

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

PRINTED: 12/16/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185349</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>12/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>JEFFERSON PLACE HEALTH &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1705 HERR LANE</b> <b>LOUISVILLE, KY 40222</b>
---	---

(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  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 11/24/14 as alleged.	{F 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.

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

PRINTED: 11/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185349</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>JEFFERSON PLACE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1705 HERR LANE LOUISVILLE, KY 40222</b>	
(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 preparation and execution of the Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiency. This Plan or Correction is prepared and executed solely because it is required by Federal and State law."	
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 indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  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).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225 <i>1225</i>	1. Resident #1 was found to be affected by the deficient practice. CNA #1 was suspended the morning of the incident (11/2/14) pending the investigation results. Resident #1 was evaluated by the Social Services Director on 11/3/14 for any psychosocial issues, none were noted. The resident is continued to be followed regularly for any psychosocial issues by both nursing and Social Services. The facility has implemented corrective action to address the deficiency in numbers 3 and 4 below.  2. No other residents were identified as being affected by the deficient practice based on interviews by the green unit manager of residents on the	<i>11/24/14</i>

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

*[Signature]*

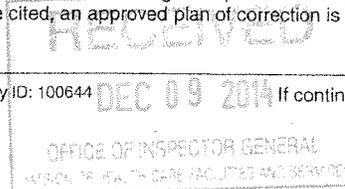
TITLE

*X Administrator X*

(X6) DATE

*12/9/14*

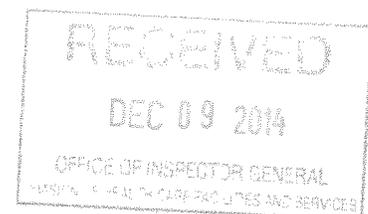
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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



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

PRINTED: 11/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

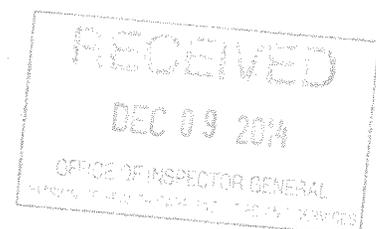
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/12/2014
NAME OF PROVIDER OR SUPPLIER  JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, 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 225	<p>Continued From page 1</p> <p>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 and record review, it was determined the facility failed to remove a staff member from duty, in order to prevent further potential abuse while the investigation was conducted, for one (1) of ten (10) sampled residents. (Resident #1) In addition, the facility failed to notify the Director of Nursing and Administrator immediately, after the allegation of verbal abuse was made by a resident.</p> <p>The findings include:</p> <p>Review of the facility's Abuse Prohibition Policy and Procedure, not dated, revealed any individual suspected of causing abuse was to be removed from direct patient care and reassigned non-patient care duties or suspended from duty until an investigation was completed and an administrative decision was made by the Administrator at the facility level or the Governing Body or appointed designee at the corporate level. The Director of Nursing and Administrator, and when appropriate the Governing Body, were to be notified immediately by the charge person who initially received the report. Events that should be reported and would be investigated included witnessed verbal or physical abusive incidents, and verbal reports/complaints by the resident or family.</p>	F 225	<p>green unit 300 hall conducted on 11/2/14. However, all residents have the potential to be affected by the deficient practice.</p> <p>3. The facility will initiate the following practices to ensure the deficient practice does not recur:</p> <ul style="list-style-type: none"> <li>Education was presented by the staff development coordinator to all facility staff regarding abuse beginning on 11/2/14 and completed 11/9/14. This education highlighted the requirement of both facility policy and CMS guidelines on reporting potential abuse to the Director of Nursing and Administrator immediately, suspending anyone suspected of abuse, and ensure resident safety.</li> </ul>		



