

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

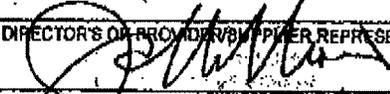
PRINTED: 09/17/2013
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185189	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/05/2013
NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard recertification survey was initiated on 09/03/13 and concluded on 09/05/13 and a Life Safety Code survey was conducted on 09/04/13 with deficiencies cited at the highest scope and severity of an "E". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition	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 of Correction is prepared and executed solely because it is required by Federal and State law."	
F 282 SS=0	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the staff followed the written plan of care for one (1) of twenty (20) sampled residents (Resident #3). The facility failed to ensure anti-embolism hose were placed on Resident #3 as care planned. The findings include: Interview with the Director of Nursing (DON), on 09/05/13 at 4:30 PM, revealed there was no policy for following the care plans. The DON stated the staff were to follow the care plans. Observations of Resident #3, on 09/03/13 at 4:55 PM, 09/04/13 at 9:00 AM, at 1:00 PM, and 09/05/13 at 1:58 PM, revealed anti-embolism hose were not in place as addressed on the care	F 282	On 9/5/13 the orthopedic surgeon for resident #3 was consulted by the Unit Manager due to the resident refusing to have the TED hose applied, the order was received to discontinue the use of TED hose. On 9/19/13 the Unit Managers reviewed records of all other residents with orders for TED hose to ensure that staff were following the residents written plan of care. Then each residents personal physician was consulted by the Unit Managers if the resident was not wearing their TED hose as ordered to evaluate if they were still needed. The DON or Staff Development Coordinator will provide education to all nursing staff on following each residents plan of care and notifying the charge nurse if physician orders are not able to be followed as ordered. All licensed staff and CMT's will be educated on ensuring that the physician orders are followed as ordered before signing the TAR	10/11/13

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

TIME

(X5) DATE

X 

X Administrator X 9/24/13

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 60 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 44 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.

