

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

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PRINTED: 03/25/10
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	APR 21 2010 OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES	(X3) DATE SURVEY COMPLETED R 03/25/2010
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NAME OF PROVIDER OR SUPPLIER JAMES S TAYLOR MEMORIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 W MAGAZINE STREET LOUISVILLE, KY 40203
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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
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{F 000}	INITIAL COMMENTS Amended CMS 2567L issued to facility on 04/19/10. A recertification follow-up survey was conducted on 03/25/10. Based on record reviews, interviews and observations, it was determined that immediate jeopardy had been removed with continued non-compliance remaining at a scope and severity of an "E" at 42 CFR 483.13 Resident Behavior, F226, at 42 CFR 483.25 Quality of Care, F323 and at 42 CFR 483.75 Administration, F490. The Administration of the facility failed to have a system to ensure the facility had documented evidence of the completion of audits, interviews, and monitoring to ensure correction of deficient practice. The facility had not completed employee questionnaires to verify knowledge of policies and procedures related to resident to resident incidents in the facility. In addition, the facility was unable to provide evidence of compliance rounds (audits) made by unit manager/supervisors/charge nurses to monitor staff knowledge and compliance with behavior interventions on resident 's care plans. The non-Immediate Jeopardy deficiencies cited during the standard/extended survey on 03/10/10 were not reviewed for compliance during the 03/25/10 revisit. Therefore, the 03/25/10 statement of deficiencies details deficient practice remaining at F323 and F490 and also includes the non-immediate Jeopardy deficiencies identified during the 03/10/10 standard/extended survey.	{F 000}		
{F 203} SS=B	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a	{F 203}	Information regarding transfer/discharge has been sent to the responsible party of Resident #13 who now resides at another facility.	4-1-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Stephanie G. Mathis</i>	TITLE <i>Administrative</i>	(X6) DATE <i>4/2/10</i>
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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.

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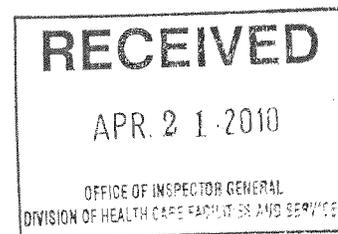
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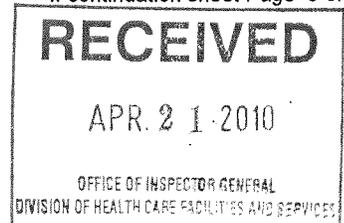
{F 203}	<p>Continued From page 1</p> <p>resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally</p>	{F 203}	<p>All residents who are transferred from the facility have the potential to be affected.</p> <p>The nurse consultant conducted an in-service for the Administrator, Social Services Director and Director of Nursing regarding the requirements for providing a notice of transfer and discharge to the resident and, if known, a family member or legal representative.</p> <p>The facility will adhere to this requirement for its residents who will be discharged or transferred. The notice states the information listed in the requirements, including the reason for transfer or discharge, the effective date of transfer or discharge, the location to which the resident is transferred or discharged, a statement that the resident has the right to appeal the action to the State and the name, address and telephone number of the State long term care ombudsman. The nurses will be instructed to include the Notice of</p>	
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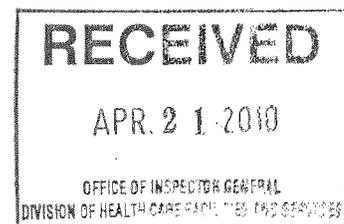
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{F 203}	<p>Continued From page 2</p> <p>disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide a notice of transfer/discharge to one (1) of the forty (40) sampled residents. Resident #13 was discharged involuntarily to a psychiatric hospital related to the resident's physically aggressive behaviors.</p> <p>The findings include:</p> <p>Review of the clinical record for Resident #13 revealed the resident was admitted to the facility from a psychiatric facility with diagnoses of Dementia with a Disturbance in Behavior and Pick's Disease (degeneration of the frontal and temporal lobes of the brain resulting in behavior problems/personality changes). The nursing notes from 01/30/10 revealed the resident grabbed other residents if there were altercations. On 01/25/10 Resident #13 grabbed another resident resulting in the other resident sustaining small abrasions. On 02/04/10, Resident #13 had a verbal and physical altercation with another resident. The physician ordered Resident #13 be sent that evening to a psychiatric hospital. Review of the social service notes from 02/05/10 revealed the hospital was called and notified the facility would not be readmitting the resident</p>	{F 203}	<p>Transfer and Discharge with the information that is sent when a resident leaves the facility. A copy will be sent to the family member or legal representative by the Social Services Director if the family member/legal representative is not available at the time of the resident's transfer to the hospital, other health care facility or home.</p> <p>It is the responsibility of the Social Services Director to ensure Transfer/Discharge Notices are sent. Medical Records will audit the medical records of discharged residents to ensure this has been done. Any discrepancies will brought to the attention of the Director of Nursing or Administrator for further action.</p>		



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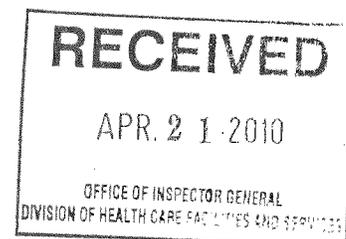
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{F 203}	Continued From page 3 related to behavior problems. Interview with the Social Services Director on 02/16/10 at 5:30pm, revealed Resident #13 was discharged from the facility related to behaviors. She stated a notice of transfer/discharge was not provided to the resident since the resident's Veteran's Worker would be able to find placement for the resident after the psychiatric hospital stay. She stated notices of transfer/discharge were not usually provided to residents transferring to another facility. She was unable to state the facility's policy on transfer/discharge notices. Interview with the Administrator on 02/16/10 at 4:40pm, revealed a notice of transfer/discharge was not provided to Resident #13 as the resident was going to another facility. She stated providing a notice of transfer/discharge did not apply to this resident. She was unable to provide information on the facility notice of transfer/discharge when residents had urgent transfers from the facility.	{F 203}			
{F 226} SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	{F 226}			



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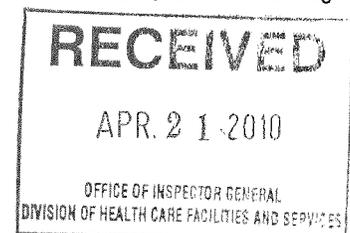
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{F 226}	Continued From page 4 by: Not Corrected Based on interview, and record review it was determined during the 03/25/10 revisit, the facility had not completed employee questionnaires to verify knowledge of policies and procedures related to resident to resident incidents in the facility. In addition, the facility was unable to provide evidence of compliance rounds (audits) made by unit manager/supervisors/charge nurses to monitor staff knowledge and compliance with behavior interventions on resident ' s care plans. The findings include: 1. Interview with the Administrator, on 03/23/10 at 6:50 PM, revealed administrative staff and department heads provided inservice education to staff regarding resident to resident incidents in the facility. The Administrator continued that staff were required to complete a questionnaire following the training which measured staff ' s knowledge of the facility ' s policies/procedures regarding resident to resident incidents in the facility. The Administrator stated one hundred percent (100%) of staff members would complete the knowledge questionnaire prior to April 8, 2010. Review of completed knowledge questionnaires revealed sixty-one (61) questionnaires had been completed. According to the Administrator, the facility had approximately one hundred fifteen (115) staff members. 2. Interview with the Director of Nursing (DON), on 03/25/10 at 5:50 PM, revealed she was unable to provide evidence of rounds made by facility unit managers, supervisors, or charge nurses, to supervise staff and monitor compliance with	{F 226}	All residents have the potential to be affected. There were no specific residents cited. The facility has a system in place to ensure that all employees have completed the employee questionnaire to verify knowledge of policies and procedures related to resident to resident incidents in the facility. The employee test are discussed at the weekly QA meeting to ensure that all newly hired staff have completed the employee questionnaire. The Unit Managers /supervisors are making rounds to monitor staffs knowledge and compliance with behavior interventions on resident's care plans. The Unit Managers/supervisors are documenting their rounds and are turning their completed rounds into the Nursing Administrative Assistance that list the staff name of who was interviewed. These rounds are discussed in the weekly Quality Assurance Committee meeting.	4-1-10	



