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

AUG 0 6 2020

PRINTED: 07/23/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (XE) MULTIPLE CONSTRUCTION TOFFICE OF INSPECTOR GENERAL A. RUMBING HEALTH CARE FACILITIES AND SERVICES (X3) DATE SURVEY
COMPLETED

_

185169

B. WING

07/10/2020

NAME OF PROVIDER OR SUPPLIER

SIGNATURE HEALTHCARE AT JEFFERSON MANOR REHAB & WE

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)

PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 000 INITIAL COMMENTS

An Abbreviated Survey investigating KY# 31910 and a COVID-19 Focused Infection Control Survey was initiated 07/02/2020 and concluded on 07/10/2020. KY# 31910 was unsubstantiated; however, related deficiencies were cited. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 72.

F 656 Develop/Implement Comprehensive Care Plan ss=p CFR(s): 483.21(b)(1)

§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and Implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will

F 000

Preparation and execution of this allegation of compliance does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in alleged deficiencies. This allegation of compliance is prepared and/or executed solely because it is required by the provisions of Federal and State law.

F 656

How correction action will be accomplished for those residents found to have been affected by the deficient practice;

The care plan has been updated on Resident #3 and #4 to reflect their adaptive equipment being utilized on 7/15/20 by Special Projects, Clinical Reimbursement Specialist.

How the facility will identify other residents having the potential to be affected by the same deficient practice; All physician's orders were reviewed by the Administrator to verify those residents with adaptive equipment orders on 7/13/20.

The Special Projects, Clinical Reimbursement Specialist reviewed all care plans of those residents with adaptive equipment orders and implemented care plans on 7/15/20.

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

TITLE

117

(X6) DATE

Any deficiency statement ending with an acterisk (*) 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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AND	PLAN	OF	CO	RRE	CT	ION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

OFFICE OF INSPECTOR GENERAL
(X2) MULTIPUR YOUNG THE SAND SERVICES
A. BUILDING

(X3) DATE SURVEY COMPLETED

C 07/10/2020

185169

B WING

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)

SIGNATURE HEALTHCARE AT JEFFERSON MANOR REHAB & WE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X3) COMPLETION DATE

F 656 Continued From page 1

provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-

- (A) The resident's goals for admission and desired outcomes.
- (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entitles, for this purpose.
- (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, it was determined the facility failed to implement the care plan for two (2) residents, Residents #3 and #4. Observations revealed facility-provided meal trays did not contain the care planned adaptive utensils or equipment.

The findings include:

Review of facility policy Comprehensive Care Plans (CCP), revised 07/19/18, revealed the person-centered Comprehensive Care Plan included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs and was developed for each

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur; MDS Coordinator's, Licensed staff and Unit Managers were educated on 7/15/20, 7/16/20 7/17/20, 7/20/20, 7/24/20, 7/25/20, 7/26/20 and 7/27/20. to implement care plans to include adaptive equipment ordered for residents.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and

The DON, Unit Managers and/or Administrator are auditing for implementation of care plans related to adaptive equipment in their daily clinical meeting. These audits began on 7/17/20 and are ongoing as part of clinical meeting. Any issued identified will be corrected immediately and staff will be counseled as necessary. Results from audits will be reviewed by the QAPI committee monthly for further review and recommendations.

