

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

PRINTED: 11/17/2015
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 R 11/14/2015
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE LOUISVILLE, KY 40222		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 11/14/15 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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185349	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 11/14/2015
Name of Facility JEFFERSON PLACE HEALTH & REHABILITATION CENTER	Street Address, City, State, Zip Code 1705 HERR LANE LOUISVILLE, KY 40222	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0156</u> Reg. # <u>483.10(b)(5) - (10), 483.10(t)</u> LSC _____	Correction Completed <u>11/14/2015</u>	ID Prefix <u>F0279</u> Reg. # <u>483.20(d), 483.20(k)(1)</u> LSC _____	Correction Completed <u>11/14/2015</u>	ID Prefix <u>F0309</u> Reg. # <u>483.25</u> LSC _____	Correction Completed <u>11/14/2015</u>
ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____	Correction Completed <u>11/14/2015</u>	ID Prefix <u>F0441</u> Reg. # <u>483.65</u> LSC _____	Correction Completed <u>11/14/2015</u>	ID Prefix <u>F0514</u> Reg. # <u>483.75(l)(1)</u> LSC _____	Correction Completed <u>11/14/2015</u>
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>my</u>	Reviewed By <u>kt</u>	Date: <u>11/17/15</u>	Signature of Surveyor: <u>Michele Zornstein</u>	Date: <u>11/17/15</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>10/8/2015</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE LOUISVILLE, KY 40222		
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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 10/06/15 and concluded on 10/08/15 with deficiencies cited at the highest scope and severity of an "E".	F 000			
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the	F 156	1. Unit Manager verified code status as DNR for residents #6 and #7. Clarification order written on 10/6/15 for DNR. Verified that DNR stickers are placed on residents chart, order changed to reflect DNR status on residents MAR, residents added to facility DNR list. Resident #6 remains in the facility, Resident #7 discharged to personal care facility on 10/23/15. 2. All residents have the potential to be affected by the deficient practice. A review of code status for all residents in the facility on 10/6/15 was completed by DON and unit managers to ensure current code status is reflected on residents chart, physician orders and MAR.	11/14/15	

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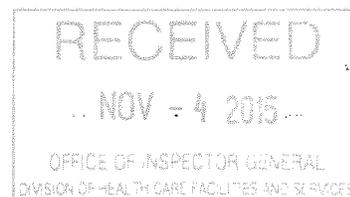
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *11/4/15*

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F 156	<p>Continued From page 1</p> <p>facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p>	F 156	<p>3. The facility will initiate the following practices to ensure the deficient practice does not recur:</p> <ul style="list-style-type: none"> a. Education will be provided to nurses by DON by 11/13/15 regarding procedure of updating resident records to reflect current code status. b. The Performance Improvement Committee QA calendar will be updated to include a 100% audit of code status monthly for 3 months to ensure the residents' current code status is reflected on the residents' medical record, physician orders and MAR. 	



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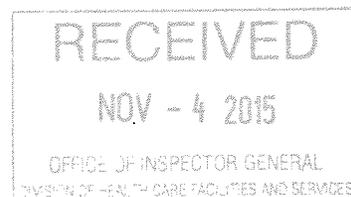
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F 156	<p>Continued From page 2</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy for Designation of Resuscitation Status, it was determined the facility failed to accurately document the Code status of two (2) of nineteen (19) sampled residents (Resident #6 and Resident #7). Resident #6's clinical record was documented for the resident as a Full Code, however, the Responsible Party signed the Do Not Resuscitate form. Resident #7's Responsible Party signed a Full Code form on admission on 09/13/15. The Responsible Party changed the code status and signed a Do Not Resuscitate form on 09/14/15. The resident's clinical record continued to be marked as a Full Code.</p> <p>The findings include:</p> <p>Review of the facility's policy for Designation of Resuscitation Status, dated 06/01/09, revealed the facility required all residents, on admission, to designate in writing their wishes for the use of Cardiopulmonary Resuscitation (CPR). A resident's resuscitation status was documented in the resident's clinical record. Any amendment was also documented in the resident's clinical</p>	F 156	<p>4. The facility plans to monitor the performance of the solution for sustainability by the following:</p> <ul style="list-style-type: none"> a) The Performance Improvement Committee will review the audits performed monthly for 3 months and make needed recommendations to the Quality Assurance and Performance Improvement Committee (QAPI). b) The QAPI Committee will review the submitted reports/audits monthly for 3 months to ensure compliance. Recommendations will be made based on the outcomes of these reports/audits as to needed revisions of the plan of correction. 	
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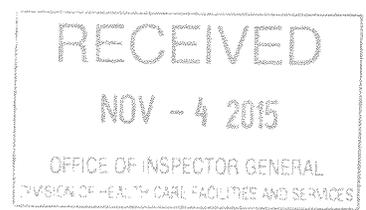
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F 156	<p>Continued From page 3</p> <p>record. The resident's clinical record was labeled as Full Code or as Do Not Resuscitate inside the front of the chart.</p> <p>1. Review of the clinical record for Resident #6, revealed the facility readmitted the resident, on 09/28/15, with diagnoses of Pulmonary Fibrosis, Hypertension, Failure to Thrive, Toxic Metabolic Encephalopathy and Generalized Weakness. The clinical record documented the resident was a full code.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #6, dated 09/05/15, revealed the facility found the resident needed limited assistance of one person for dressing, grooming, and ambulation. The resident was incontinent of bowel and bladder. A Brief Interview for Mental Status (BIMS) revealed the resident scored thirteen (13) out of fifteen (15) and was interviewable.</p> <p>Review of the physician's orders for October 2015 for Resident #6, revealed the resident was a full code.</p> <p>Review of the clinical record for Resident #6, revealed a Code Status form was completed for the resident by the Responsible Party for Do Not Resuscitate on 10/02/15.</p> <p>2. Review of the clinical record for Resident #7, revealed the facility admitted the resident on 09/13/15 with diagnoses of Atrial Fibrillation/Flutter, Dementia with Behavior, Alzheimer's Disease and Dysphagia.</p> <p>Review of the clinical record revealed the facility completed an admission MDS assessment on</p>	F 156		
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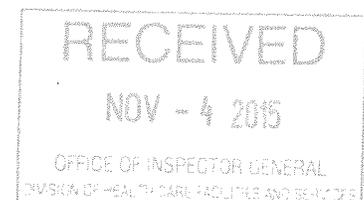
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F 156	<p>Continued From page 4</p> <p>09/20/15, which indicated Resident #7's BIMS score was thirteen (13) out of fifteen (15) and the resident was interviewable. The resident required extensive assistance with all activities of daily living.</p> <p>Review of the clinical record for Resident #7, revealed the the resident was a full code per the admission physician's orders and the responsible party's documentation when admitted on 09/13/15. However, the Responsible Party determined the resident was a Do Not Resuscitate and completed the paper work the next day on 09/14/15. The label inside the front of the clinical record revealed the resident was a full code which did not reflect the resident's change to a Do Not Resuscitate.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 10/06/15 at 1:51 PM, revealed Resident #7 was a full code. She stated the resident's medical record was labeled as a full code as was the medication administration record. She stated the she was not aware the resident was actually a do not resuscitate and the records would be corrected. She stated the family would have been very upset if cardiopulmonary resuscitation had been implemented.</p> <p>Interview with the Unit Manager, on 10/06/15 at 2:12 PM, revealed anytime a Code Status form was signed, the nurse involved wrote an order to reflect the code status after notifying the physician. She stated the Do Not Resuscitate List was updated as was the care plan. She stated a negative outcome could have resulted if the resident suffered a cardiopulmonary arrest and received resuscitation.</p>	F 156		