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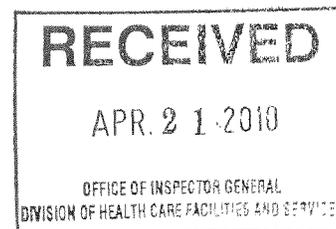
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{F 226}	Continued From page 5 behavioral interventions listed on each resident 's care plan. She stated administrative staff had completed the rounds " for awhile " , but did not document the evidence obtained during the rounds. According to the DON, " I didn ' t think to tell them " (to document evidence of the rounds). However, she stated the charge nurses marked the Certified Nursing Assistant (CNA) care plan sheets with a highlighter after they completed random interviews to verify the CNS ' s knowledge of individual residents to which they provided care. Staff were afforded the opportunity to provide evidence of examples of highlighted care plans and were unable. Interview with LPN #10, a unit manager, on 03/25/10 at 5:45 PM, revealed the LPN interviewed two (2) CNAs three (3) or four (4) days ago to verify knowledge regarding behavioral interventions included on resident ' s care plans, for residents for whom the CNAs provided care. However, the unit manager was unable to provide evidence of the interviews. Interview with LPN #8, a unit manager, on 03/25/10 at 5:55 PM, revealed she interviewed three (3) CNAs, at random, regarding knowledge of facility policies on resident to resident incidents. The LPN was unable to provide any evidence the interviews were conducted. The LPN was unaware she should verify CNA ' s knowledge about resident ' s care plan interventions.	{F 226}			
{F 241} SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	{F 241}	The catheter bag for Resident #11 was positioned properly and covered for privacy when brought to the attention of the staff. Resident #11's care plan was updated on February 2, 2010, relating to care of the catheter. Dignity and proper care of the catheter for Resident #11 is being provided by staff.	4-1-10	



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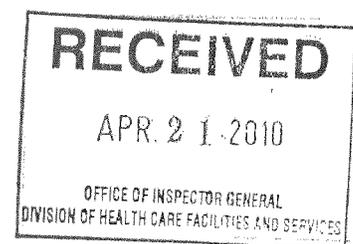
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{F 241}	Continued From page 6 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to promote care to residents in a manner that maintains or enhances resident dignity for one (1) of the forty (40) sampled residents (Resident #11). Resident #11's indwelling catheter drainage bag was observed uncovered and lying on the floor in the resident's room, and in the dining room during meal times, despite multiple staff members walking/working in close proximity to the drainage bag and tubing. The findings include: Record review on 02/02/10 at 11:00am of Resident #11 revealed a re-admission date of 11/11/09 and diagnoses of Paraplegia secondary to Polio. The quarterly MDS assessment dated 11/10/09 indicated the resident was incontinent of bladder. There was no indication of an indwelling catheter utilized by the resident. The treatment records did not indicate there was a urinary catheter in use. The plan of care did not indicate the use of the urinary catheter. Observation on 02/02/10 at 6:00am revealed Resident #11's indwelling catheter bag lying on the floor in the resident's room. The catheter bag was not covered by a privacy pouch. Observation on 02/02/10 at 6:40am revealed CNA #1 coming out of Resident #11's room. Further observation revealed the urinary catheter bag lying on the floor, uncovered.	{F 241}	All residents, including those with indwelling catheters, have the potential to be affected regarding dignity All residents have been checked to ensure that dignity is being provided. All residents who have catheters were checked and catheter covers were in place. . All nursing staff will be inserviced by the Director of Nursing by March 31, 2010, on providing dignity to the residents including the proper care and management of urinary catheters. The Unit Managers have been instructed of their responsibility to monitor staff's compliance related to dignity toward the residents, including privacy for those with catheters. Dignity issues, including proper care of catheter tubing and bag, will be monitored during routine, established administrative rounds conducted by administrative staff. These documented rounds will be reviewed by the QA Committee at the weekly QA meeting and action taken as a result of the rounds.	



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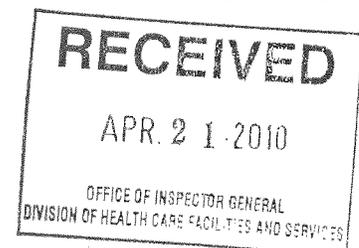
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{F 241}	Continued From page 7 Observation on 02/02/10 at 8:10am revealed Resident #11 was up in a chair in the dining room for the breakfast meal. The urinary catheter bag was observed with the tubing lying on the floor and multiple staff members repositioning residents, talking with residents, and feeding residents in close proximity to Resident #11's urinary catheter tubing that was lying on the dining room floor. Observation on 02/03/10 at 12:00pm revealed the resident sitting up in a Geri-chair in the resident's room with the urinary catheter bag lying on the floor uncovered. Interview with State Registered Nursing Assistant (SRNA) #1 on 02/03/10 at 5:00pm revealed the urinary catheters should be secured to the resident or onto the side of the bed, or the wheelchair and should not be lying on the floor. The SRNA went on to state placing the urinary bag into a pouch is the best; this will give the resident privacy from everyone seeing the urine in the bag. Interview via telephone with SRNA #1 on 02/04/10 at 2:00pm, SRNA #2 on 02/04/10 at 3:15pm, LPN #1 on 02/04/10 at 4:00pm, and LPN #2 on 02/04/10 at 4:15pm revealed they did not realize the urinary catheter bag was on the resident's floor, and that it should not have been on the floor, uncovered. They did not know why the catheter bag was on the floor, or why it was not covered. LPN #2 additionally stated the Nurse is ultimately responsible to make sure resident care is carried out appropriately. Record review of Resident #11's plan of care on	{F 241}		



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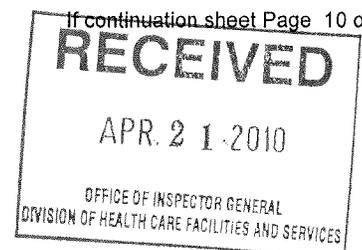
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{F 241}	Continued From page 8 02/04/10 at 1:00pm revealed no care planning related to care of the urinary catheter.	{F 241}			
{F 272} SS=E	Interview with the Director of Nursing on 02/03/10 at 4:00pm revealed the urinary catheter bag should be covered with a privacy pouch at all times. Any staff person that observed an uncovered urinary catheter bag should cover it immediately to provide dignity to the resident. 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the	{F 272}	The MDS Coordinator completed new assessments (MDSs) that contain accurate information for Residents #5 and #19 (Resident #13 has been discharged from the facility). Detailed RAPS were also completed that reflect pertinent areas addressed on the MDSs. These residents' care plans were updated to reflect the accurate information from the newly conducted MDS and RAPS. This correct RAI process was completed for these residents on February 17, 2010. All residents have the potential to be affected. The MDS Coordinator developed a revised accurate schedule on February 11, 2010 for completing the RAI process to ensure the MDSs, RAPs and care plans are completed in accordance with the regulations.	4-1-10	



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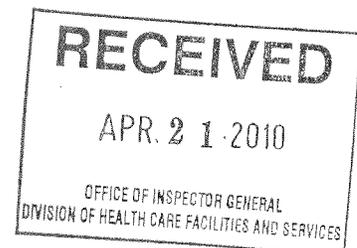
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{F 272}	<p>Continued From page 9 resident assessment protocols; and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to ensure the Resident Assessment Instrument (RAI) process was accurate, timely and all aspects of the RAI process was completed as they triggered for three (3) of the forty (40) sampled residents (#5, #13 and #19). Resident #5's Minimum Data Set (MDS) was contradictory to the Resident Assessment Protocols (RAP) completed. Resident #13 did not have RAPs completed and Resident #19's MDS was incomplete.</p> <p>The findings include:</p> <p>1) Record review for Resident #5 revealed an admission date of 05/13/08 and a re-admission date of 01/21/10 with diagnoses of Toxic Metabolic Encephalopathy, Renal Failure on Chronic Kidney Disease, Anorexia and status post Colectomy related to a Mass. Review of the Significant Change MDS assessment dated 07/01/09 indicated the resident had two stage IV pressure areas; however, review of the Pressure RAP revealed the resident had a small stage II on the sacrum. The same MDS indicated the resident had sustained a fall within the 31-180 day period. However, the FALLs RAP stated the resident had no falls and no history of falls. In addition, there were 114 days between the Significant Change MDS and the next Quarterly assessment completed on October 21, 2009.</p> <p>Interview with the MDS Coordinator on 02/03/10</p>	{F 272}	<p>A schedule has been established so that the MDS Coordinator will review all MDSs, RAPs, and care plans. The review will consist of ensuring all aspects of the RAI process, including accuracy and timeliness, are correct. Any discrepancies will be addressed by updating the care plan, completing a significant correction (including updated RAPS as appropriate) or completing a new full assessment. This will be completed by April 1, 2010.</p> <p>The MDS Coordinator, the Social Services Director and the interdisciplinary team were in-serviced by the Director of Nursing (a previous MDS Coordinator) on 3/23/10 regarding requirements related to the RAI process. The in-service will include the importance of completing the MDS timely and accurately. Details regarding the required content of the RAPs will be presented. Care Plan content will be discussed that include addressing areas triggered on the MDS</p>	