Completion Date - 7/30/2020

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

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		185169	B: WING		C
NAME OF	PROVIDER OR SUPPLIER				07/10/2020
MANUE OF !	PROVIDER OR SUPPLIER		ŧ	STREET ADDRESS, CITY, STATE, ZIP CODE	
SIGNATI	IDE HEALTHOADE A			1801 LYNN WAY	
SIGNALL	INE HEALIHUARE A	T JEFFERSON MANOR REHAB &	.WE	LOUISVILLE, KY 40222	
1				LOUISVILLE, RT 40222	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 655	- "				
F 056	Continued From pa	ge 2	F 65	56	
	resident Additional	ly, the CCP included how the			
ļ					
		resident to meet their needs,			
	goals and preference	ces and included specialized			
	services.				
ŀ					
Ì	Review of facility po	olicy Adaptive Equipment -			
!		evised 08/30/19, revealed			
		uipment was used by			
	residents who need	ed to improve their ability to			
	feed themselves.				
	Review of facility re	cord revealed the facility			
		nt #3 on 01/23/2020 with			
		Diabetes Type 2, Iron			
	Deficiency Anemia,	Muscle Weakness, and			
	Vitamin Deficiency,	Unspecified.			
	i.				
	Paylow of the Physi	ician Orders for Resident #3			
		ated 05/21/2020 that specified			
		tency CCHO (consistent			
	carbohydrate) no sa	ilt packets, no bananas, no			
		juice), no fresh potatoes.			
		ninety (90) degree spoon.			
	Divided higher also a	imiety (au) degree spoon.			
	D				
		revealed the problem resident			
	has a potential for n	utritional risks, secondary to			
		ons: Diabetes Meilitus Type			
		igh BMI (body mass index).			
		s problem listed to provide diet			
	as ordered.				
		lunch service, on 07/02/2020			
	at 12:20 PM, revea	led Resident #3's tray			
		(90) degree spoon and the			
		g a regular teaspoon to eat.			
		ard specified the tray required			
	a ninety (90) degree	spoon.			

Review of facility record revealed the facility

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

OFFICE OF INSPECTOR GENERAL (XENASOUTIPEENOBRETERMENTEMAND SERVICES A. BUILDING

(X3) DATE SURVEY COMPLETED.

07/10/2020

AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

IDENTIFICATION NUMBER

185169 B. WING

SIGNATURE HEALTHCARE AT JEFFERSON MANOR REHAB & WE

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)

PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 656 Continued From page 3

re-admitted Resident #4 on 02/13/19 with diagnoses including Multiple Sclerosis. Muscle Weakness, and Dysphagia, Oropharyngeal Phase.

Review of the Physician Orders for Resident #4 revealed an order in the section, Dietary Flow Sheet, dated 03/02/2020 that specified sippy cup for liquids at meals.

Review of the CCP revealed a problem nutritionally at risk related to therapeutic diet and noncompliance with diet. Risk for alterations in fluid maintenance related to heart failure with diuretic use. Approaches for the Problem included diet as ordered.

Observation during lunch service, on 07/02/2020 at 12:37 PM, revealed Resident #4's trav contained a cup of water and a cup containing a light yellow liquid.

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

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

F 656

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		185169	B WING		C 07/10/2020
		T JEFFERSON MANOR REHAB	& WE	STREET ADDRESS, CITY, STATE, ZIP COD 1801 LYNN WAY LOUISVILLE, KY 40222	E 67710/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE COMPLETION
F 656	Continued From pa	ge 4	F6	556	
	revealed staff devel goals and guideline. did not provide care then staff did not im Interview with Greer on 07/08/2020 at 4:10 plans directed staff resident and staff improvide good and not UM stated staff individualized care paddress the resident UM stated the ordered Interview with the Blon 07/09/2020 at 2:5 individualized care paddress the resident UM stated CNA's we adaptive equipment meal trays.	#4, on 07/09/2020 at 3:25 PM, oped resident care plans with a to meet the goals and if staff planned adaptive equipment plement the care plan. In Unit Manager (Green UM), 04 PM, revealed resident care on the care necessary for the aplemented the care plan to ecessary care. The Green widualized resident care plans and of the resident and all ple to insure meal trays and adaptive equipment. The Unit Manager (Blue UM), 55 PM, revealed staff all ple in sure medical needs. The Blue are responsible to insure was included on resident.			
,	07/09/2020 at 2:01 F initially prepare resid adaptive equipment adaptive equipment resident eat and failu equipment may hindudrinking properly.	etary Manager (DM), on PM, revealed dietary staff ent trays, including providing as ordered. The DM stated was necessary to help the ire to provide adaptive er a resident from eating or			
(07/10/2020 at 8:45 A responsible to insure	rector of Nursing (DON), on M, revealed all staff were resident meal trays quipment as ordered.			

