020 at 1:49 PM, revealed staff should check for product expiration dates when auditing emergency carts and indicated all items listed on the inventory should be present and unexpired. The Blue UM stated an expired item may not have the effect as intended and sterility was not guaranteed.

Interview with the Green Unit Manager (Green UM), on 07/02/2020 at 2:40 PM, revealed staff should check product expiration dates when auditing the emergency carts. The Green UM stated expired items might not have the sama efficacy as intended; and use of expired items may delay care and a resident status may decline.

Interview with Licensed Practical Nurse (LPN) #2, on 07/08/2020 at 1:19 PM, revealed staff audited emergency carts to insure items were stocked appropriately and not expired. LPN #2 stated using expired items might lead to an allergic reaction, and a delay in care.

Interview with the Director of Nursing (DON), on 07/10/2020 at 8:45 AM, revealed she was unaware the facility emergency cart audit checklist did not prompt staff to audit product for an expiration date. The DON stated she was unaware of any issues concerning the facility emergency carts.

Interview with the Administrator, on 07/10/2020 at 9:42 AM, revealed she was unaware of any issues surrounding the facility emergency crash carts.

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F 810 SS=D	Continued From page 8 Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide special eating equipment and utensils for two (2) residents, Residents #3 and #4. Observations revealed facility-provided meal trays did not contain the ordered adaptive equipment. The findings include: Review of facility policy Adaptive Equipment - Feeding Devices, revised 08/30/19, revealed adaptive feeding equipment was used by residents who needed to improve their abilIty to feed themselves. Review of facility record revealed the facility re-admitted Resident #3 on 01/23/2020 with diagnoses including Diabetes Type 2, Iron Deficiency Anemia, Muscle Weakness, and Vitamin Deficiency, Unspecified. Review of the Physician Orders for Resident #3 revealed an order dated 05/21/2020 that specified Diet: regular consistency CCHO (consistent carbohydrate) no salt packets, no bananas, no oranges/OJ (orange juice), no fresh potatoes.	F 810 F 810	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #3 and #4 had no adverse effects related to adaptive equipment not being on tray on survey date of 7/2/20. How the facility will identify other resident's having the potential to be affected by the same deficient practice; All physician orders were reviewed by Administrator on 7/13/20 to verify all resident receiving adaptive equipment were listed on dietary's adaptive equipment list. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur; Education was provided to Licensed staff, Certified Nursing Assistants, dietary staff, therapy and Ambassadors by the Staff Development Coordinator on 7/15/20, 7/16/20, 7/20/20, 7/23/20, 7/24/20, 7/25/20, 7/26/20 and 7/27/20 on reading tray card for adaptive equipment and verifying resident has it on their meal tray. Any staff not educated by 7/29/20 will not be allowed to work until education is completed.	

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F 810	Continued From page 9 Divided plate and a ninety (90) degree spoon. Review of the CCP revealed the problem resident has a potential for nutritional risks, secondary to the following conditions: Diabetes Mellitus Type 2, Dementia, and High BMI (body mass index). An approach for this problem listed to provide diet as ordered. Observation during lunch service, on 07/02/2020 at 12:20 revealed Resident #3's tray contained no ninety (90) degree spoon and the resident was utilizing a regular teaspoon to eat. Review of the tray card specified the tray required a ninety (90) degree spoon. Review of facility record revealed the facility re-admitted Resident #4 on 02/13/19 with diagnoses including Multiple Sclerosis, Muscle Weakness, and Dysphagia, Oropharyngeal Phase. Review of the Physician Orders for Resident #4 revealed an order in the section, Dietary Flow Sheet, dated 03/02/2020 that specified sippy cup for liquids at meals. Review of the CCP revealed a problem nutritionally at risk related to therapeutic diet and noncompliance with diet. Risk for alterations in fluid maintenance related to heart failure with diuretic use. Approaches for the Problem included diet as ordered. Observation during lunch service, on 07/02/2020 at 12:37 PM, revealed Resident #4's tray contained a cup of water and a cup of a light-yellow colored liquid.	F 810	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and Dietary Manager and or Dietary Assistant is randomly auditing three trays a day, five days a week to verify adaptive equipment is on the tray. This audit began on 7/20/20. Department Managers are auditing three meal trays for adaptive equipment five days/week. This audit began on 7/17/20 Manager of Duty is auditing three trays for adaptive equipment on the weekends. This audit began on 7/18/20. These audits will continue daily for one month and then weekly for three months. Any issues identified will be corrected immediately and staff will be counseled as necessary. Results from the audits will be reviewed by the QAPI committee monthly for further review and recommendations. Completion Date – 7/30/20	

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F 810	Continued From page 10	F 810		

Interview with Certified Nursing Assistant (CNA) #1, on 07/02/2020 at 1:00 PM, revealed CNA's were responsible to insure resident meal trays included the correct adaptive equipment. CNA #1 stated adaptive equipment was necessary to enable a resident to eat better and prevent potential choking.

Interview with Licensed Practical Nurse (LPN) #2, on 07/08/2020 at 1:19 PM, revealed all staff were responsible to insure the resident's meal trays contained the ordered adaptive utensils and devices. LPN #2 stated adaptive utensils were necessary to insure a resident did not potentially lose nutrition.

Interview with Green Unit Manager (Green UM), on 07/08/2020 at 4:04 PM, revealed all staff were responsible to insure meal trays contained the ordered adaptive equipment.

Interview with the Blue Unit Manager (Blue UM), on 07/09/2020 at 2:55 PM, revealed CNA's were responsible to insure adaptive equipment was included on resident meal trays.

Interview with the Dietary Manager (DM), on 07/09/2020 at 2:01 PM, revealed dietary staff initially prepare resident trays, including providing adaptive equipment as ordered. The DM stated adaptive equipment was necessary to help the resident eat and failure to provide adaptive equipment may hinder a resident from eating or drinking properly.

Interview with the Director of Nursing (DON), on 07/10/2020 at 8:45 AM, revealed all staff were responsible to insure resident meal trays contained adaptive equipment as ordered.

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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)	(X5) COMPLETION DATE
F 810	Continued From page 11	F 810		

Interview with the Administrator, on 07/10/2020 at 9:42 AM, revealed she was unaware of any issue with residents receiving adaptive equipment with meal trays. The Administrator stated the facility audited orders to meal tray cards but did not specify if the facility audited meal tray cards to the meal tray provided to residents.

RECEIVED
AUG 06 2020
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185169	A. BUILDING _____ B. WING _____	07/10/2020

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SIGNATURE HEALTHCARE AT JEFFERSON MANOR REHAB & WE	1801 LYNN WAY LOUISVILLE, KY 40222

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 07/02/2020 and concluded on 07/10/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6). Facility census was 72.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/28/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100533	A. BUILDING: _____ B. WING _____	07/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE AT JEFFERSON MANOR F	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)	(X5) COMPLETE DATE
N 000	Initial Comments A Complaint Survey investigating KY# 31910 and a COVID-19 Focused Infection Control Survey was initiated 07/02/2020 and concluded on 07/10/2020. KY# 31910 was unsubstantiated; however, related deficiencies were cited. The facility was found to be in compliance pursuant to 42 CFR 483.80.	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/28/20