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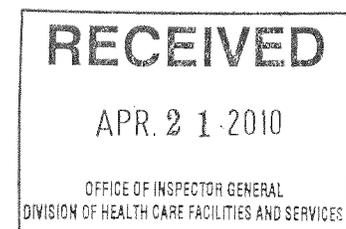
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{F 272}	<p>Continued From page 10</p> <p>at 9:30am revealed she had been involved in the MDS process for 10 years. She indicated she was quite overwhelmed doing the process by herself. In addition, when speaking to the contradiction between the MDS and the RAPs it was indicated it was like she was completing two RAPs because the computer was pulling information from the old RAPs and putting them in the new RAPs. However, she stated she was not doing a full RAP as required. She further stated the MDS was correct and not the RAPs. In addition, the time frame between the Significant Change and the Quarterly was due to not changing the schedule for any future MDS assessments after the Significant Change assessment was completed. She continued to use the old schedule.</p> <p>Interview with the Administrator on 02/04/10 at 3:00pm revealed the MDS Coordinator oversees the MDS process with the Director of Nursing as the supervisor. The facility identified the MDS needed assistance back in December 2009 or January 2010; however, there were no applicants until recently. The Administrator was not aware the MDS Coordinator had been behind since April 2009. However, the administrator was aware of a concern in August 2009 when the DON retrained the Coordinator. The Administrator further indicated the MDS Coordinator did not report the MDSs' were not completed accurately, that care plans were not done or appropriate. She was not aware that some RAP summary's consisted of two sentences. She was aware the MDS Coordinator was having problems with the computer program as she was provided additional training.</p> <p>Review of the facility's policy on Resident</p>	{F 272}	<p>and adding other pertinent issues as well. A post-test will be given to validate the knowledge of the participants.</p> <p>The Director of Nursing (a previous MDS Coordinator) assisted in revising the system for completing the RAI process so that the process is accurate, timely and all aspects of the process completed for all residents in accordance with the regulations. The MDS Coordinator has also revised the system for reviewing previous RAPs to decrease chance of error. This was completed on March 23, 2010.</p> <p>The MDS Coordinator attended an RAI/MDS Training Session on March 11-12, 2010, presented by the Kentucky Health Care Association to enhance her knowledge of the RAI process. She will conducted an inservice on March 23, 2010, to the interdisciplinary team regarding the information obtained at the training session.</p>		



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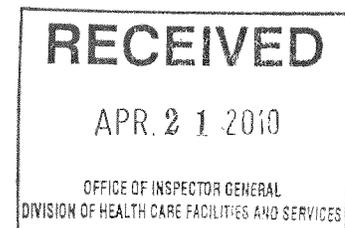
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{F 272}	<p>Continued From page 11</p> <p>Assessment Instrument (RAI) completion, revealed an RAI on each resident will be completed as required by regulations. The facility will follow the guidelines as set forth in the CMS's RAI User's Manual or as published by the federal or state government.</p> <p>2) Record review revealed the admission Minimum Data Set assessment dated 01/13/10 on Resident #13 triggered for behaviors. No Resident Assessment Protocol (RAP) Summary was completed for behaviors. The social service note on 01/05/10 acknowledged the resident had a history of being assaultive and uncooperative. The psychosocial well being RAP summary consisted of two sentences, which stated Resident #13 came to the facility post Psychiatric visit for severe and sometimes combative dementia and needed to acclimate to the nursing home facility. No additional information was provided in the psychosocial well being RAP summary.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 02/03/10 at 5:00pm confirmed there was no RAP summary completed on Resident #13 for behaviors. The MDS Coordinator stated there should be a summary completed for any triggered area of concern and it was an oversight that a RAP summary was not completed on Resident #13's triggered area of behaviors. It was acknowledged there was potential for harm to other residents.</p> <p>3) Record review of Resident #19 revealed the resident was non-English speaking, admitted on 10/03/08 with the diagnosis of Alzheimer's Disease, Dementia without Behaviors, Depressive Disorder, and Hypertension. The</p>	{F 272}	<p>The Director of Nursing (previous MDS Coordinator) will audit 50% of newly completed MDSs, RAPs and Care Plans for one week; then, at least 25% for the next two weeks and then at minimum 5 will be audited each month for the next 6 months. This will start March 23, 2010. Any problems will be discussed with the MDS Coordinator and corrections made. Results of these audits will be presented to the QA Committee at the weekly QA meeting that will determine the need and frequency for continued audits.</p>	



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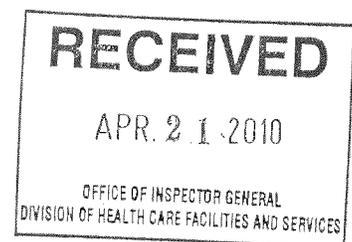
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{F 272}	<p>Continued From page 12</p> <p>annual Minimum Data Set (MDS) dated 09/22/09 was coded by the facility for speech clarity as clear speech, sometimes understood, and sometimes understands. The MDS was incomplete as evidenced by an invalid data entry in cognitive skills for daily decision making, and no change for cognitive status. The resident was assessed by the facility on the annual MDS with periods of altered perception or awareness of surrounding, episodes of disorganized speech, and mental function varied over the course of the day. The quarterly MDS dated 12/15/09 was incomplete as evidenced by an invalid data entry in short-term memory, long-term memory, and cognitive skill for daily decision making. The resident was assessed by the facility with periods of altered perception or awareness of surroundings, and episodes of disorganized speech.</p> <p>The annual MDS dated 09/22/09 triggered for cognitive loss/dementia, communication, mood, and behaviors. The Resident Assessment Protocol (RAP) revealed Resident #19 was Vietnamese, and the resident was unable to speak English at this time. However, the RAPs did not detail the required four (4) components to analyze his/her altered perception.</p> <p>Interview with the Minimum Data Set (MDS) Nurse on 02/03/10 at 2:55pm revealed she had assessed Resident #19 with garbled speech because she could not understand this resident when the resident spoke. She reported Resident #19 speaks Vietnamese, and no longer speaks English. She denied the ability to speak or understand the Vietnamese language herself. She reported the MDS and the plan of care is just what it is.</p>	{F 272}		



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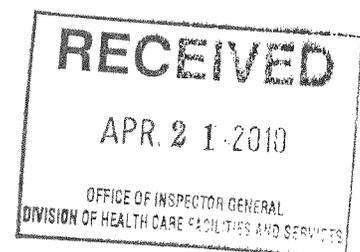
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{F 272}	Continued From page 13	{F 272}		
{F 279} SS=E	<p>Interview with the Administrator of the facility on 02/04/10 at 12:05pm revealed a contracted interpreter's service was available to use with residents that are non-English speaking. The administrator reported the staff was aware the interpreter service was available; however, it had never been used for Resident #19, even though the staff and the resident could not communicate with other.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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 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 and record review the facility failed to develop a</p>	{F 279}	<p>The MDS Coordinator reviewed and updated the care plans of Residents #6, #11, and #19 to reflect accurate information, including areas cited in this report. Residents #10, #13 and #15 are no longer reside in the facility.</p> <p>A schedule has been established so that the MDS Coordinator will review the MDSs, RAPs, and care plans for all residents. The review will consist of ensuring all appropriate problems with pertinent interventions are listed on the care plans. This review will be completed by April 1, 2010.</p>	4-1-10



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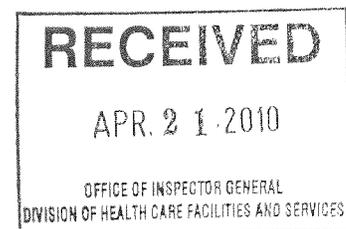
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{F 279}	<p>Continued From page 14</p> <p>comprehensive plan of care for six (6) of the forty (40) sampled residents (#6, #10, #11, #13, #15, and #19) . Care plans were not developed for Resident #6's heels, Resident #10's dialysis shunt, Resident #11's indwelling catheter, Resident #13's and #15's behaviors and Resident #19's language barrier.</p> <p>The findings include:</p> <p>1) Record review for Resident #10 revealed an admission date of 10/15/08 with a diagnosis of End Stage Renal Disease requiring dialysis three times a week. The quarterly Minimum Data Set (MDS) assessment dated 12/16/09 revealed the resident required renal dialysis. The facility failed to provide evidence a care plan was developed to address the care of the resident's dialysis shunt. In addition, the nurse aide care plan did not communicate to the nurse aide that a shunt was in place.</p> <p>Observation of Resident #10 on 02/02/10 at 8:20am revealed a shunt in the right forearm. Observation of the resident's room on 02/02/10 at 8:20am revealed no sign posted forbidding blood pressures and laboratory blood draws in the right arm.</p> <p>Interview with the Certified Nursing Aide (CNA) #2 on 02/03/10 at 10:30am revealed knowledge of the resident having a shunt for dialysis. CNA #2 stated a sign had been previously posted in the resident's room stating no blood pressures or laboratory blood draws in the right arm and acknowledged the sign was no longer in the room and could not recall when the sign had been removed. CNA #2 acknowledged a CNA not familiar with Resident #10 may attempt to take</p>	{F 279}	<p>A comprehensive care plan policy will be developed by March 26, 2010, by the Director of Nursing and MDS Coordinator that will include the proper procedure for updating the resident's care plan and the CNA Care Needs Sheet as appropriate when a new physician order is received. The Director of Nursing, MDS Coordinator and nurse consultant will present an in-service to nursing staff on the updated policy. In addition the Unit Managers will be instructed by the Director of Nursing of their responsibility to review all new physician orders to ensure pertinent information has been added to the care plans and CNA Care Needs Sheets.</p> <p>The MDS Coordinator, Social Services Director and the interdisciplinary team, including the Unit Managers, were in-serviced by the Director of Nursing (a previous MDS Coordinator) on March 23, 2010, regarding requirements related to the RAI process. Care Plan content will be discussed that include addressing areas triggered on the MDS and adding other pertinent issues as well. A post-test will be given to validate the knowledge of the participants.</p> <p>The Director of Nursing (previous MDS Coordinator) will audit 50% of newly completed MDSs, RAPs and Care Plans for one week; then, at least 25% for the next two weeks then at minimum 5 will be audited each month for the next 6 months. This began on March 22, 2010. Any problems will be discussed with the MDS Coordinator</p>	