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION TOR GENERAL (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 185169 B. WING 07/10/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY SIGNATURE HEALTHCARE AT JEFFERSON MANOR REHAB & WE LOUISVILLE, KY 40222 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 656 Continued From page 5 F 656 Interview with the Administrator, on 07/10/2020 at 9:42 AM, revealed she was unaware of any issue with residents receiving adaptive equipment with meal trays. The Administrator stated the facility audited orders to meal tray cards but did not specify if the facility audited meal tray cards to the meal tray provided to residents. F 761 Label/Store Drugs and Biologicals F 761 How corrective action will be SS=D CFR(s): 483.45(g)(h)(1)(2) accomplished for those residents found §483.45(g) Labeling of Drugs and Biologicals to have been affected by deficient Drugs and biologicals used in the facility must be practice: labeled in accordance with currently accepted professional principles, and include the No residents were affected by the cited appropriate accessory and cautionary deficiency. instructions, and the expiration date when The expired normal saline solution, applicable. sterile saline solution, oxygen tubing and §483.45(h) Storage of Drugs and Biologicals IV start kits were removed from emergency cart on 7/2/20 by Central §483.45(h)(1) In accordance with State and Supply Clerk. Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized How the facility will identify other personnel to have access to the keys. residents having the potential to be affected by the same deficient practice; §483.45(h)(2) The facility must provide separately The Central Supply Clerk audited the two locked, permanently affixed compartments for emergency carts on 7/2/20 to verify no storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and another expired items were on the Control Act of 1976 and other drugs subject to emergency carts. abuse, except when the facility uses single unit

be readily detected.

package drug distribution systems in which the quantity stored is minimal and a missing dose can

What measures will be put into place, or

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

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		185169	B WING		C
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	07/10/2020 E. ZIP CODE
SIGNAT	URE HEALTHCARE A	F JEFFERSON MANOR REHAB	& WE	1801 LYNN WAY LOUISVILLE, KY 40222	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION OATE
F 761	by: Based on observate review, it was determined the professional standal expired items. Observations and items of the emergency cart daily and restocked. Observation of the empression daily and restocked. Observation of the empression daily and restocked. Observation of the empression date of 05 administration set with the empression date of 05 administration of the empression of the empress	ion, interview, and record mined the facility failed to iologicals were stored in a rd to prevent the presence of ervations revealed expired on and sterile saline solution gency carts. In addition, on revealed expired medical exygen tubing and intravenous :: licy Emergency Carts, revealed the facility insured and staff audited the carts	F 7	by the Staff Develor 7/15/20, 7/16/20, a7/24/20, 7/25/20 Any staff not education not work until educations (s) to ensure practice is being corecur, and The Unit Manager (semergency cart(s) with medications. These 7/24/20. Any issue corrected immediate.	ated by 7/29/20 will cation has been all monitor its corrective that the deficient rrection and will not weekly for any expired a audits began on a identified will be sary. Results from the ved by the QAPI for further review ons.

solution with an expiration date of 03/08/19 and an IV start kit with an expiration date of 05/31/2020.