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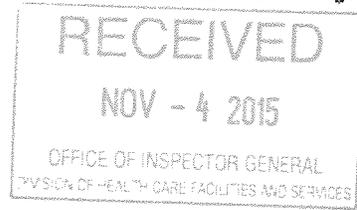
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F 156	Continued From page 5 Interview with the Assistant Director of Nursing, on 10/06/15 at 11:23 AM, revealed the Code Status of residents was determined by the resident or responsible party and the decision was documented on a Code Status form and placed in the clinical record. She stated a sticker was placed inside the record front indicating the resident's code status. She stated the pharmacy was also notified and the medication record contained the code status. She stated the facility had a Do Not Resuscitate list that was updated as needed. Interview with the Director of Nursing, on 10/07/15 at 9:22 AM, revealed the Code Status of residents had to be accurate and clearly indicated on the clinical record. He stated there would definitely be a negative outcome if the resident's Code Status was not honored.	F 156	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279	1. On 10/7/15, Director of MDS completed an acute care plan for infection r/t c-diff for resident #16, verifying that contact precautions were included in the plan of care. Resident #16 discharged to personal care facility on 10/22/15. 11/14/15



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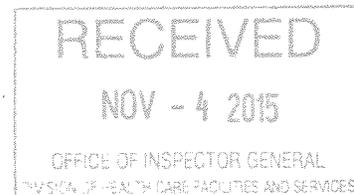
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F 279	<p>Continued From page 6</p> <p>be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility policy and the Resident Assessment Instrument (RAI) Manual, it was determined the facility failed to develop a comprehensive care plan for one (1) of sixteen (16) sampled residents. Resident #16's care plan did not address Contact Isolation.</p> <p>The findings include:</p> <p>The facility did not provide a policy for developing care plans, stating the RAI is their reference.</p> <p>Review of the Resident Assessment Instrument (RAI) Manual, Minimum Data Set (MDS), Chapter 4, page 4-8, dated May 2013, revealed the facility was responsible for assessing and addressing all care issues relevant to the individual residents, regardless of whether or not they are covered by the RAI, including monitoring each resident's condition and responding with appropriate interventions. Pages 4-12 revealed the overall care plan should be oriented towards: preventing avoidable declines; managing risk factors; addressing resident's strength; evaluating treatments; and, addressing additional care planning areas relevant to meeting the resident's needs.</p> <p>Review of the facility policy Initiating Transmission Based Precautions, dated 08/01/15, states</p>	F 279	<p>2. All residents with active infection have the potential to be affected by the deficient practice. On 10/7/15, DON and MDS director completed 100% audit of current residents with infections, to verify that an acute care plan was in place, and, if needed, isolation precautions were included in the plan of care.</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"> a) Staff in-services conducted by the DON, during the week of 10/19/15-10/23/15, to include education on Hand Washing, C-Diff infections, PPE practices and isolation precautions b) Education to be completed with nurses by DON, on implementation of acute care plans and development of care plans by 11/13/15. c) The Performance Improvement Committee QA calendar will be updated to include a 100% audit of acute care plans for 3 months to be completed monthly by DON or MDS Director. 	