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{F 279}	Continued From page 15 blood pressures in the right arm and potentially cause harm to the resident. Interview with CNA #4 on 02/03/10 at 9:20am revealed knowledge of Resident #10 having a shunt in the right forearm. The CNA stated the nurse aide care plan did not alert staff to Resident #10 as having a shunt for dialysis. CNA #4 admitted a CNA unfamiliar with shunts and Resident #10 could cause harm by taking blood pressures in the shunted arm. CNA #4 stated her experience of nine years as a Certified Nurse Aide had given her the knowledge not to take blood pressures in an arm with a shunt. Interview with the Minimum Data Set (MDS) Coordinator on 02/02/10 at 11:10am revealed she had not developed a care plan for Resident #10's shunt. It was acknowledged that there could be potential harm to the resident if blood pressures were taken in the arm with the shunt. The MDS Coordinator admitted the care plans were not as resident specific as she would have liked. According to the MDS Coordinator, an assistant was in the process of being hired to assist with the MDS process and care plans. 2) Record review revealed Resident #13 was admitted on 12/31/09 with diagnoses of Dementia, Behavior Disorder, and Pick's Disease (degeneration of the frontal and temporal lobes of the brain resulting in behaviors/personality changes). There was no evidence a care plan had been developed to address the resident's aggressive, assaultive behaviors towards others. The resident was admitted to the facility from a hospital psychiatric unit for assaultive behaviors. The social service note on admission dated 01/05/10 acknowledged the resident had a history	{F 279}	and corrections made. Results of these audits will be presented to the QA Committee that will determine the need and frequency for continued audits. Copies of all new physicians' orders are reviewed in the morning meeting and given to the MDS Coordinator daily Monday through Friday. The MDS Coordinator validates that the care plans and have been updated appropriately by the nurses for any new orders. Findings of this review will be forwarded to the Director of Nursing who will present to the QA Committee at the weekly QA meeting.		



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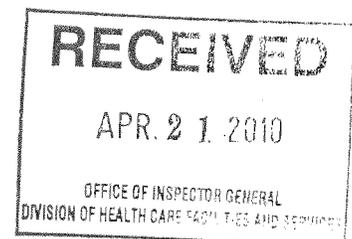
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{F 279}	<p>Continued From page 16 of being assaultive and uncooperative. On 01/16/10 the resident was striking staff, ripping a staff member's shirt and pulling on the jacket of another resident. In addition, the nurse aide care plan dated 02/01/10 did not mention the resident's assaultive, aggressive behaviors to alert the staff for monitoring and guidance.</p> <p>Observation of Resident #13 on 02/02/10 at 2:00pm by a surveyor, and two housekeeping staff revealed an altercation with Resident #10 in the dining area. Resident #13 swung at Resident #10 after a verbal exchange. The housekeeping staff removed Resident #13 from the situation and alerted the nursing staff.</p> <p>Interview with Housekeeper #1 on 02/04/10 at 10:20am revealed she witnessed the altercation in the dining area on 02/02/10 between Resident #13 and Resident #10. According to Housekeeper #1, Resident #13 and Resident #10 were having a verbal exchange and the housekeeper assumed it was a playful exchange until it became physical between the residents. The housekeeper wheeled Resident #13 away from Resident #10 and sent another housekeeper to seek a CNA.</p> <p>Interview with CNA #1 on 02/04/10 at 3:30pm revealed the nurse aide care plan did not address Resident #13's behaviors to alert staff on how to monitor or intervene during the resident's exhibited behaviors.</p> <p>Interview with the MDS Coordinator and the Social Service Director (SSD) on 02/03/10 at 5:00pm revealed they had prior knowledge of the assaultive and aggressive behavior for Resident #13. The MDS Coordinator stated it is the</p>	{F 279}		
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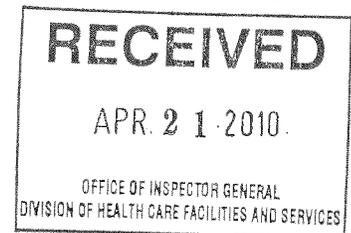
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{F 279}	<p>Continued From page 17</p> <p>responsibility of the SSD to care plan behaviors. The SSD stated it was an oversight that Resident #13 had no care plan for behaviors and had no update after the 01/16/10 incident involving the staff and another resident. Both the MDS Coordinator and the SSD acknowledged the behavior had a high potential to reoccur and they should have developed a care plan to direct the staff in monitoring and intervention. It was also stated there was potential harm to other residents with this type of behavior and staff not knowing what interventions to use with this resident.</p> <p>3) Record review of Resident #19, revealed the resident was non-English speaking and was admitted on 10/03/08 with the diagnoses of Alzheimer's Disease, Dementia without Behaviors, Depressive Disorder, and Hypertension.</p> <p>Observation of Resident #19's room on 02/02/10 at 3:05pm and on 02/04/10 at 9:22am revealed an English calendar for the month of February, 2010 taped to the closet door.</p> <p>Observation of Resident #19 on 02/03/10 at 2:08pm revealed the resident in the activities room sitting in a wheelchair, off to the side, away from the group and not interacting with other residents and/or staff. During the activity it was not observed that any attempts were made to include the resident in the activity.</p> <p>Observation on 02/02/10 at 2:40pm revealed Resident #19 speaking a foreign language with expressive body language which indicated the resident was emotionally upset when attempting to speak to a Certified Nurse Aide (CNA), and the Licensed Practical Nurse (LPN). The CNA, and</p>	{F 279}		
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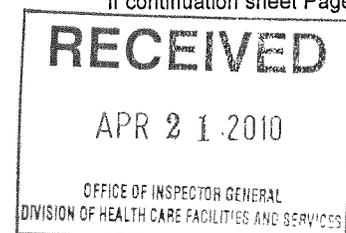
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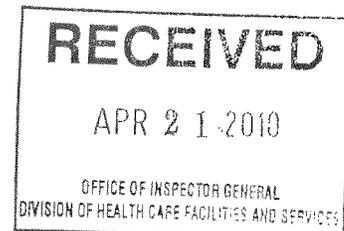
{F 279}	<p>Continued From page 18</p> <p>the LPN were observed speaking to the resident in English, and the resident continued to speak in the resident's native language. Resident #19 had a frown on his/her face, and the resident's arms were flailing in the air as the resident spoke in their native language. The LPN placed a telephone call to the resident's daughter, and observed the resident to continue to speak in their native tongue and would not accept the telephone to speak with the daughter. There were no other sources of interpretation provided to the non-English speaking resident.</p> <p>Record Review of the Social Services (SS) notes dated 01/07/09 revealed Resident #19 preferred to respond in the resident's native tongue (Vietnamese), and the daughter often visited to update the communication board and interpret when necessary. The SS notes dated 04/02/09 revealed Resident #19 had exhibited confusion, and had been wandering in the facility. The SS note dated 09/17/09 indicated Resident #19 was vocal and could verbalize, but due to the Dementia diagnosis had reverted back to Vietnamese language. The SS note reported the daughter is available via telephone, with weekly, almost daily visits. The SS note dated 12/10/09 revealed the daughter visited daily for interpretation. However, the daughter was not observed in the facility during the three days of the survey. The SS note dated 12/14/09 indicated Resident #19 could not speak English and had reverted back to the resident's native language of Vietnamese.</p> <p>The nurses' notes for Resident #19 dated 11/04/09 revealed the LPN was unable to assess the level of alertness related to the language barrier. The nurses' notes dated 11/25/09</p>	{F 279}		
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NAME OF PROVIDER OR SUPPLIER JAMES S TAYLOR MEMORIAL HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1015 W MAGAZINE STREET LOUISVILLE, KY 40203		
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{F 279}	<p>Continued From page 19</p> <p>revealed Resident #19 was displaying extreme agitation, yelling and chattering on and on, and the staff were unable to understand related to the language barrier. The Resident was not cooperative with the communication tool. The nurses' notes dated 12/04/09 identified Resident #19 with a language barrier and could not understand English very well. The nurses' notes dated 12/22/09 identified Resident #19 had a language barrier, and did not speak English, but did have some gestures of communications. The nurses' notes dated 01/04/10 revealed the staff identified they were unable to assess Resident #19's level of communication due to the language barrier. The nurses' notes dated 02/02/10 revealed Resident #19 was very upset speaking in Vietnamese. The staff called the daughter and the resident refused to talk to her on the telephone.</p> <p>Review of the plan of care dated 09/17/09 revealed a problem of verbal communication that was impaired related to dementia and language. The goal indicated the resident would have needs anticipated and met by staff daily and continue to make needs known verbally. The interventions listed were: 1. Ask yes/no questions when appropriate; 2. Encourage clear enunciation of words; 3. Encourage self-expression to ensure needs are met; 4. Encourage to talk when possible, allow time for a response; and 5. Encourage the use of flash cards/picture book for communication, as needed. The plan of care for communication was updated on 12/14/09 which indicated no changes noted by the MDS Nurse.</p> <p>In addition, a problem of impaired thought processes related to dementia and communication due to a language barrier was</p>	{F 279}		