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

PRINTED: 07/23/2020 FORM APPROVED OMB NO: 0938-0391

		& WEDICAID SERVICES			MB NO. 0938-039
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILC	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
No. of Br		185169	B. WING	residence of the second	C 07/10/2020
		T JEFFERSON MANOR REHA	B & WE	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 4022Z	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	BE COMPLETION

F 761 Continued From page 7

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

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

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

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

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

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AUG 0 6 2020

OFFICE OF INSPECTOR GENERAL

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

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIFLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		185169	B. WING		C 07/10/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	07/10/2020
SIGNATU	JRE HEALTHCARE AT	JEFFERSON MANOR REHAB 8	WE	1801 LYNN WAY LOUISVILLE, KY 40222	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CO {EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY}	IN SHOULD BE COMPLETION DATE
F 810	Continued From pa	de 8	F 81	How corrective action	will be
		Eating Equipment/Utensils	F 81	accomplished for those	e residents found
SS=D	CFR(s): 483.60(g)	caming adorbitions of citalia	FO	to have been affected	by the deficient
				practice;	
	§483.60(g) Assistive	devices wide special eating equipment		Resident #3 and #4 had	d no adverse
	and utensils for resi	dents who need them and		effects related to adap	itive equipment
	appropriate assistar	ice to ensure that the resident		not being on tray on su	urvey date of
	can use the assistiv meals and snacks.	e devices when consuming		7/2/20.	
				How the facility will ide	entify other
	This REQUIREMEN	T is not met as evidenced		resident's having the p	otential to be
	by:			affected by the same d	leficient practice;
	Based on observati	on, interview, and record		All physician orders we	ere reviewed by
	provide special eatir	nined the facility falled to ig equipment and utensils for		Administrator on 7/13,	/20 to verify all
	two (2) residents, Re	esidents #3 and #4.		resident receiving adap	ptive equipment
	Observations reveal did not contain the o	ed facility-provided meal trays rdered adaptive equipment.		were listed on dietary'. equipment list.	s adaptive
	The findings include	6		What measures will be p	out into place, or
	Review of facility pol	icy Adaptive Equipment -		systemic changes made,	
	Feeding Devices, re	vised 08/30/19, revealed		the deficient practice wi	
		ipment was used by d to improve their ability to		Education was provided	
	feed themselves.	d to improve their ability to		Certified Nursing Assista	
				therapy and Ambassado	rs by the Staff
		ord revealed the facility		Development Coordinate	
		#3 on 01/23/2020 with Diabetes Type 2, Iron		7/16/20, 7/20/20, 7/23/	
	Deficiency Anemia, N	Nuscle Weakness, and		7/25/20, 7/26/20 and 7/	
	Vitamin Deficiency, L			tray card for adaptive eq	
1	Deview of the Dhoet	ion Orders for Bootstook are		verifying resident has it o	
		ian Orders for Resident #3 ted 05/21/2020 that specified		tray. Any staff not educa	
	Diet: regular consiste	ncy CCHO (consistent		will not be allowed to wo	
(carbohydrate) no sali	packets, no bananas, no		education is completed.	

FORM CMS-2567(02-99) Previous Versions Obsolete

oranges/OJ (orange juice), no fresh potatoes.

Event ID: QLHA11

Facility ID: 100533

If continuation sheet Page 9 of 12



PRINTED: 07/23/2020

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		OMB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
		185169	B WING	C 07/10/2020
	PROVIDER OR SUPPLIER URE HEALTHCARE A	JEFFERSON MANOR REHAB	WE	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 810	Review of the CCP has a potential for rathe following conditions, and H An approach for this as ordered. Observation during at 12:20 revealed Rainety (90) degree sutilizing a regular testray card specified to degree spoon. Review of facility recreadmitted Resider diagnoses including Waakness, and Dyservealed an order in Sheet, dated 03/02/2 for liquids at meals. Review of the CCP rautritionally at risk reconcompliance with fluid maintenance rediuretic use. Approaincluded diet as order	revealed the problem resident nutritional risks, secondary to ions: Diabetes Mellitus Type ligh BMI (body mass index), s problem listed to provide diet lunch service, on 07/02/2020 esident #3's tray contained no spoon and the resident was aspoon to eat. Review of the he tray required a ninety (90) cord revealed the facility of the facility of the facility of the phagia, Oropharyngeal cian Orders for Resident #4 the section, Dietary Flow 2020 that specified sippy cup revealed a problem elated to therapeutic diet and diet. Risk for alterations in lated to heart failure with eaches for the Problem ered.	F 8	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and Dietary Manager and or Dietary Assistant is randomly auditing three trays a day, five days a week to verify adaptive equipment is on the tray. This audit began on 7/20/20. Department Managers are auditing three meal trays for adaptive equipment five days/week. This audit began on 7/17/20 Manager of Duty is auditing three trays for adaptive equipment on the weekends. This audit began on 7/18/20. These audits will continue daily for one month and then weekly for three months. Any issues identified will be corrected immediately and staff will be counseled as necessary. Results from the audits will be reviewed by the QAPI committee monthly for further review and recommendations. Completion Date – 7/30/20 RECEIVED AUG 06 2020