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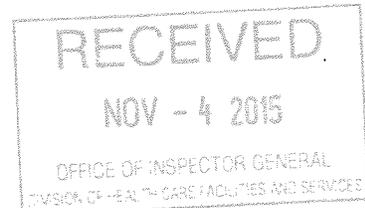
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F 279	<p>Continued From page 7</p> <p>Transmission-Based Precautions will be initiated when there is a reason to believe a resident has a communicable infectious disease. Transmission-Based Precautions may include Contact Precautions, Droplet Precautions, or Airborne Precautions.</p> <p>Review of the facility policy regarding Isolation for Transmission-Based Precautions, dated 08/01/15 states the facility would implement Contact Precautions for residents known or suspected to be infected or colonized with micro-organisms transmitted by direct contact with the resident or indirect contact with the environmental surfaces or resident-care items. Examples of infections requiring Contact Precautions included Diarrhea associated with Clostridium Difficile (C. diff). The facility would also ensure residents care plans indicated the type of precautions implemented for the resident.</p> <p>Review of the clinical record for Resident #16 revealed the facility admitted the resident on 09/08/15 with diagnoses of Hypertension, Hyperlipidemia, Arthritis, Dementia, Anxiety Disorder, Depression, Irritable Bowel Syndrome, Diverticulitis and post Shoulder Dislocation.</p> <p>Review of Resident #16's Annual Minimum Data Set (MDS) assessment, completed on 09/15/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of five (5) of fifteen (15) meaning the resident was not interviewable.</p> <p>Review of the Physician's Order, dated 09/11/15, revealed Resident #16's physician ordered a stool study with cultures to determine if the resident</p>	F 279	<p>4. The facility plans to monitor the performance of the solution for sustainability by the following:</p> <ul style="list-style-type: none"> a) The Performance Improvement Committee will review the audits performed monthly for 3 months and make needed recommendations to the Quality Assurance and Performance Improvement Committee (QAPI). b) The QAPI Committee will review the submitted reports/audits monthly for 3 months to ensure compliance. Recommendations will be made based on the outcomes of these reports/audits as to needed revisions of the plan of correction. 	



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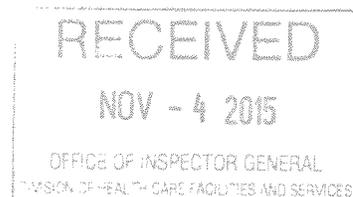
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
	185349			10/08/2015
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F 279	Continued From page 8 had a C. diff infection. The stool sample for the order was not obtained by staff. Review of the Physician's Order, dated 09/28/15 revealed Resident #16's physician reordered the stool study with cultures to determine if the resident had C. diff. Review of Laboratory results, dated 10/07/15, revealed Resident #16's stool culture tested positive for C. diff. Review of the Comprehensive Care Plan for Resident #16, dated 10/08/15 revealed an Infection Control plan of care for Contact Precautions was not developed at the time the physician wrote the initial, secondary order or after the facility received confirmation, Resident #16 had the infectious disease, C. diff. Interview with Unit Manager #2, on 10/07/15 at 4:50 PM, revealed upon review of Resident #16's Comprehensive Plan of Care, there was not an Infection Control plan for Contact Precautions present. She stated she did not create the care plan for Resident #16 on 09/11/15, when the Physician first suspected C. diff and wrote the initial order for a stool culture, per the facility policy.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	1. For resident #16, stool sample was collected on 10/6/15, results received from lab on 10/7/15. MD was notified of results on 10/7/15, new orders received and initiated. Resident placed in contact isolation prior to receiving results r/t suspicion of c-diff.	11/14/15



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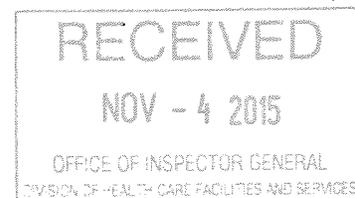
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F 309	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review it was determined the facility failed to follow physician orders for one (1) of sixteen (16) sampled residents, Resident #16. Resident #16 was suspected of having an infection with Clostridium Difficile and the Physician's order for stool cultures was not followed by the facility.</p> <p>The findings include:</p> <p>The facility did not provide a policy outlining procedures for physician orders of laboratory specimens.</p> <p>Review of the facility policy, Prescriber Medication Orders, dated 03/02/2015 revealed that the prescriber is contacted for direction when delivery of a medication will be delayed or the medication is not or will not be available.</p> <p>Review of the clinical record for Resident #16 revealed the facility admitted the resident on 09/08/15 with the diagnoses of Dementia, recent Shoulder Dislocation, Diverticulitis, Hypertension and Irritable Bowel Syndrome.</p> <p>Review of the clinical for Resident #16, revealed the facility completed an admission Minimum Data Set (MDS) assessment on 09/15/15 which revealed the resident scored 5/15 on a Brief Interview for Mental Status and was not</p>	F 309		



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F 309	<p>Continued From page 10</p> <p>interviewable. The resident required extensive assistance with activities of daily living and was continent of bladder and bowel.</p> <p>Review of the Physician Order, dated 09/11/15, revealed Resident #16's physician ordered a stool study with cultures to determine if the resident had C. diff. The stool sample was not obtained by staff.</p> <p>Review of the Physician Order, dated 09/28/15, revealed Resident #16's physician ordered a second stool study.</p> <p>Review of Laboratory results, dated 10/07/15, revealed Resident #16's stool tested positive for C. diff.</p> <p>Observation on Resident #16, on 10/7/15 at 4:20 PM, revealed that the resident was in isolation. The sign on his/her door indicated the importance of contacting the nurse before entry. There was a Personal Protective Equipment (PPE) cart outside his/her door. On the cart was a PPE card outlining the steps of donning and proper disposal of PPE garb.</p> <p>Interview with Unit Manager #2, on 10/07/15 at 4:50 PM, revealed Resident #16's stool had not been obtained until 10/06/2015. She stated staff had trouble getting the stool for a variety of reasons. She stated she did not, nor did her staff, call the MD to report the order completion was not carried out.</p> <p>Interview with Director of Nursing, on 10/08/2015 at 2:25 PM, revealed that Resident #16's stool culture should have been obtained within three (3) days of the original order, he stated the</p>	F 309	<p>2. All residents have the potential to be affected by the deficient practice. A review of current residents' new physician orders in the last 30 days to be completed by 10/9/15 by DON to ensure orders have been processed and implemented.</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"> a) DON to educate nurses about procedures for obtaining physician orders and timely follow up. Education to include notification of physician if an order cannot be followed for any reason. Education to be completed by 11/13/15. b) The Performance Improvement Committee QA calendar will be updated to include 25% audit of physician orders for 3 months concentrating on lab orders to ensure implementation, to be completed monthly by DON, Unit manager or MDS Director. 	