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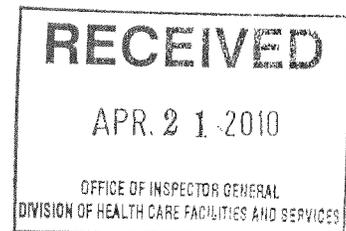
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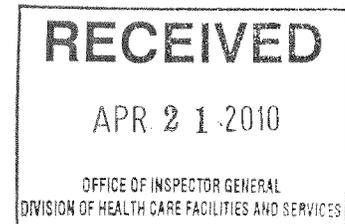
{F 279}	<p>Continued From page 20</p> <p>identified. The goal was to receive daily opportunities for social contact and will be involved in at least one non-verbal activity per week. The interventions listed were: 1. Utilize big gestures and smiles; 2. Encourage family visits; 3. Furnish resident with their own personal activity calendar; 4. Identify past social patterns and choice of lifestyle; 5. Converse to resident and attempt to get appropriate reply; and 6. Converse with resident during care; asking question and reminiscing with resident.</p> <p>The plan of care did not include any updated or revised interventions and did not address the resident's inability to communicate with staff in his spoken language. The facility failed to provide evidence to show they developed a care plan to address the resident's language barrier.</p> <p>Interview with CNA #5 on 02/02/10 at 2:40pm regarding Resident #19's language barrier, and not speaking in English. She reported the resident spoke the Vietnamese language. She acknowledged she does not speak, or understand Vietnamese. She reported the staff attempted to use the communication book, and the resident points, but when that doesn't work; the staff will call the resident's daughter for interpretation. The CNA denied any other options for communications with the resident.</p> <p>Interview with Licensed Practical Nurse (LPN) #7, assigned to care for Resident #19, on 02/02/10 at 2:47pm revealed the sources of communication were the communication book and the resident's daughter for interpretation. The LPN was unable to determine the accuracy of the interpretation for this resident when the daughter acted as the interpreter. The LPN denied knowledge of any</p>	{F 279}		
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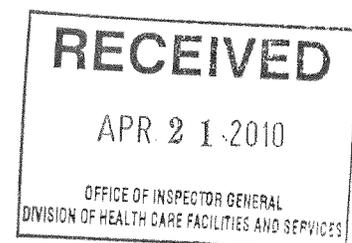
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{F 279}	<p>Continued From page 21 other sources for interpretation available.</p> <p>Interview with the Director of Nursing (DON) on 02/02/10 at 3:25pm revealed the sources of communication were the communication book and the resident's daughter for interpretation. She was unable to determine the accuracy of the interpretation for this resident when the daughter acted as the interpreter. The DON denied knowledge of any other sources for interpretation available</p> <p>Interview with the Minimum Data Set (MDS) Nurse on 02/03/10 at 2:55pm revealed she had assessed Resident #19 with garbled speech because she could not understand the resident. She reported Resident #19 speaks Vietnamese, and no longer speaks English. She denied the ability to speak or understand the Vietnamese language. She reported the MDS and the plan of care is just what it is.</p> <p>Interview with the Social Services Director on 02/04/10 at 9:35am revealed the facility has a contract with a service to provide interpreters for residents unable to speak English when needed. She reported the facility has never used the service. The Social Services Director indicated the facility did not have a staff member that speaks or understands the Vietnamese language. She acknowledged she was unable to verify the accuracy of the interpretation from the resident to the daughter and back to staff and vice versa.</p> <p>Interview with the Administrator of the facility on 02/04/10 at 12:05pm revealed a contracted interpreter's service was available to use with residents that are non-English speaking. The administrator reported the staff were aware the</p>	{F 279}		



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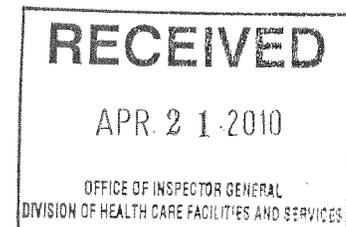
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{F 279}	<p>Continued From page 22</p> <p>interpreter service was available. The Administrator revealed the service had never been used for Resident #19 even though the resident and staff could not communicate with other.</p> <p>4) Record review for Resident #11 revealed a re-admission date of 11/11/09 and diagnoses of Paraplegia secondary to Polio. The quarterly MDS assessment dated 11/10/09 indicated the resident was incontinent of bladder and there was no indication an indwelling catheter was utilized by the resident. The treatment records did not indicate there was a catheter in use. The plan of care did not indicate the use of the catheter.</p> <p>Observation on 02/02/10 at 6:00am revealed Resident #11 had an indwelling catheter to bedside drainage.</p> <p>Interview with the Minimum Data Set (MDS) Nurse on 02/04/10 at 9:15am revealed she did not care plan the resident's indwelling catheter or catheter care because she was not aware that Resident #11 had a catheter. She went on to state that she had not received any physician orders or notes related to the insertion of the catheter. The MDS nurse went on to state that she is often left out of the loop of information therefore the resident care plans are not always updated accordingly.</p> <p>5. Record review for Resident #6 revealed the resident was admitted on 09/18/08 with diagnoses of Dementia, Muscle Weakness, Cataracts, Osteoarthritis, Glaucoma and Anemia. The facility completed a quarterly MDS assessment dated 11/10/09 which indicated the resident was at risk for developing pressure</p>	{F 279}		



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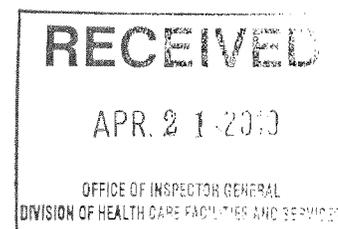
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{F 279}	<p>Continued From page 23</p> <p>ulcers. The physician's orders dated for February 2010 revealed an order to keep the resident's heels floated off the bed at all times. There was no evidence provided to show the facility revised the care plan dated 07/14/09 to indicate the resident's heels were to be elevated off the mattress at all times.</p> <p>Observation of Resident #6 on 02/02/10 at 2:00pm and 3:30pm, and on 02/03/10 at 1:00pm and 3:30pm revealed both heels pressed into the mattress.</p> <p>Interview with Registered Nurse (RN) #1 on 02/03/10 at 3:30pm revealed the resident's heels should be elevated off the mattress, especially if there is a doctor's order. The RN went on to state continuous pressure on the heels might cause skin breakdown. The RN also stated the nurse is ultimately responsible for each resident's care and how the care is delivered.</p> <p>Observation of RN #1 on 02/03/10 at 3:10pm revealed the nurse walking out of the resident's room without elevating the resident heels off of the mattress.</p> <p>Observation of Resident #6 on 02/04/10 at 8:00am revealed both heels pressed into the mattress.</p> <p>Interview with the Minimum Data Set (MDS) Nurse on 02/04/10 at 9:15am revealed she did not care plan for prevention of pressure ulcers on the resident's heels because she was not aware that Resident #6 had specific physician orders to protect the heels. The MDS nurse stated she is often left out of the loop of information pertaining to new physician orders; therefore, the resident's</p>	{F 279}		