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

PRINTED: 11/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

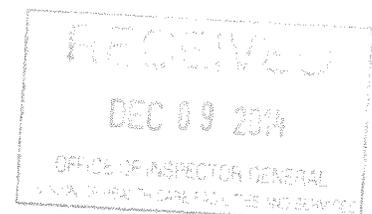
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/12/2014
NAME OF PROVIDER OR SUPPLIER  JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, 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 225	Continued From page 2  Review of the Resident Incident Report, not dated, revealed the allegation of verbal abuse was reported at 12:30 AM on 11/02/14. The report indicated the Administrator was notified on 11/02/14 with no time documented, other than a circled notation of AM. Continued review of attached type written report revealed RN #1 notified the Director of Nursing of the allegation at 8:00 AM on 11/02/14. Section II of the report stated the resident called the third (3rd) shift nurse into his/her room to make a complaint. When the nurse asked the resident what was wrong, the resident stated, that girl told me to shut up.  Review of Resident #1's Admission Minimum Data Set (MDS) assessment, completed on 11/14/14, revealed a Brief Interview Mental Status (BIMS) exam was conducted and the resident scored a fifteen (15) out of fifteen (15) indicating his/her cognition was intact.  Interview with Resident #1, on 11/12/14 at 8:32 AM, revealed two (2) CNA's came into the room to provide requested care. The resident reported CNA #1 told him/her to shut up. The resident stated the incident was reported to the nursing staff.  Telephone interview with CNA #2, on 11/12/14 at 12:10 PM, revealed she was in the room with CNA #1 providing care to Resident #1. She stated after providing care CNA #1 was exiting the room and had her back to the resident, when she heard CNA #1 say shut up. CNA #2 stated she did not question CNA #1 about the comment; however, decided to immediately report the incident to the supervisor.	F 225	<ul style="list-style-type: none"> <li>The Performance Improvement Committee calendar will be updated by the administrator by 11/24/14 to include a monthly audit beginning 11/24/14 in which a mock abuse allegation is raised and employees are to react to this allegation appropriately. The administrator will observe and/or review the procedures followed and report the audit findings to the Performance Improvement Committee monthly.</li> <li>A Triage Line was implemented on 11/12/14 and all staff were educated by the staff development coordinator on this phone communication tool on 11/12/14. This includes phoning the administrator and Director of Nursing</li> </ul>		



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

PRINTED: 11/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

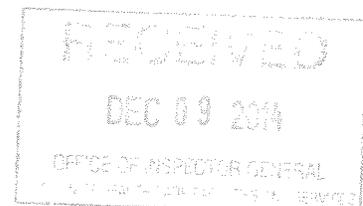
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/12/2014
NAME OF PROVIDER OR SUPPLIER  JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, 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 225	Continued From page 3  Telephone interview with LPN #1, on 11/12/14 at 11:25 AM, revealed LPN #1 received a verbal abuse complaint from Resident #1 at approximately 1:00 AM. She stated the resident reported to her, that CNA #1 to him/her to shut up while providing care. LPN #1 stated after receiving the allegation of verbal abuse from Resident #1 she immediately completed the incident report form and then placed it under the supervisor's door. LPN #1 stated it was approximately one hour after talking to Resident #1 before she interviewed CNA #1 regarding the allegation of verbal abuse. LPN #1 stated the CNA reported to her the shut up comment was not directed toward Resident #1. LPN #1 stated she informed the CNA a report was written regarding the incident. However, she did not remove the CNA from duty after their conversation. In addition, LPN #1 stated her interview with CNA #2 regarding CNA #1 revealed CNA #2 had heard CNA #1 talking to herself before. LPN #1 stated since CNA #1's shut up comment was not directed toward the resident and CNA #2's account of hearing CNA #1 talking to herself in the past, she did not believe Resident #1's incident was a substantiated allegation of verbal abuse.  Continued interview with LPN #1 revealed she was not aware it was her responsibility to remove the CNA from duty until her discussion with RN #1. She stated she recently obtained her LPN license three months ago, and although, she was trained on the facility Abuse P&P, she did not remember that removing the potential perpetrator was her responsibility.  Telephone interview with the Weekend	F 225	with a multitude of circumstances including allegations of abuse. The Triage Line sets parameters which require staff to call immediately and multiple times if needed to reach the administrator and/or Director of Nursing. This Triage Line is posted throughout the facility and includes the phone numbers of both administrator and Director of Nursing.  4. The facility plans to monitor the performance of the solution for sustainability by the following:  • The Performance Improvement Committee will review the audits performed on a monthly basis and make needed recommendations to the Quality Assurance		