4. The facility plans to monitor the performance of the solution for sustainability by the following:

- a) The Performance Improvement Committee will review the audits for 3 months which were performed monthly and make needed recommendations to the Quality Assurance and Performance Improvement Committee (QAPI).
- b) The QAPI Committee will review the submitted reports/audits monthly for 3 months to ensure compliance. Recommendations will be made based on the outcomes of these reports/audits as to needed revisions of the plan of correction.

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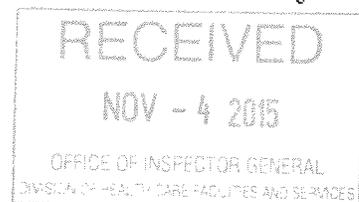
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F 309	Continued From page 11 resident would normally be care planned for the infection and updated with appropriate interventions at the time of the stool specimen order. Interview with Physician #2, on 10/08/2015 at 2:20 PM, stated when he didn't receive results or a call regarding 09/11/15 stool specimen he reordered the sample on 09/28/2015.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and Training Guideline Procedures, it was determined the facility failed to ensure residents were free from potentially hazardous substances to prevent accidents. A bottle of Hepacide Quat II was observed stored in an unlocked area accessible to residents on one (1) of two (2) halls. The findings include: Observation during the initial environmental tour on 10/06/15 at 9:01 AM, revealed a white spray bottle labeled Hepacide Quat II. The bottle labeled Hepacide Quat II was observed in an unlocked cabinet close to the floor, in a unlocked	F 323	1. No residents were found to have been affected by the deficient practice, however the chemical in question was removed from the unlocked cabinet and placed in a locked utility room. 2. All residents who are able to ambulate about the facility have the potential to be affected by the deficient practice. No resident was found to be affected by the deficient practice. 3. The facility will initiate the following practices to ensure the deficient practice does not recur: a. Education will be provided to all staff by the staff development coordinator by 11/13/2015 on ensuring all chemicals are locked in the utility rooms or housekeeping carts where residents are not able to access.	11/14/15



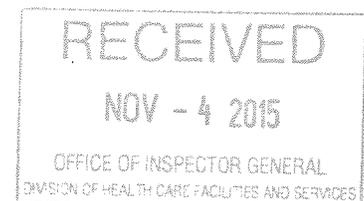
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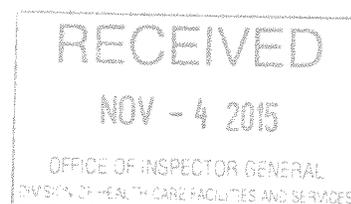
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F 323	<p>Continued From page 12</p> <p>ladies whirlpool room on the Maroon Hall.</p> <p>Observation, on 10/07/15 at 9:57 AM, revealed the bottle of Hepacide Quat II was in the unlocked cabinet in the unlocked ladies whirlpool room on the Maroon Hall. Further observation of the Hepacide Quat II bottle revealed, the bottle had printing on it that read the product was effective against the following: VIRUSES-HIV-1 (AIDS Virus), Hepatitis C Virus (HCV), Hepatitis B Virus (HBV), Herpes simplex Type 2, Influenza A2/Hong Kong viruses, and Pandemic 2009 H1N1 influenza A virus, GERMS-Staphylococcus aureus, Pseudomonas aeruginosa, and Salmonella enterica, BACTERIAS-Vancomycin resistant Enterococcus faecalis (VRE), and Methicillin resistant Staphylococcus aureus (MRSA).</p> <p>The facility did not provide a policy on Storage of Hazardous Chemicals and Staff Accessibility of the Material Safety Data Sheets (MSDS), when it was requested.</p> <p>Review of the facility's training guideline procedure titled Housekeeping and Laundry Preparation dated, 08/07/15, revealed that all housekeeping chemical bottles were kept inside of locked carts.</p> <p>Review of the Safety Data Sheet (SDS), also know as Material Safety Data Sheet (MSDS), dated 07/08/13, revealed Hepacide Quat II contained the cleaning ingredients of Isopropyl Alcohol, Dialkyl Dimethyl Ammonium Chloride, and Alkyl Dimethyl Benzyl Ammonium Chloride. The MSDS also revealed, the product's health hazard data stated to avoid contact with eyes, skin, or clothing, do not swallow, and to avoid</p>	F 323	<ul style="list-style-type: none"> b. Education will be provided to housekeeping staff on chemical risk to residents by the housekeeping director by 11/8/15. c. The Safety Data Sheets (SDS) binders will be updated by the housekeeping director with all facility chemicals and located in areas readily accessible to employees by 10/30/15. d. The housekeeping supervisor will be tasked with ensuring the SDS binders are up to date on a monthly basis or when new chemicals are procured. All staff will be educated by the housekeeping supervisor that all chemical procurement will go through the housekeeping supervisor for all departments. This will be an ongoing procedure. e. The Performance Improvement Committee QA calendar will be updated to include an audit performed monthly for 3 months audit of chemical storage and SDS binder readiness to be completed by the housekeeping director. 	