SEP 27 2013

OFFICE OF INSPECTOR GENERAL
 CENTERS FOR MEDICARE & MEDICAID SERVICES

Office of Inspector General
 Northern Region

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

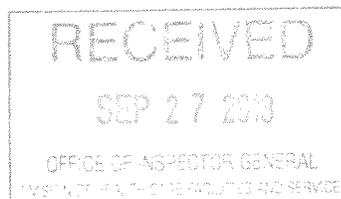
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NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222
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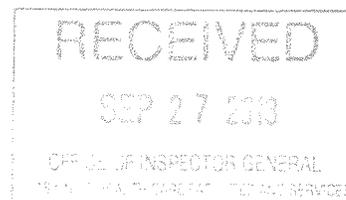
F 282	<p>Continued From page 1 plan.</p> <p>Review of the medical record for Resident #3 revealed the September 2013 physician's orders to have anti-embolism hose to bilateral lower extremities on at 8:00 AM, and off at 8:00 PM.</p> <p>Review of the Nurse Aide care plans for Resident #3 revealed anti-embolism hose were to be placed on the lower extremities at 8:00 AM and removed at 8:00 PM.</p> <p>Interview with Certified Nursing Assistant (CNA) #4, on 09/05/13 at 1:45 PM, CNA #5 at 1:50 PM, and CNA #6 at 2:00 PM revealed the care plan indicated resident #3 was to have anti embolism hose on in the morning and off at night. CNA #4 checked Resident #3's room and no anti-embolism hose were available for use for the resident. The CNAs stated they did not know of Resident #3 wearing anti-embolism hose.</p> <p>Interview, on 09/05/13 at 2:10 PM, with LPN #1 revealed the care plan for Resident #3 had anti-embolism hose to be on in the AM and off at HS. According to LPN #1, the CNA's were responsible for putting anti-embolism hose on the residents. LPN #1 further stated it was the nurses responsibility to ensure the anti-embolism hose were in place for the resident. Resident #3's TARs were initialed to indicated the anti-embolism hose were in place for the Resident. LPN #1 was unaware Resident #3 did not have anti-embolism hose in place.</p> <p>Interview with RN #2 (Unit Manager for the green hall), on 09/05/13 at 2:15 PM, revealed the care plan for Resident #3 indicated anti-embolism</p>	F 282	<p>or MAR. All newly hired nursing staff will receive this education during orientation by the Staff Development Coordinator.</p> <p>The Unit Managers or Assistant Unit Managers are to review 25% of RA Care Plans/nurse aide assignment sheets weekly for 4 weeks then 25% monthly for 4 months to ensure care plans/assignment sheets reflect the current needs of the resident and that interventions are reflective of the care being provided. Any changes needed will be made to reflect the individualized needs of the residents. The Unit Managers or Charge Nurse will audit all residents with an order for TED hose on a weekly basis for 3 months and then monthly to ensure that all TED hose are being donned and removed as ordered. All non-compliance will be addressed at the time it is noted. Non-compliance will be reported to the DON who will report on compliance no less than quarterly for one year to the facility Quality Assurance Committee.</p>	
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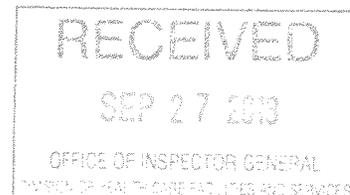
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F 282	Continued From page 2 hose should be worn by Resident #3 and the hose should have been in place for the resident. RN #2 stated the floor nurses had initialed Resident #3's TARs indicating the anti-embolism hose were in place for the resident. RN #2 stated observations were made to try and ensure treatments were carried out as ordered; however, was unaware Resident #3 did not have anti-embolism hose as ordered. Interview with the Director of Nursing, on 09/05/13 at 3:20 PM, revealed the anti-embolism hose should have been in place for Resident #3. According to the DON, the CNAs should have placed the anti-embolism hose on Resident #3's lower extremities in the AM and removed at bedtime as the care plan directed. The DON said the nurses should have been monitoring that anti-embolism hose were in place for Resident #3, and by initialing the TARs the nurses were stating the anti-embolism hose were in place. The DON was unsure why the anti-embolism hose were not in place for Resident #3 according to the care plan.	F 282		
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. This REQUIREMENT is not met as evidenced	F 309	On 9/5/13 the orthopedic surgeon for resident #3 was consulted by the Unit Manager due to the resident refusing to have the TED hose applied, the order was received to discontinue the use of TED hose. The Unit Managers or Assistant Unit Managers will review all records of other residents to ensure that staff are following the residents written plan of care/ physician orders. Any non-compliance will be addressed when identified & re-education provided.	



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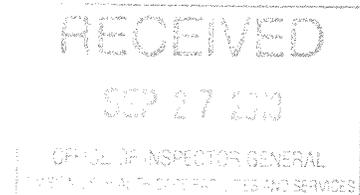
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F 309	<p>Continued From page 3</p> <p>by: Based on observation, interview, and record review, it was determined the facility failed to follow physician orders for one (1) of twenty (20) sampled residents (Resident #3). The facility failed to provide Resident #3 with anti-embolism hose to be on during the day as ordered by the physician.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 09/05/13 at 4:30 PM, revealed there was no policy for following the physician's orders. The DON stated the nurses should always follow the physician's orders.</p> <p>Observations, on 09/03/13 at 4:55 PM, 09/04/13 at 9:00 AM, at 1:00 PM, and on 09/05/13 at 1:58 PM, revealed anti-embolism hose were not place on the resident as ordered by the physician.</p> <p>Review of Resident #3's medical record revealed physician's orders dated 09/01/13 through 09/30/13 to have anti-embolism hose to bilateral lower extremities to be placed on at 8:00 AM, and taken off at 8:00 PM.</p> <p>Review of the September 2013 Treatment Administration Records (TARs) revealed the anti-embolism hose were initiated by the nurses which indicated the anti-embolism hose were placed on Resident #3.</p> <p>Interviews, on 09/05/13 with Certified Nursing Assistant (CNA) #4 at 1:45 PM, CNA #5 at 1:50 PM, and CNA #6 at 2:00 PM, revealed they all stated Resident #3 did not wear anti-embolism hose. The CNA's reviewed the care plan and</p>	F 309	<p>The DON or Staff Development Coordinator will provide education to all nursing staff on following each residents plan of care and notifying the charge nurse if physician orders are not able to be followed as ordered. All licensed staff and CMT's will be educated on ensuring that the physician orders are followed as ordered before signing the TAR or MAR. All newly hired nursing staff will receive this education during orientation by the Staff Development Coordinator.</p> <p>The Unit Managers or Assistant Unit Managers are to review 25% of RA Care Plans/nurse aide assignment sheets/physician orders weekly for 4 weeks then 25% monthly for 4 months to ensure care plans/assignment sheets/physician orders reflect the current needs of the resident and that interventions are reflective of the care being provided. Any changes needed will be made to reflect the individualized needs of the residents. The Unit Managers or Charge Nurse will audit all residents with an order for TED hose on a weekly basis for 3 months and then monthly to ensure that all TED hose are being donned and removed as ordered. All non-compliance will be addressed at the time it is noted.</p>	10/18/13	