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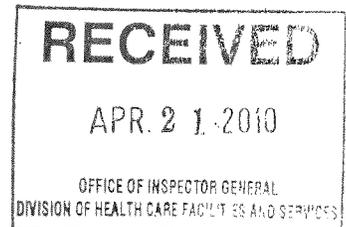
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{F 279}	<p>Continued From page 24 care plans are not consistently updated.</p> <p>6. Observation on 02/03/10 at 5:00pm revealed Resident #15 in bed sleeping. Four (4) different staff had made attempts to get the resident cleaned up, but Resident #15 refused care. At 5:10pm two more staff went into the resident's room and were able to encourage the resident to get cleaned up and change clothes.</p> <p>Review of the clinical record revealed Resident #15 was admitted on 07/29/08 with diagnoses of Dementia, Cerebral Vascular Accident times three, Depression and Anxiety Disorder. Resident #15's annual Minimum Data Set (MDS) assessment dated 07/08/09 revealed the resident's cognition level was undetermined due to the resident choosing to be nonverbal. The Resident Assessment Protocol Summary (RAPS) dated 07/22/09 revealed the resident would answer questions by shaking their head yes or no and by gesturing for needs and wants. The annual MDS assessment revealed the resident's behavior to include wandering daily, and resisting care one (1) to three (3) times in last seven (7) days. Resident #15's quarterly MDS assessment dated 12/23/09 revealed there were no change in behaviors. Review reports from Resident #15's stays at two (2) psychiatric hospitals revealed a history of sexually inappropriate behaviors by Resident #15 prior to admission to the facility. There was no evidence provided to show the facility developed a care plan for the resident's history of sexual aggression.</p> <p>Interview with the Director of Nursing (DON) on 02/04/10 at 11:45am revealed she was not aware Resident #15 had a history of sexually inappropriate behavior, and she did not find out</p>	{F 279}		



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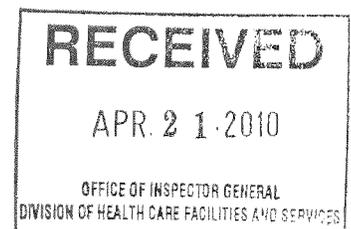
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{F 279}	Continued From page 25 about the incident that occurred on 01/30/10 until the second incident occurred on 02/03/10. She stated she was unsure why she was not notified. The DON stated if she had known the resident's history of sexually inappropriate behaviors, she would have developed a care plan to address the resident's specific needs. A review of the initial report of suspected abuse of a resident on 02/03/10 revealed Resident #15 was found in the activities room inappropriately touching Resident #5's breast. An interview with Certified Nurse Aide (CNA) #14 on 02/04/10 at 2:00pm revealed she witnessed Resident #15 in the activities room touching all over Resident #5's body on 02/03/10. She reported it to the Social Worker, then to the DON. CNA #14 stated she was not aware of Resident #15's previous incident of sexually inappropriate touching of Resident #12 on 01/30/10. CNA #14 continued to say she had heard that Resident #15 had done this in the past, but never witnessed anything until this incident.	{F 279}			
{F 280} SS=D	The facility policy revealed residents will have care plans developed to address their needs. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	{F 280}	Resident #15 has been discharged from the facility. A schedule has been established so that the MDS Coordinator and the new MDS nurse will review the MDSs, RAPs, and care plans for all residents. The review will consist of ensuring all appropriate problems, including behavior problems, with pertinent interventions are listed on the care plans. This will be completed by April 1, 2010.	4-1-10	



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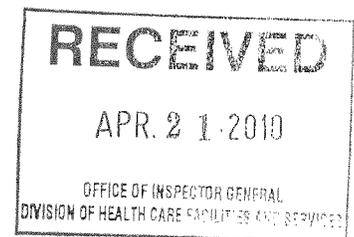
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{F 280}	<p>Continued From page 26</p> <p>interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to review and revise the Comprehensive Care Plan for one (1) of the forty (40) sampled residents (#15). Resident #15's comprehensive care plan did not reflect a history of sexually inappropriate behaviors. In addition, Resident #15 had a documented incident of touching Resident #12's breast on 01/30/10 and the facility failed to revise the care plan to reflect and prevent sexually inappropriate behavior.</p> <p>The findings include:</p> <p>Review of the clinical record for Resident #15 revealed an admission date of 07/29/08 with diagnoses of Dementia, Cerebral Vascular Accident times three, Depression and Anxiety Disorder. Resident #15's Minimum Data Set (MDS) assessment dated 07/08/09 revealed Cognition undetermined due to the resident's "chooses" to be nonverbal. The Resident Assessment Protocol Summary (RAPS) dated 07/22/09 revealed the resident will answer</p>	{F 280}	<p>A comprehensive care plan policy will be developed by March 30, 2010, by the Director of Nursing and MDS Coordinator that will include the proper procedure for updating the resident's care plan and the CNA Care Needs Sheet as appropriate when a new physician order is received. The Director of Nursing, MDS Coordinator and nurse consultant will present an in-service on March 31, 2010, to nursing staff on the updated policy. In addition, the Unit Managers have been instructed by the Director of Nursing of their responsibility to review all new physician orders to ensure pertinent information has been added to the care plans and CNA Care Needs Sheets. Copies of all new physicians' orders are given to the MDS Coordinator daily Monday through Friday. The MDS Coordinator validates that the care plans and CNA Care Needs sheets have been updated appropriately by the nurses for any new orders. Findings of this review will be forwarded to the Director of Nursing who will present to the QA Committee at the weekly QA meeting.</p>		



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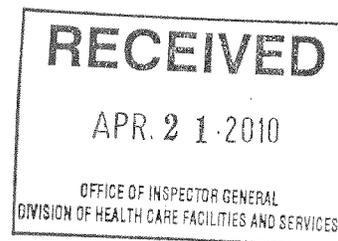
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{F 280}	<p>Continued From page 27</p> <p>questions by shaking their head yes or no and by gesturing for needs and wants. The MDS revealed the resident's behavior included wandering daily and resisting care one to three times in last seven days. Resident #15's MDS dated 12/23/09 revealed no changes in behaviors.</p> <p>Observation on 02/03/10 at 5:00pm revealed resident #15 in bed sleeping. Four different staff had made attempts to get the resident cleaned up, but Resident #15 refused care. At 5:10pm two more staff went into the resident's room and were able to get Resident #15 to get cleaned up and change clothes.</p> <p>A review of the initial report of suspected abuse of a resident completed on 02/01/10 revealed Resident #12 was touched on the breast by Resident #15. A physician's order revealed Resident #15 received Ativan 2mg intramuscular for aggressive sexual behavior on 01/30/10 at 1:00pm. Review of the care plan for Resident #15 revealed it was not revised, and no new interventions were put into place to address the behaviors, monitor or give direction to staff in how to manage the inappropriate behavior.</p> <p>Record review revealed the facility had sent Resident #15 to the Hospital on 10/24/08 for aggressive behavior, extremely agitated, very difficult to redirect, aggressive toward staff, refusing medications and sexually inappropriate behavior.</p> <p>Record review revealed a hospital discharge summary from dated 04/21/08 which detailed that Resident #15 had behaviors at another facility that included threatening staff, running out of the</p>	{F 280}			



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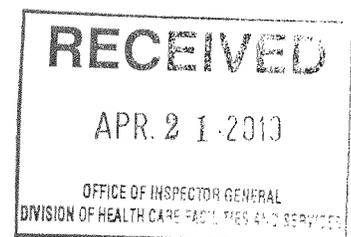
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{F 280}	Continued From page 28 room naked, and inappropriately touching female residents. Interview on 02/04/10 at 11:25am with the MDS coordinator revealed she is responsible for the MDS and Care Plans. She stated that the nurse is supposed to update the care plan if they received a new order. This has been an ongoing problem with care plans not getting updated. Resident #15's care plan did not get updated because the nurse who took the order did not follow through. She also stated she had no prior knowledge that Resident #15 had sexually inappropriate behavior. Interview with the Director of Nursing (DON) on 02/04/10 at 11:45am revealed she was not aware Resident #15 had a history of sexually inappropriate behavior, and she did not find out about the incident that occurred on 01/30/10 until the second incident occurred on 02/03/10. She stated she was unsure why she was not notified. The DON stated if she had known she would have care planned for inappropriate sexual behaviors, so the staff could monitor more closely. Review with the DON of the reports for Resident #15's stay at two hospitals revealed a history of inappropriate sexual behaviors.	{F 280}		
{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}	Resident #7's physician was notified by floor nurse on 2/2/10 and clarification orders for dosage of Trazodone were received. The order was faxed to pharmacy and transcribed correctly on the MAR, on 2/2/10 according to the physician order. Resident #7 is receiving her medications, including Trazodone and Buspar, in accordance with current physicians' orders.	4-1-10