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F 323	<p>Continued From page 13</p> <p>breathing product mist. The MSDS further revealed, the product was harmful and medical attention should be sought immediately if exposed to the product.</p> <p>Review of the United States Department of Labor, Occupational Safety and Health Administration's (OSHA) website titled Hazard Communication Standard: Safety Data Sheets (SDS), dated 2012, revealed employers were obligated to ensure that the SDS's were kept readily accessible to employees for all hazardous chemicals in their workplace. OSHA also revealed, employers were allowed to keep the SDS's in a binder or on computers as long as the employees have immediate access to the information without leaving their work area for rapid access to the SDS in the case of a power outage or other emergency. OSHA furthermore revealed, employers should have a designated person(s) responsible for obtaining and maintaining the SDS information.</p> <p>Interview with the Unit Manger on Maroon Hall, on 10/07/15 at 10:11 AM, revealed all information about the facility's cleaning chemicals was kept in the SDS binder at the nursing stations, however she wasn't able to locate the the SDS for Hepacide Quat II in the nursing station binders after it was requested. The Unit Manger on Maroon Hall additionally stated that nursing staff haven't received any training on keeping cleaning supplies locked or on SDS binder updates. Unit Manger on Maroon Hall stated cleaning chemicals were never located in unlocked locations because the products were dangerous to the residents. Unit Manger on Maroon Hall also stated that if she knew a resident had consumed Hepacide Quat II she would have assessed the</p>	F 323	<p>4. The facility plans to monitor the performance of the solution for sustainability by the following:</p> <ul style="list-style-type: none"> a) The Performance Improvement Committee will review the audits performed monthly for 3 months and make needed recommendations to the Quality Assurance and Performance Improvement Committee (QAPI). b) The QAPI Committee will review the submitted reports/audits monthly for 3 months to ensure compliance. Recommendations will be made based on the outcomes of these reports/audits as to needed revisions of the plan of correction. 		



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F 323	Continued From page 14 resident, obtained the SDS from the nursing station, contacted the Medical Director, and the poison control center to seek advice on emergency medical treatment. Interview with CNA #4, on 10/07/15 at 10:17 AM, revealed all the cleaning chemicals were kept locked because a resident can get it into his/her eyes and/or swallow it. CNA #4 stated our residents don't understand the dangers associated with Hepacide Quat II and if it isn't locked up they would get into it. CNA #4 also stated that they were trained and she knew the importance of locking dangerous chemicals up. CNA #4, further stated they have kept all the cleaning supplies and products in the locked Utility Room. Interview with Housekeeping Staff #1, on 10/07/15 at 10:39 AM, revealed cleaning supplies and chemicals were kept in the storage room on their carts and in the laundry room. Housekeeping Staff #1 stated their cleaning supplies and chemicals don't need to be kept locked because it wasn't a safety risk to the residents. Housekeeping Staff #1 also stated she hadn't been trained on how to store her cleaning products. Interview with Housekeeping Staff #2, on 10/07/15 at 10:51 AM, revealed staff were trained to keep all cleaning chemicals locked at all times to prevent the residents from getting hurt. Housekeeping Staff #2 stated if the residents had access to the cleaning chemicals they might drink it, spray it on their skin, or spray it into their eyes. Housekeeping Staff #2 also stated the housekeeping staff were required to wear gloves when they used Hepacide Quat II.	F 323		

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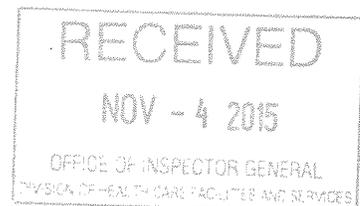
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F 323	Continued From page 15 Interview with the Director of Housekeeping and Laundry, on 10/07/15 at 10:56 AM, revealed the residents only went into the Ladies Whirlpool Room to be weighed and no cleaning chemicals were housed in there. The Director of Housekeeping and Laundry stated all housekeeping staff were trained to keep cleaning supplies and chemicals locked at all times. Director of Housekeeping and Laundry also stated Hepacide Quat II was a dangerous chemical used to clean areas that had been contaminated by blood and that if exposed to the product it would irritate a resident's eyes and skin, also if ingested the resident should have to be seen by a physician immediately. Further interview with the Director of Housekeeping and Laundry on 10/07/15 at 12:33 PM, revealed Hepacide Quat II's MSDS sheet was located in her office and another up-to-date MSDS binder was located in the front office and the binders located at the nurse's stations aren't updated. The Director of Housekeeping and Laundry stated staff don't have emergency access to the current MSDS binders located in her office and at the front office after administrative staff have left the building. The Director of Housekeeping and Laundry further stated it was important to keep the MSDS binders up-to-date because it would delay emergency medical treatment if they aren't readily accessible. Interview with the Medical Director, on 10/07/15 at 12:01 PM, revealed he would have obtained a resident's vital signs and followed the treatment instruction listed on the MSDS to treat a resident who had came into contact with Hepacide Quat II. The Medical Director stated he would have also	F 323		