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

PRINTED: 11/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

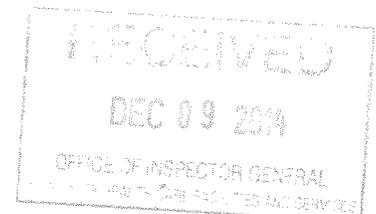
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185349</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>JEFFERSON PLACE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1705 HERR LANE</b> <b>LOUISVILLE, KY 40222</b>		
(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 225	<p>Continued From page 4</p> <p>Supervisor (RN #1), on 11/12/14 at 11:40 AM, revealed LPN #1 reported Resident #1's allegation of verbal abuse to her the morning of 11/02/14. RN #1 stated she questioned LPN #1 regarding her investigation into the incident to ensure resident safety. She stated LPN #1 informed her she had interviewed the resident and CNA#1 about the incident. However, she had not removed CNA #1 from duty after the allegation was made; and, she did not contact the Director of Nursing (DON) or Administrator. RN #1 stated after receiving this information she conducted an investigation into the allegation. RN #1 stated she then contacted the DON and called CNA #1 at home to inform her she was suspended until the investigation into the allegation was completed.</p> <p>Telephone interview with CNA #1, on 11/12/14 at 11:55 AM, revealed she requested help from CNA #2 to move Resident #1 up in bed. After moving the resident up in bed and as she was leaving the room, CNA #1 said she did say shut up. However, the comment was not made toward the resident. The CNA stated she was in pain and was about to say a bad word so she told herself to shut up. CNA #1 stated LPN #1 did question her regarding the comment and she told the LPN the comment was not made toward the resident, but to herself. The CNA stated she continued to provide care to Resident #1 during her 11PM-7 AM shift on 11/02/14. She stated RN #1 notified her by phone, that she was suspended until the investigation into the allegation was completed and a determination was made.</p> <p>Interview with the DON, on 11/12/14 at 11:40 AM, revealed she was notified of the allegation of verbal abuse the morning of 11/02/14 by RN #1.</p>	F 225	<p>and Performance Improvement committee (QAPI).</p> <ul style="list-style-type: none"> <li>The QAPI committee will review the submitted reports/audits monthly to ensure compliance. Recommendations will be made based on the outcomes of the reports/audits as to needed revisions of the plan of correction.</li> </ul>		



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

PRINTED: 11/18/2014  
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  C 11/12/2014
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 225	Continued From page 5 The DON stated she believed the investigation was completed timely and thoroughly per policy and procedure even though the allegation was documented as occurring at 12:30 AM; the next line supervisor RN #1 was not notified until 6:30 AM; and, she was not notified until 8:15 AM on 11/02/14. The DON also stated she notified the Administrator of the allegation on the morning of 11/02/14.	F 225			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to follow their policy and procedures for investigating an allegation of abuse for one (1) of ten (10) sampled residents. (Resident #1)  The findings include: Review of the facility's Abuse Prohibition Policy	F 226	1. Resident #1 was found to be affected by the deficient practice. CNA #1 was suspended the morning of the incident (11/2/14) pending the investigation results. Resident #1 was evaluated by the Social Services Director on 11/3/14 for any psychosocial issues, none were noted. The resident is continued to be followed regularly for any psychosocial issues by both nursing and Social Services. The facility has implemented corrective action to address the deficiency in numbers 3 and 4 below.	11/24/14	