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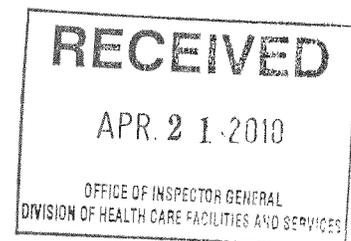
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{F 309}	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure physician orders were transcribed accurately and followed physician orders for two (2) of the forty (40) sampled residents, (#7 and #6). Resident #7 had physician orders transcribed inaccurately for three (3) months without physician notification and Resident #6 was not provided care according to physician's order, assuring pressure was relieved by floating the heels off the bed. The findings included: Record review of Resident #7 revealed the resident was admitted on 03/19/02 with the diagnoses of Diabetes Mellitus II, Chronic Obstructive Pulmonary Disease, Pulmonary Hypertension, Dementia with Depressive Mood, Chronic Obstructive Disease, Pulmonary Hypertension, and Dementia with Depressive Mood, Chronic Renal Insufficiency, and Osteoarthritis. The Medication Administration Record (MAR) dated February, 2010, revealed Trazodone 50 mg one half tablet by mouth ordered on 06/18/09 was to be administered at bedtime. Record review of the physician's orders for Resident #7, dated 11/04/09, revealed an order to increase Trazodone 50 mg by mouth every night at bedtime. The December, 2009, January, and February, 2010 MAR's did not have the increased Trazodone dosage transcribed as ordered by the physician on 11/04/09. The MAR dated December 2009, revealed the Buspar 5 mg one tablet by mouth once daily was	{F 309}	It was difficult to position Resident #6 in a manner to keep his heels floated. The wound care nurse notified the ARNP of this on 2/4/10 and the order to float heels was discontinued. (This resident had no skin breakdown). However, a new order was received for heel lift boots. The resident's care plan was updated on 2/4/10 to include the new intervention to prevent skin breakdown. This intervention was also added to the CNA Care Needs Sheet. All residents have the potential to be affected. The physician orders were reviewed on February 25 th and February 26 th for all residents by the Unit Manager and consultant nurse to validate that all had been transcribed correctly. All nurses will be inserviced by 4/1/10 by the Director of Nursing regarding the Medication Order Policy. The inservice will include the procedure to follow when a new order changes regarding the dosage of a previously prescribed medication. Additionally, all nurses will be inserviced by 3/31/10 by the Director of Nursing regarding the procedure of updating the resident's care plan and the CNA Care Needs	



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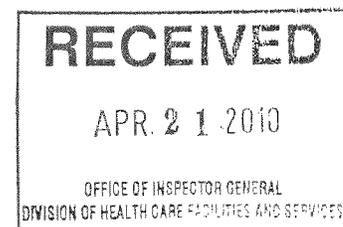
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{F 309}	Continued From page 30 ordered on 6/17/09. Record review of the MAR dated December 2009, through January 6, 2010, did not have the transcribed medication order to increase the Buspar dosage as ordered by the physician on 11/04/09. The physician's order dated 01/06/10 indicated to increase Buspar 10 mg twice a day by mouth for increased agitation. The nurse's notes dated 02/02/10 by LPN #7 indicated a new order was received for an increased medication regime for Trazodone. The nurse's notes dated 02/03/10 by LPN #7 revealed a late entry done for the notification of the Physician (MD), and the Advanced Registered Nurse Practitioner (ARNP) of the transcription error for medications: Trazodone; and Buspar. The Consultant Pharmacist Medication Regimen Review dated 11/12/09, and 01/06/10 revealed the clinical medication regimen checked with no irregularities noted. Review of the facility's Medication Orders Policy (MOP) that was undated stated the medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Verbal orders are received only by licensed nurses or pharmacists and confirmed in writing by the prescriber. Verbal orders received by pharmacists must also be communicated to the facility. Medication orders from physician assistants, nurse practitioners, clinical nurse specialists, and pharmacist are accepted if they comply with the requirements listed, and are in accordance with the state law, and comply with the applicable formularies or prescribing protocols that have been provided to the facility by the responsible physician. The facility's MOP procedure included (E.) Documentation of the medication order: 1. each medication order is documented in the resident's medical record with	{F 309}	Sheet as appropriate when a new physician order is received. All physician orders, MARs and TARs will be checked for month-end changeover by the two Unit Managers and/or any specially designated licensed nurse(s) determined by the Director of Nursing. The Unit Managers will be inserviced by 3/26/10 by the Director of Nursing regarding the proper procedure for checking orders/MARs/TARs/CNA Care Needs Sheets at the end of each month. The inservice will include the review of all physician orders to ensure they are listed on the MAR, TAR, CNA Care Needs Sheet as appropriate. This inservice will be provided for any designated nurse assigned to check the physicians' orders at the end of the month.		



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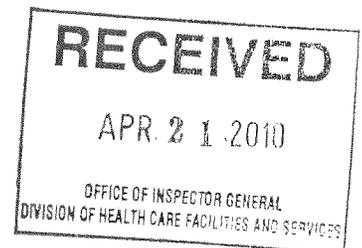
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{F 309}	Continued From page 31 the date, time, and signature of the person receiving the order. The order is recorded on the physician order sheet, or the telephone order sheet when it is a verbal order, on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR). If the facility uses electronic records the facility will follow their policy and procedures for entering information into the electronic record systems to record on physician orders, telephone orders, MAR and/or TAR. The facility's MOP included (E.) 2. The following steps are initiated to complete documentation, and receive the medication: a. Clarify the order; b. fax, or electronically transfer the medication order to the provider pharmacy; c. transcribe newly prescribed medication on the MAR or TAR. When a new order changes the dosage of a previously prescribed medication, discontinue the previous entry by writing DC'd and the date and highlight the entry in yellow. Then enter the new order on the MAR/TAR; d. after completion, document each medication order entered on the appropriate form with a date, time, and signature. Interview with the pharmacy consultant on 02/03/10 at 3:50pm reported the pharmacy never received the physician's order dated 11/04/09 for the Trazodone and Buspar medication change. She reported the medications are dispensed according to the orders received and would not provide additional medications without the order to increase the medications, Trazodone and Buspar. She reported the medication regimen review was done on Resident #7, when the physician orders are reviewed, and when new orders are added, and as they are received from nursing. Interview with LPN #7 on 02/02/10 at 9:55am	{F 309}	The QA Nurse will audit the new physicians' orders to identify problems related to the transcription of the orders to the MARs and TARs. The QA Nurse will audit 100% of new orders for four weeks beginning 3/7/2010 and then 50% for an additional two weeks. The DON will monitor at least 5 new MD orders per week to validate accurate transcription. The results of these audits will be given to the Director of Nursing for follow-up and to the QA Committee at the weekly QA meeting. The continued frequency of audits will be determined by the QA Committee based on the audit results. Copies of all new physicians' orders are reviewed at the morning meeting and given to the MDS Coordinator daily Monday through Friday. The MDS Coordinator validates that the care plans and CNA Care Needs sheets have been updated appropriately by the nurses for any new orders.		



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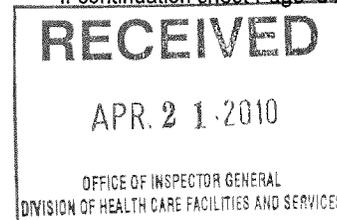
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{F 309}	<p>Continued From page 32</p> <p>revealed she was not aware the Trazodone dosage was not correct. She reported the medication orders are faxed to the pharmacy for the medications to be provided in the medication carts. She was unable to explain how the transcription error occurred, or how it was missed.</p> <p>Interview with LPN #6 on 02/03/10 at 5:00pm revealed she was unaware of the transcription error. She reported she had not received a medication error report on the Trazodone or Buspar transcription error. She reviewed the steps taken when physician orders are received with medication orders, such as transcribing to the medication administration record, faxing the order to the pharmacy, and checking the monthly orders against the individual orders. She acknowledged there was a breakdown in the process to ensure Resident #7 received the medications as ordered by the physician.</p> <p>Record review for Resident #6 revealed the resident was admitted on 09/18/08 with a diagnosis of dementia, muscle weakness, cataracts, osteoarthritis, glaucoma and anemia. The resident was assessed on the Quarterly MDS assessment dated 11/10/09 as at risk for developing pressure ulcers. Continued record review of the resident physician's orders dated 02/10 revealed the medical doctor had written an order to keep the resident's heels floated off the bed at all times. Record review of Resident #6's care plan, dated 7/14/09, did not indicate the resident's heels were to be elevated off the mattress at all times.</p> <p>Observations of Resident #6 on 02/02/10 at 2:00pm and 3:30pm and on 02/03/10 at 1:00pm</p>	{F 309}		



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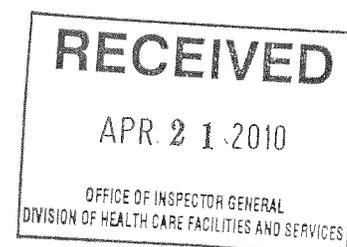
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{F 309}	<p>Continued From page 33 and 3:30pm revealed both heels pressed into the mattress.</p> <p>Interview with RN #1 on 02/03/10 at 3:30pm revealed the resident's heels should be elevated off the mattress, especially if there is a doctor's order. Continuous pressure on the heels might cause skin breakdown. The nurse is ultimately responsible for each resident's care, and how the care is delivered.</p> <p>Observation of RN #1 on 02/03/10 at 3:10pm revealed the nurse walking out of the resident's room without elevating the resident heels off of the mattress.</p> <p>Observation of Resident #6 on 2/4/10 at 8:00am revealed both heels pressed into the mattress.</p> <p>Interview with the Minimum Data Set (MDS) nurse on 2/4/10 at 09:15am revealed she did not care plan for prevention of pressure ulcers on the resident's heels because she was not aware that Resident #6 had specific MD orders to protect the heels. The MDS nurse stated that she is often left out of the loop of information pertaining to new physician orders.</p>	{F 309}		
{F 323} SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p>	{F 323}		