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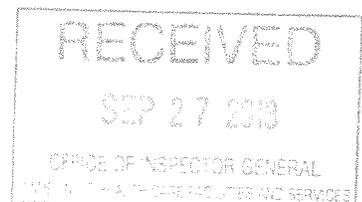
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NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222		
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F 309	<p>Continued From page 4</p> <p>stated the care plan indicated Resident #3 was to have anti-embolism hose on in the morning and off at night. CNA #4 checked Resident #3's room and no anti-embolism hose were available for use for the resident.</p> <p>Interview with LPN #1, on 09/05/13 at 2:10 PM, revealed current physician's orders for Resident #3 indicated anti-embolism hose were to be on in the AM and off at bedtime. LPN #1 further stated the Treatment Administration Records (TARs) were signed daily for the anti-embolism hose by the nurses indicating the hose were put on the resident. LPN #1 stated the CNA's were responsible for putting anti-embolism hose on residents. LPN #1 further stated it was the nurses responsibility to ensure the anti-embolism hose were in place for the resident. Resident #3's TARs were initialed to indicated the anti-embolism hose were in place for the Resident. LPN #1 was unaware Resident #3 did not have anti-embolism hose in place.</p> <p>Interview with RN #2 (Unit Manager for the green hall), on 09/05/13 at 2:15 PM, revealed when the nurses initialed TARs for a treatment to indicate the treatment had been completed. RN #2 stated the nurses had initialed Resident #3's TARs indicating the anti-embolism hose were in place for the resident. RN #2 stated on rounds observations were made to try and ensure treatments were carried out as ordered. RN #2 was unaware Resident #3 did not have anti-embolism hose as ordered.</p> <p>Interview with the Director of Nursing, on 09/05/13 at 3:20 PM, revealed the anti-embolism hose should have been in place for Resident #3. The nurses should have been monitoring that the</p>	F 309		



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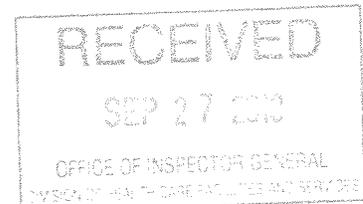
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185159	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/05/2013
NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222		
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F 309	Continued From page 5 anti-embolism hose were in place for Resident #3, and by initialing the TARs the nurses were stating the anti-embolism hose were in place. The DON was unsure why the anti-embolism hose were not in place for Resident #3 as prescribed by the physician.	F 309			
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure all nursing assistants completed twelve (12) hours of in-service training hours per year. Six (6) of eight (8) sampled nursing assistants did not complete twelve (12) hours of training. The findings include: Review of the facility's policy regarding Staff Development/State Registered Nursing Assistant	F 497	The DON reviewed all in-service training hours on 9/6/13 for all State Registered Nursing Assistants (SRNA) to determine each SRNA's needed hours. All SRNA's that were found not to have 12 hours of in-service training by their anniversary date will be required to obtain their hours by 10/17/13 or they will be removed from the schedule until their hours are completed. All SRNA's will be given the number of in-service hours needed by their anniversary date by the DON or Staff Development Coordinator. The DON or Staff Development Coordinator will provide education to all SRNA's regarding the need for 12 hours of in-service education in order to meet the State requirements. SRNA's will not be able to work if they have not completed their 12 hours of in-service education by their anniversary date. The DON or Staff Development	10/18/13	