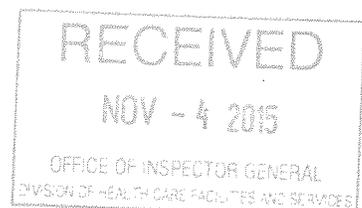
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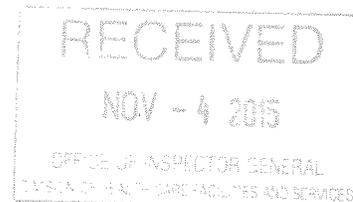
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F 323	<p>Continued From page 16</p> <p>called a poison control center for treatment instructions. The Medical Director also stated cleaning chemicals shouldn't be kept in common areas where residents have access to them, they should've been kept locked away from the residents.</p> <p>Interview with the Poison Control Operator, on 10/07/15 at 12:17 PM, revealed that it was a requirement to have worn gloves and goggles when a person has handled Hepacide Quat II. The Poison control Operator stated Hepacide Quat II was poisonous and harmful. The Poison control Operator also stated if Hepacide Quat II was ingested, inhaled, or sprayed onto the skin or into the eyes, medical attention should've been sought immediately.</p> <p>Interview with the Administrator, on 10/07/15 at 4:24 PM, revealed the facility hasn't had a specific policy on Storage of Hazardous Chemicals and Staff Accessibility of the SDS's, they have utilized CMS and OSHA guidelines instead. The Administrator stated the facility hasn't had a staff person who was responsible for the upkeep of the SDS binders located at the nursing stations and he wasn't aware of when it was last updated. The administrator also stated cleaning chemicals should've been kept locked and staff should have had access to the SDS information. The administrator further stated housekeeping staff have been trained to keep cleaning supplies locked.</p> <p>Interview with the Director of Nursing, on 10/08/15 at 9:25 AM, revealed all cleaning chemicals should've been kept in areas where the residents wouldn't have access to them and the cleaning chemicals should've been kept</p>	F 323		



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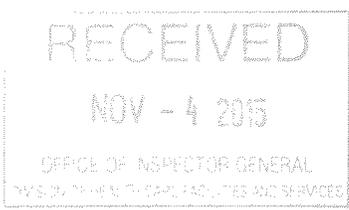
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/08/2015	
NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE LOUISVILLE, KY 40222		
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F 323	Continued From page 17 locked at all times. The Director of Nursing stated if a resident had accessed Hepacide Quat II and sprayed it in their eyes, sprayed it onto their skin, or ingested it he would have obtained the residents vital signs, pulled the SDS sheet, contacted poison control, and the physician immediately for treatment of the resident. The Director of Nursing also stated if he wasn't able to access the SDS information in an emergency situation it would've delayed emergency medical treatment of the resident who needed it.	F 323		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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	F 441	1. On 10/6/15 CNA #7 was educated by Unit manager on infection control, proper use of PPE, and proper hand hygiene with c-diff residents. On 10/7/15 LPN #2 was educated by Unit Manager on proper use of PPE, including proper steps for removal, and hand hygiene with c-diff residents. On 10/6/15, CNA #1 was educated by Unit Manager on proper hand hygiene with c-diff residents. On 10/6/15, Unit Manager and MDS director updated CNA care plans for residents #7, #8, #16, to reflect contact precautions and to wash hands with soap and water prior to leaving the residents' room.	11/14/15



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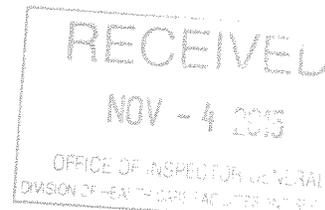
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F 441	<p>Continued From page 18</p> <p>direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy, it was determined the facility failed to ensure all staff followed Contact Precautions for Clostridium difficile for three (3) of four (4) sampled residents on those precautions, Residents #7, #8 and #16 on the Green Unit. Nursing staff were observed to remove personal protective equipment incorrectly, enter contact precautions rooms without personal protective equipment and fail to wash hands using soap and water.</p> <p>The findings include:</p> <p>Review of the facility's policy for Contact Precautions, dated 08/01/12, revealed in addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected or colonized with microorganisms that could be transmitted by direct contact with the resident or by indirect contact with environmental surfaces or resident-care items in the resident's</p>	F 441	<p># 1 Continued.</p> <p>The hand sanitizer bottles were removed from the isolation carts. Resident #7 was cleared from isolation and contact precautions on 10/6/15, as treatment for c-diff complete, resident having formed stools x 4 days.</p> <p>2. All residents of the green unit had potential to be affected by the deficient practice. A review to direct care staff on isolation precautions and c-diff precautions was given by the Assistant Director of Nursing and completed by 10/8/15. Audit to identify signs or symptoms of c-diff among current residents on the green unit was completed by DON and MDS director on 10/8/15. No other residents found to be affected by the deficient practice.</p>		



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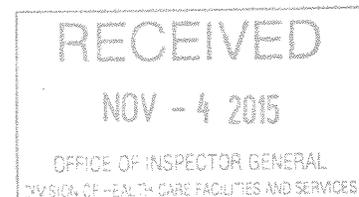
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	<p>Continued From page 19</p> <p>environment. An example of an infection requiring Contact Precautions was Clostridium difficile (C. diff). In addition to wearing gloves, wear a gown for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment.</p> <p>Review of the facility's Directions for How to Safely Remove Personal Protective Equipment (PPE) published by the Center for Disease Control, undated, revealed removal of gloves first was related to the gloves being contaminated. After gloves were removed, remove the gown remembering the front of the gown was contaminated. Untie the gown ties and pull the gown away from the neck and shoulders, touching the inside of the gown only, turn the gown inside out and throw it away. Wash hands or use an alcohol-based sanitizer immediately.</p> <p>1. Review of the clinical record for Resident #7, revealed the facility admitted the resident, on 09/13/15, with diagnoses of Clostridium difficile Infection (C. diff), Alzheimer's Dementia with Behaviors, and Dysphagia.</p> <p>Review of the clinical record for Resident #7, revealed the facility completed an admission Minimum Data Set (MDS) assessment on 09/20/15 which revealed the resident scored a thirteen (13) of fifteen (15) on a Brief Interview for Mental Status and was interviewable. The resident required extensive assistance with activities of daily living and was incontinent of bladder with occasional incontinence of bowel.</p> <p>Review of the Care Guide for Certified Nurse Aides (CNA), dated 08/22/15, revealed Resident #7 was on Contact Isolation. There was no</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"> a) Education conducted for staff in all departments, by the DON, during the week of 10/19/15-10/23/15, to include education on Hand Washing, C-Diff infections, PPE practices, removal of contaminated PPE in the room in an isolation trash can, and isolation precautions. b) Beginning 10/8/15 CNA care plans will be updated by the unit manager or nurse supervisor as needed to reflect residents in isolation, including the type of isolation and reason for isolation. c) The Performance Improvement Committee QA calendar will be updated to include an audit of staff following proper isolation precaution procedures and proper use of PPE, and to ensure isolation precautions and reason for isolation is communicated on CNA care plans. Audit to be completed monthly for 3 months by DON or MDS director. 	