light-yellow colored liquid.

OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES

PRINTED: 07/23/2020 FORM APPROVED OMB NO 0038-0391

r	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A SUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
			185169	B W!NG		C
Ì	NAME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE,	07/10/2020
	SIGNATU	JRE HEALTHCARE A	JEFFERSON MANOR REHAB	8. WE	1801 LYNN WAY LOUISVILLE, KY 40222	DP GGDE
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
		#1, on 07/02/2020 at were responsible to included the correct stated adaptive equipment and potential choking. Interview with Licen on 07/08/2020 at 1: responsible to insure devices. LPN #2 stracessary to insure lose nutrition. Interview with Greer on 07/08/2020 at 4:0 responsible to insure lose nutrition. Interview with Greer on 07/08/2020 at 4:0 responsible to insure ordered adaptive equipment and properties on the properties of the pr	fied Nursing Assistant (CNA) at 1:00 PM, revealed CNA's insure resident meal trays adaptive equipment. CNA #1 ipment was necessary to eat better and prevent sed Practical Nurse (LPN) #2, 19 PM, revealed all staff were the resident's meal trays adaptive utensils and ated adaptive utensils were a resident did not potentially in Unit Manager (Green UM), 14 PM, revealed all staff were meal trays contained the uipment. The Unit Manager (Blue UM), 15 PM, revealed CNA's were adaptive equipment was	F 8	10	
		nterview with the Dir 07/10/2020 at 8:45 A esponsible to insure	ector of Nursing (DON), on M, revealed all staff were resident meal trays			

contained adaptive equipment as ordered.

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

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		1			OIVID 140	. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.00	(X2) MULTIPLE CONSTRUCTION A BUILDING		E SURVEY APLETED
		185169	B WING		07/	C /10/2020
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		10.2020
SIGNATUR	RE HEALTHCARE A	AT JEFFERSON MANOR REHA	B & WE	1801 LYNN WAY LOUISVILLE, KY 40222		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE

F 810 Continued From page 11

F 810

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



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185169	B. WING _		07/	/10/2020
	ROVIDER OR SUPPLIER	FFERSON MANOR REHAB & WE		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 000	Survey was initiated of concluded on 07/10/2	020. The facility was found vith 42 CFR 483.73 related	EO			
ARORATORY	DIRECTOR'S OR PROVIDER/S	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.

07/28/2020

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Office of Inspector General

	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER	١.		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		100533		B. WING		07	/10/2020
	ROVIDER OR SUPPLIER	FFERSON MANOR F	STREET ADDRI 1801 LYNN V LOUISVILLE		TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 0000	A Complaint Survey is a COVID-19 Focused was initiated 07/02/2007/10/2020. KY# 319 however, related defi	nvestigating KY# 31910 at Infection Control Survey 020 and concluded on 910 was unsubstantiated; ciencies were cited. The pe in compliance pursuant	,	N 000			

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

TITLE

(X6) DATE 07/28/20

STATE FORM 6899 QLHA11 If continuation sheet 1 of 1