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F 497	<p>Continued From page 6</p> <p>(SRNA), revealed each nursing facility was required by state regulation to provide a minimum of 12 hours of in-service education annually for each SRNA employee. It was the responsibility of the nursing facility to be in compliance with the regulation.</p> <p>Review of the SRNA education tracking sheets revealed six (6) of eight (8) sampled SRNAs did not have the required twelve (12) hours of in-service training. The six SRNAs had 4.75 hours, 3.2 hours, 2.75 hours, 5.8 hours, 5.5 hours and 6.25 hours of in-service training hours.</p> <p>Interview with the Staff Development Coordinator, on 09/05/13 at 4:37 PM, revealed it was her responsibility to monitor the SRNA education to ensure they had the required education. She stated it was important for SRNAs to have education in order to keep up with their skills. It was also important to keep current with any changes in policies and procedures in order to keep providing quality of care.</p> <p>Interview with the Director of Nursing (DON), on 09/05/13 at 4:45 PM, revealed they were having an issue getting SRNAs to attend the in-service offerings. It was not a concern last survey and had not been taken to the Quality Assurance Committee. She stated the classes were being offered but the SRNAs were not attending. There had been a failure in the process by failing to accurately monitor the SRNA education hours for each SRNA.</p>	F 497	hours are being met. All findings will be reported at least quarterly for one year to the Quality Assurance Committee.	



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NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222		
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{F 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/18/13 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.

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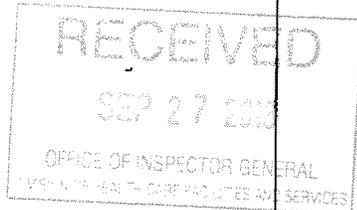
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165169	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/04/2013
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1982</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (111)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 09/04/13. Jefferson Manor was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has one-hundred (100) certified beds with a census of ninety-eight (98) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>"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 of Correction is prepared and executed solely because it is required by Federal and State law."</p>	
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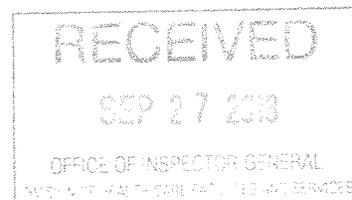
LABORATORY DIRECTOR'S OR PROVIDER/CORPUS REPRESENTATIVE'S SIGNATURE *[Signature]* X *Administrator* X *9/24/13*

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

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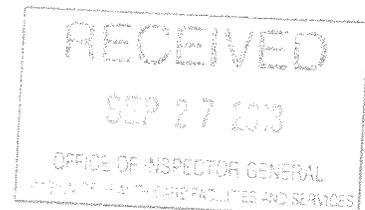
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185169	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/04/2013
NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	Continued From page 1	K 000			
K 076 55=E	<p>Deficiencies were cited with the highest deficiency identified at E level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage rooms were protected in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, approximately fifty (50) residents, staff and visitors. The facility has one-hundred (100) certified beds and the census was ninety-eight (98) on the day of the survey. The facility failed to ensure oxygen cylinders were stored a minimum of five (5) feet away from any combustibles items stored within the room.</p>	K 076	<p>On 9/6/13 the unit secretaries moved all combustible supplies from the oxygen rooms on both units and placed them in the clean storage room. All other storage areas were found to be in compliance on the date of the survey. A re-inspection of the facility storage areas was performed by the maintenance on 9/27/13 and all were found to be in compliance.</p> <p>The Director of Maintenance shall perform monthly inspections of all storage areas to ensure all supplies are stored in a proper and safe manner. If any non compliance is detected it will be corrected immediately. The monthly inspections will be recorded in the TEL's program book and reviewed by the Regional Director of Facilities Maintenance who will report any missed reviews to the facility Administrator. The Director of Maintenance will report on all TEL's reviews no less than quarterly for a year to the Facility Quality Assurance committee.</p>	9/27/13	