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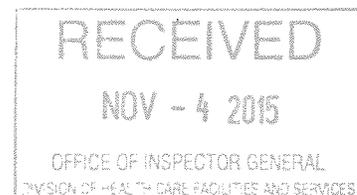
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F 441	<p>Continued From page 20</p> <p>evidence of documentation regarding the type of infection (C. diff) and the specific instructions for washing hands with soap and water prior to leaving the room.</p> <p>Observation of Resident #7, on 10/06/15 at 8:20 AM, revealed a cart outside the room with personal protective equipment. On top of the cart, there was a bottle of alcohol-based hand sanitizer. CNA #7 was in the room without personal protective equipment setting up the resident's meal tray. She exited the room and used the hand sanitizer on the cart to clean her hands. A sign on the top of the cart advised persons entering the room to see the nurse prior to entering the room. In addition, a paper instructing all staff on use of the PPE was on top of the cart, however, there was no information found advising staff to use soap and water handwashing related to C. diff instead of using hand sanitizer related to the resident's C. diff.</p> <p>Interview with CNA #7, on 10/06/15 at 8:45 AM, revealed Resident #7 was on Contact Precautions related to an infection, however, she was not aware of the type of infection. She stated she did not wear a gown into the room as she did not plan to touch anything in the room. She stated she may have touched her clothing to the resident's bed and she should have worn a gown to prevent contaminating her clothing. She stated she used the alcohol sanitizer to clean her hands since it was on the isolation cart. She stated she was trained several months ago on isolation precautions and germs could spread to make other persons sick.</p> <p>2. Review of the clinical record for Resident #8, revealed the facility admitted the resident on</p>	F 441	<p>4. The facility plans to monitor the performance of the solution for sustainability by the following:</p> <ul style="list-style-type: none"> a) The Performance Improvement Committee will review the audits performed monthly for 3 months and make needed recommendations to the Quality Assurance and Performance Committee (QAPI). b) The QAPI Committee will review the submitted reports/audits monthly for 3 months to ensure compliance. Recommendations will be made based on the outcomes of these reports/audits as to needed revisions of the plan of correction. 	



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F 441	<p>Continued From page 21</p> <p>09/19/15 with diagnoses of Clostridium difficile Infection, Hypertension, Congestive Heart Failure and Cardiomyopathy.</p> <p>Review of the clinical record for Resident #8, revealed the facility completed an admission MDS assessment on 09/26/15. The resident scored a fifteen (15) of fifteen (15) on the Brief Interview for Mental Status and was interviewable. The resident required limited assistance with activities of daily living and extensive assistance with transfers.</p> <p>Observation of Resident #8, on 10/07/15 at 12:06 PM, revealed LPN #2 inside Resident #8's contact precautions room removing her gown by untying the ties around her neck. After she removed her gown, she removed her gloves.</p> <p>Interview with LPN #2, on 10/07/15 at 12:11 PM, revealed she was in Resident #8's room administering medications. She stated she was trained this morning on contact precautions and thought the gown was removed prior to the gloves when exiting a contact isolation room. She stated the C. diff infection could be spread to others if PPE was not removed correctly and by failure to wash hands with soap and water.</p> <p>Interview with CNA #3, on 10/06/15 at 5:58 PM, revealed she was trained by facility on contact precautions and the spread of bacteria to others. She stated the nurses did not consistently share the type of infection a resident had related to HIPPA privacy regulations. She stated everyone should use soap and water to wash hands as CNAs were too busy to find the nurse and ask about the type of infection present.</p>	F 441		



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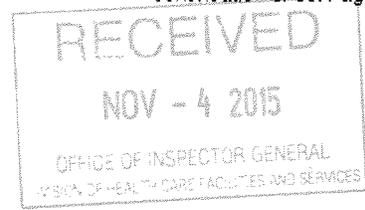
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F 441	<p>Continued From page 22</p> <p>3. Review of the clinical record for Resident #16 revealed the facility admitted the resident on 09/08/15 with the diagnoses of Dementia, recent Shoulder Dislocation, Diverticulitis, Hypertension and Irritable Bowel Syndrome.</p> <p>Review of the clinical for Resident #16, revealed the facility completed an admission Minimum Data Set (MDS) assessment on 09/15/15 which revealed the resident scored five (5) of fifteen (15) on a Brief Interview for Mental Status and was not interviewable. The resident required extensive assistance with activities of daily living and was continent of bladder and bowel.</p> <p>Observation of Resident #16, on 10/06/15 at 5:18 PM, revealed CNA #1 delivering a meal tray to the resident. There was a sign on the cart outside the room to see the nurse prior to entering the room. The cart contained gowns and gloves. A sign was on the cart to advise step by step how to don PPE and how to remove PPE. The CNA donned gloves and a gown prior to entering the room. She was observed removing the PPE and leaving the room without using soap and water to wash her hands. She was observed to use the alcohol sanitizer on top of the isolation cart to sanitize her hands.</p> <p>Interview with CNA #1, on 10/06/15 at 5:28 PM, revealed she was aware Resident #16 required contact precautions and was always taught to use alcohol hand sanitizer. She stated she was not sure why the resident required contact precautions and she would ask the nurse. She returned quickly and stated the resident's</p>	F 441		
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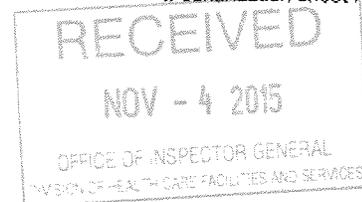
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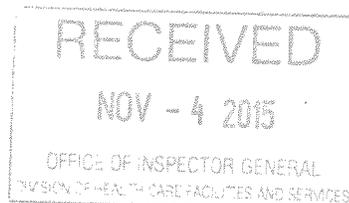
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F 441	Continued From page 23 physician thought the resident had C. diff. She stated she knew nothing regarding C. diff or how it changed hand washing but she would ask the nurse. She stated she was trained by the facility on contact precautions and providing isolation care and that alcohol was the strongest way to kill germs.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of facility training material, and review of facility policy, it was determined the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for one (1) of nineteen (19) sampled residents (Resident #1). The facility failed to ensure Resident #1's medical record included nursing	F 514	1. Resident #1's nursing notes did not show record of the fall at the time of incident. A review of resident #1's record will be completed by 11/7/15 by the Director of Nursing (DON) to ensure documentation exists related to other incident's 7/16/15 or more recent. 2. Residents who have had an incident have the potential to be affected by the deficient practice.	11/4/15