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

PRINTED: 11/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

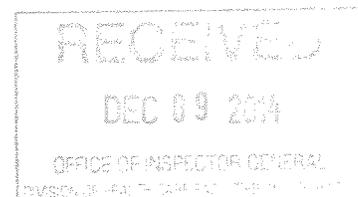
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/12/2014
NAME OF PROVIDER OR SUPPLIER  JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, 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 226	<p>Continued From page 6</p> <p>and Procedure, not dated, revealed any individual suspected of causing abuse was to be removed from direct patient care and reassigned non-patient care duties or suspended from duty until an investigation was completed and an administrative decision was made by the Administrator at the facility level or the Governing Body or appointed designee at the corporate level. The resident or residents were to receive measures to ensure their immediate safety and well being following the initial suspected abuse report and during the investigation process. The Director of Nursing and Administrator, and when appropriate the Governing Body, were to be notified immediately by the charge person who initially received the report. Events that should be reported and would be investigated included witnessed verbal or physical abusive incidents, and verbal reports/complaints by the resident or family.</p> <p>Review of Resident #1's Admission Minimum Data Set (MDS) assessment, completed on 11/14/14, revealed a Brief Interview Mental Status (BIMS) exam was conducted and the resident scored a fifteen (15) out of fifteen (15) indicating his/her cognition was intact.</p> <p>Interview with Resident #1, on 11/12/14 at 8:32 AM, revealed two (2) CNA's came into the room to provide requested care. The resident reported CNA#1 stated shut up to the resident. The resident stated the incident was reported to the nursing staff.</p> <p>Telephone interview with CNA #2, on 11/12/14 at 12:10 PM, revealed she was in the room with CNA #1 providing care to Resident #1. She stated after providing resident care CNA #1 was exiting</p>	F 226	<p>2. No other residents were identified as being affected by the deficient practice based on interviews by the green unit manager of residents on the green unit 300 hall conducted on 11/2/14. However, all residents have the potential to be affected by the deficient practice.</p> <p>3. The facility will initiate the following practices to ensure the deficient practice does not recur:</p> <ul style="list-style-type: none"> <li>Education was presented by the staff development coordinator to all facility staff regarding abuse beginning on 11/2/14 and completed 11/9/14. This education highlighted the requirement of both facility policy and CMS guidelines on reporting</li> </ul>		



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

PRINTED: 11/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

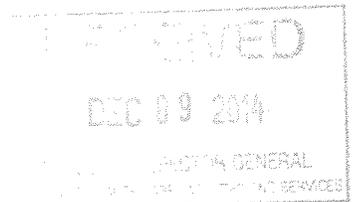
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/12/2014
NAME OF PROVIDER OR SUPPLIER  JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, 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 226	<p>Continued From page 7</p> <p>the room, and had her back to the resident when she heard CNA #1 say shut up. CNA #2 stated she did not question CNA #1 about the comment; however, decided to report the incident to the supervisor.</p> <p>Review of the Resident Incident Report, not dated, revealed the allegation of verbal abuse was reported at 12:30 AM on 11/02/14. Although interview with the DON, on 11/12/14 at 11:40 AM, revealed the next line supervisor, RN #1 was not notified until 6:30 AM; and, she was not notified until 8:15 AM on 11/02/14 by RN #1. The DON stated she notified the Administrator of the allegation on the morning of 11/02/14. Review of the policy and procedure revealed the Administrator and DON should have been notified immediately. She further stated RN #1 conducted the preliminary investigation that consisted of completing the interview with Resident #1; completing the nursing assessment; interviewing CNA #1; and, interviews with additional residents and other staff members.</p> <p>Review of Resident #1's medical record revealed the nursing staff did not immediately complete or document an assessment of Resident #1 for possible psychological effects regarding a report of verbal abuse.</p> <p>Continued review of the Resident Incident Report revealed the nursing assessment was documented as completed on 11/02/14 at 8:30 AM by RN #1.</p> <p>Telephone interview with LPN #1, on 11/12/14 at 11:25 AM, revealed LPN #1 received a verbal abuse complaint from Resident #1 at approximately 1:00 AM. She stated the resident</p>	F 226	<p>potential abuse to the Director of Nursing and Administrator immediately, suspending anyone suspected of abuse, and ensure resident safety.</p> <ul style="list-style-type: none"> <li>The Performance Improvement Committee calendar will be updated by the administrator by 11/24/14 to include a monthly audit beginning 11/24/14 in which a mock abuse allegation is raised and employees are to react to this allegation appropriately. The administrator will observe and/or review the procedures followed and report the audit findings to the Performance Improvement Committee monthly.</li> <li>A Triage Line was implemented on</li> </ul>		