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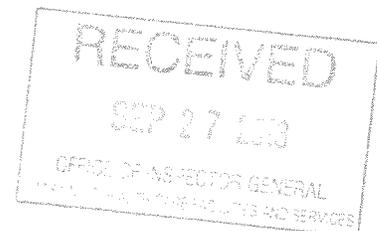
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185169	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/04/2013
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(X4) ID PREFIX TAG	SUMMARY 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 076	<p>Continued From page 2</p> <p>The findings include:</p> <p>Observation, on 09/04/13 at 1:11 PM, with the Maintenance Director revealed the Oxygen Storage Room located in the 100 Wing, had oxygen cylinders stored within five (5) feet of combustible medical supplies on open shelves.</p> <p>Interview, on 09/04/13 at 1:11 PM, with the Maintenance Director revealed he was unaware oxygen cylinders could not be stored within five (5) feet of combustible items and acknowledged the potential of a hazardous situation.</p> <p>Observation, on 09/04/13 at 2:32 PM, with the Maintenance Director revealed the Oxygen Storage Room located in the 800 Wing, had oxygen cylinders stored within five (5) feet of combustible medical supplies on open shelves.</p> <p>Interview, on 09/04/13 at 2:32 PM, with the Maintenance Director revealed he was unaware oxygen cylinders could not be stored within five (5) feet of combustible items and acknowledged the potential of a hazardous situation.</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable</p>	K 076		



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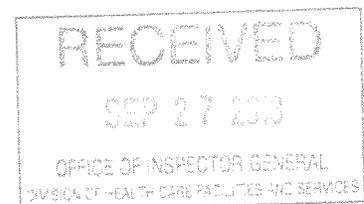
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185169	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/04/2013
NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 LYNN WAY LOUISVILLE, KY 40222	
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K 076	Continued From page 3 gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	To ensure compliance with NFA 101 Life Safety Code Standard, tag 147 on 9/4/13 the microwave, cookie maker and refrigerator	9/27/13



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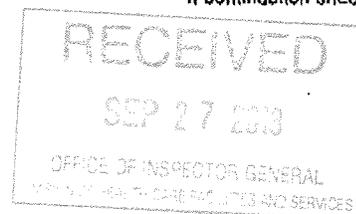
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185169	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/04/2013
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K 147	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, approximately twenty-five (25) residents, staff, and visitors. The facility has one-hundred (100) certified beds and the census was ninety-eight (98) on the day of the survey. The findings include: Observation, on 09/04/13 at 1:40 PM, with the Maintenance Director revealed three (3) small appliances (a refrigerator, a microwave oven and a cookie maker) were plugged into a power strip located in the Activities Room. Interview, on 09/04/13 at 1:40 PM, with the Maintenance Director revealed he was aware of the requirements for the usage of power strips; however, he was not aware of the three (3) small appliances being plugged into a power strip located in the Activities Room. Further interview with the Activities Staff, at 1:43 PM, revealed the room had been painted as a part of the facility's renovation project and the three (3) small appliances were relocated to the opposite wall within the room. Reference: NFPA 99 (1999 edition)	K 147	located in the Activity Room were unplugged from the power strip and plugged into a wall receptacle by the Director of Maintenance and Activity Assistants. On 9/4/13 all other areas were checked by the Director of Maintenance to ensure the proper use of power strips. No other deficient practice was noted. The Director of Maintenance to observe all office and resident areas monthly for proper use of power strips and record findings in the TELs System. Power Strips will be removed if observed being used inappropriately. The Regional Director of Facility Maintenance will review the TELs documentation no less than quarterly and report any missed reviews to the Administrator. The Director of Maintenance will report on all TEL's review no less than quarterly for one year to the facility Quality Assurance Committee at least quarterly.		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185168	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/04/2013
NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222		
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K 147	Continued From page 5 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147			



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NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222
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{K 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/27/13 as alleged.</p>	{K 000}		
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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.