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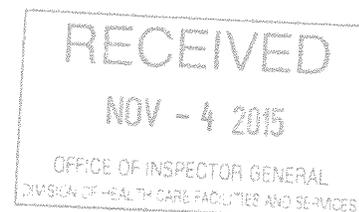
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F 514	<p>Continued From page 24</p> <p>documentation to reflect the resident sustained a fall.</p> <p>The findings include:</p> <p>Review of the facility's documentation training material, not dated, revealed documentation was done to create a tool for communication between health care team members. Further reviewed revealed nurses were responsible for ongoing monitoring of residents who had experienced an incident and documentation should reflect interventions taken. Observations on incident reports should be documented in the nurse's notes.</p> <p>Review of the facility's policy, Incident Report, dated June 2006, revealed the nurse should obtain the relevant facts and complete the incident report. After the incident report was completed, the nurse was to make sure to document in the Nurses Note exactly what happened or occurred. The observations on the Incident Report should be included in the Nurses Notes.</p> <p>Review of Resident #1's incident report, dated 07/16/15, revealed Resident #1 was found in his/her room on the floor without injury at 8:00 PM. However, review of Resident #1's Nursing Observations and Nursing Notes in the clinical record, dated 07/16/15, revealed no documentation in the record that addressed the resident's fall.</p>	F 514	<p>3. The facility will initiate the following practices to ensure the deficient practice does not recur;</p> <p>a) Education will be provided by the staff development coordinator by 11/13/15 to all nurses regarding timely documentation of incidents such as falls, skin tears, etc.</p>	



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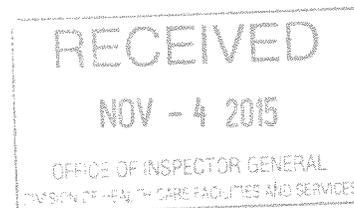
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F 514	<p>Continued From page 25</p> <p>Interview with the Maroon Hall Unit Manager (UM), on 10/08/15 at 8:00 AM, revealed there should have been a nursing note made documenting Resident #1's fall on 09/01/15. She stated a nurse's note was to be made when an incident occurred, such as a skin tear, bruising or fall. The UM further stated she kept a sheet in the nurse's station that showed when and on whom nurse's notes were to be made. She stated resident falls were reviewed during daily morning meetings which included making sure documentation was completed. She stated it must have been overlooked during the meeting that the nurse's note related to Resident #1's fall was missing.</p> <p>Interview with Licensed Practical Nurse #6, on 10/08/18 at 9:20 AM, revealed a nurse's note should be completed after a resident fall. She stated the purpose of making a nurse's note was to communicate with staff about resident care.</p> <p>Interview with the Director of Nursing, on 10/08/15 at 10:40 AM, revealed nurse's notes were required after an incident such as a fall. He stated the Unit Manager was in charge of making sure routine charting was completed. He stated a computer was brought into the daily morning meetings to make sure documentation was completed regarding an incident. He further stated nurse's notes were made to ensure continuity of care, so staff could go back and see if there had been a change with a resident, and to communicate with the physicians. He stated a nurse's note should have been made related to Resident #1's fall. He stated documentation</p>	F 514	<p>b) The Performance Improvement Committee calendar will be updated to include an audit of incidents and documentation of incidents to be completed monthly for 3 months by the DON.</p> <p>4. The facility plans to monitor the performance of the solution for sustainability by the following:</p> <p>a) The Performance Improvement Committee will review the audits performed monthly for 3 months and make needed recommendations to the Quality Assurance and Performance Improvement Committee (QAPI).</p> <p>b) The QAPI Committee will review the submitted reports/audits monthly for 3 months to ensure compliance. Recommendations will be made based on the outcomes of these reports/audits as to needed revisions of the plan of correction.</p>



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F 514	Continued From page 26 training for staff was completed at time of hire.	F 514		



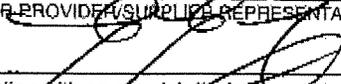
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NAME OF PROVIDER OR SUPPLIER JEFFERSON PLACE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE LOUISVILLE, KY 40222
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1991 (original building), 2011 (physical therapy modifications and addition).</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III unprotected.</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, wet sprinkler system; hydraulically designed.</p> <p>GENERATOR: Type II, 150 KW generator; fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey, utilizing the 2786S, Short Form, was conducted on 10/07/15. The facility was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10/30/15
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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.