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

PRINTED: 11/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

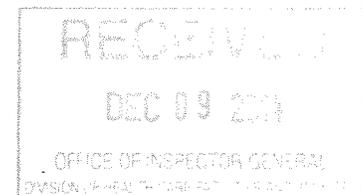
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/12/2014
NAME OF PROVIDER OR SUPPLIER  JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, 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 226	Continued From page 8 reported to her, that CNA#1 had said shut up to the resident while providing care. LPN #1 stated after receiving the allegation of verbal abuse from Resident #1 she immediately completed an incident report form and then placed it under the supervisor's door. LPN #1 stated it was approximately one hour after talking with Resident #1 about the verbal abuse allegation, before she interviewed CNA #1 regarding the shut up comment. LPN #1 stated the CNA reported to her the shut up comment was not directed toward Resident #1, but she was talking to herself. LPN #1 stated she informed CNA #1 a report was written regarding the incident. LPN #1 stated she did not remove the CNA, per facility policy and procedure, from duty after their conversation. Continued interview with LPN #1 revealed she was trained on the Abuse policy and procedure; however, she did not know to immediately contact the Director of Nursing and Administrator regarding an allegation of abuse. In addition, until her discussion with RN #1 the morning of 11/02/14, LPN #1 did not know it was her responsibility to remove the CNA from duty.  Telephone interview with RN #1, the Weekend Supervisor, on 11/12/14 at 11:40 AM, revealed LPN #1 reported an allegation of verbal abuse to her the morning of 11/02/14. RN #1 stated she questioned LPN #1 on what portions of the abuse policy and procedure she had completed. She stated LPN #1 was not knowledgeable of the policy requirements and did not remove CNA #1 from duty after the allegation was made; contacted the Director of Nursing (DON) or the Administrator; and, did not complete a nursing assessment for Resident #1. RN #1 stated she immediately interviewed the resident; completed the nursing assessment; interviewed CNA#1;	F 226	11/12/14 and all staff were educated by the staff development coordinator on this phone communication tool on 11/12/14. This includes phoning the administrator and Director of Nursing with a multitude of circumstances including allegations of abuse. The Triage Line sets parameters which require staff to call immediately and multiple times if needed to reach the administrator and/or Director of Nursing. This Triage Line is posted throughout the facility and includes the phone numbers of both administrator and Director of Nursing.  4. The facility plans to monitor the performance of the solution for sustainability by the following:		



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

PRINTED: 11/18/2014  
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  C 11/12/2014
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 226	<p>Continued From page 9</p> <p>and, conducted interviews with other residents in the facility. After completing those tasks she contacted the DON, and informed CNA #1 by phone that she was suspended until the investigation into the allegation was completed.</p> <p>Telephone interview with CNA #1, on 11/12/14 at 11:55 AM, revealed she requested help from CNA #2 to move Resident #1 up in bed. After moving the resident up in bed and as CNA #2 was leaving the room, she made the comment shut up. However, the comment was not made toward the resident. The CNA stated she was in pain and was about to say a bad word so she told herself to shut up. CNA #1 stated LPN #1 did question her regarding the comment and she told the LPN the comment was not made toward the resident but to herself. The CNA stated she continued to provide care to Resident #1 during her 11 PM-7 AM shift on 11/02/14. She stated RN #1 notified her she was suspended until the investigation into the allegation was completed and a determination was made.</p> <p>Interview with the Administrator, on 11/12/14 at 10:00 AM, revealed he was notified of the allegation on the morning of 11/02/14. He stated he was aware the investigation into Resident #1's allegation of abuse was not conducted per facility policy and procedure.</p>	F 226	<ul style="list-style-type: none"> <li>The Performance Improvement Committee will review the audits performed on a monthly basis and make needed recommendations to the Quality Assurance and Performance Improvement committee (QAPI).</li> <li>The QAPI committee will review the submitted reports/audits monthly to ensure compliance. Recommendations will be made based on the outcomes of the reports/audits as to needed revisions of the plan of correction.</li> </ul>		



Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>100644</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 12/09/2014</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>JEFFERSON PLACE HEALTH &amp; REHABILITATI</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1705 HERR LANE LOUISVILLE, KY 40222</b>
--	---

(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}	<p><b>INITIAL COMMENTS</b></p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 11/24/14 as alleged.</p>	{N 000}		
---------	--	---------	--	--

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

TITLE

(X6) DATE