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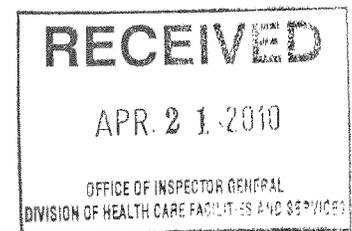
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{F 323}	<p>Continued From page 34</p> <p>This REQUIREMENT is not met as evidenced by: Not Corrected</p> <p>Based on interview, and record review it was determined during the 03/25/10 revisit, the facility had not completed employee questionnaires to verify knowledge of policies and procedures related to resident to resident incidents in the facility. In addition, the facility was unable to provide evidence of compliance rounds (audits) made by unit manager/supervisors/charge nurses to monitor staff knowledge and compliance with behavior interventions on resident ' s care plans.</p> <p>The findings include:</p> <p>1. Interview with the Administrator, on 03/23/10 at 6:50 PM, revealed administrative staff and department heads provided inservice education to staff regarding resident to resident incidents in the facility. The Administrator continued that staff were required to complete a questionnaire following the training which measured staff ' s knowledge of the facility ' s policies/procedures regarding resident to resident incidents in the facility. The Administrator stated one hundred percent (100%) of staff members would complete the knowledge questionnaire prior to April 8, 2010. Review of completed knowledge questionnaires revealed sixty-one (61) questionnaires had been completed. According to the Administrator, the facility had approximately one hundred fifteen (115) staff members.</p> <p>2. Interview with the Director of Nursing (DON), on 03/25/10 at 5:50 PM, revealed she was unable to provide evidence of rounds made by facility unit managers, supervisors, or charge nurses, to</p>	{F 323}	<p>All residents have the potential to be affected. There were no specific residents cited.</p> <p>The facility has a system in place to ensure that all employees have completed the employee questionnaire to verify knowledge of policies and procedures related to resident to resident incidents in the facility. The employee test are discussed at the weekly QA meeting to ensure that all newly hired staff have completed the employee questionnaire.</p> <p>The Unit Managers /supervisors are making rounds to monitor staffs knowledge and compliance with behavior interventions on resident ' s care plans. The Unit Managers/supervisors are documenting their rounds and are turning their completed rounds into the Nursing Administrative Assistance that list the staff name of who was interviewed. These rounds are discussed in the weekly Quality Assurance Committee meeting.</p>	4-1-10	



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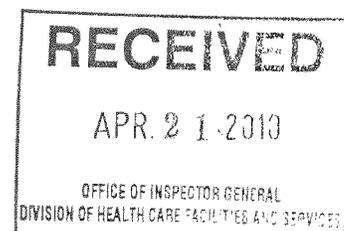
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{F 323}	Continued From page 35 supervise staff and monitor compliance with behavioral interventions listed on each resident ' s care plan. She stated administrative staff had completed the rounds " for awhile " , but did not document the evidence obtained during the rounds. According to the DON, " I didn ' t think to tell them " (to document evidence of the rounds). However, she stated the charge nurses marked the Certified Nursing Assistant (CNA) care plan sheets with a highlighter after they completed random interviews to verify the CNS ' s knowledge of individual residents to which they provided care. Staff were afforded the opportunity to provide evidence of examples of highlighted care plans and were unable. Interview with LPN #10, a unit manager, on 03/25/10 at 5:45 PM, revealed the LPN interviewed two (2) CNAs three (3) or four (4) days ago to verify knowledge regarding behavioral interventions included on resident ' s care plans, for residents for whom the CNAs provided care. However, the unit manager was unable to provide evidence of the interviews. Interview with LPN #8, a unit manager, on 03/25/10 at 5:55 PM, revealed she interviewed three (3) CNAs, at random, regarding knowledge of facility policies on resident to resident incidents. The LPN was unable to provide any evidence the interviews were conducted. The LPN was unaware she should verify CNA ' s knowledge about resident ' s care plan interventions.	{F 323}			
{F 332} SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	{F 332}	The Director of Nursing in-serviced CMT #1 and CMT #2 regarding the medication errors for Residents #19 and #39 on 2/9/10. Residents #19 and #39 are receiving their medications in the correct form and at the correct time, (Resident #39 was not identified on the Resident Roster. However, this resident was identified by the facility from review of the medications on the MAR).	4-1-10	



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{F 332}	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined the facility failed to ensure the medication error rate was less than 5%. Two Certified Medication Technicians and one Registered Nurse were observed passing forty three medications. Four errors were noted during the medication pass resulting in a medication error rate of 9.3%. The findings include: Observation of the medication pass on 02/03/10 at 9:00am on the D hall revealed the Certified Medication Technician (CMT) #2 crushed Prilosec (a do not crush medication) and administered it to Residents #40 and #39 during the 9:00am medication pass on the D hall. Observation of CMT #1 during the medication pass on the E hall on 02/03/10 at 9:00am revealed the CMT omitted a scheduled dose of Thiamine 1 mg for 9:00am and administered Flomax at the incorrect time of 9:00am to Resident #39. Record review of Resident #39 revealed Flomax 0.4mg was ordered to be given at bedtime and Thiamine 1 mg was ordered to be given daily at 9:00am. The Medication Administration Record (MAR) for Resident #39 and Resident #40 listed Prilosec as a do not crush medication. Interview with Certified Medication Technician (CMT) #1 on 02/03/10 at 10:30am revealed the	{F 332}	All residents who receive medications have the potential to be affected. The pharmacy consultant will conduct a med pass in-service for CMTs and nurses on 3/31/2010. All residents have the potential to be affected. The Director of Nursing placed the guidelines for "Do Not Crush" medications in each MAR on 3/15/10. In addition, "Do Not Crush" is printed on the MAR by each medication to which it pertains. In-service on proper medication administration will be presented by the pharmacy consultant by 3/31/10 to staff who pass medications. (Two pharmacy consultants did a med pass in-service on October 27, 2009.) Any staff not in attendance for the medication administration in-service will not be allowed to pass meds after 3/31/10 until they have received the in-service. The pharmacy consultant will also conduct Train the Trainer sessions so that licensed nurses will be proficient in	



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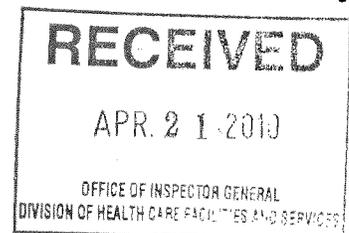
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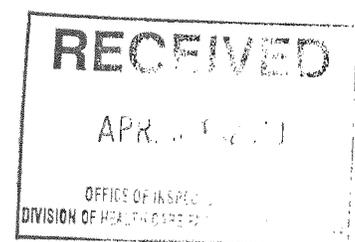
{F 332}	<p>Continued From page 37</p> <p>9:00am Thiamine dose on Resident #39 was an omitted medication and would be considered a medication error. In addition, the MAR on Resident #39 was changed to give Flomax at 9:00am. The physician's order stated Flomax was to be given at bedtime. CMT #1 could not explain why the time was changed on the MAR and stated Flomax was usually given in the evening.</p> <p>Interview with CMT #2 on 02/03/10 at 11:00am revealed the CMT crushed Prilosec for Resident #40 because he would not swallow whole pills. However, observation revealed Resident #40 was given Flomax in whole form and swallowed the pill.</p> <p>Resident #40 received Prilosec crushed but received Colace as a whole pill. No explanation was given for the inconsistency of giving one medication whole and crushing others for Resident #40.</p> <p>Interview with the Registered Pharmacist revealed medication pass audits had been completed on 09/25/09 with an error rate of 33% and on 10/07/09 with an error rate of 20%. According to the pharmacist, the Director of Nursing (DON) was given the audit reports and concerns were discussed. However, the pharmacist was not aware of any action plan and had not been requested to do another medication audit.</p> <p>Interview with the DON on 02/04/10 at 8:25am revealed the pharmacy did complete medication pass audits and the results were discussed. If there was a concern with an individual, the person would be counseled and a repeat audit would be</p>	{F 332}	<p>conducting medication pass audits. Random medication pass audits will be conducted beginning March 31, 2010.</p> <p>At least two per week will be conducted until all staff who pass medications have successfully completed the audit and results reported to the QA Committee by the Director of Nursing and/or pharmacy consultant. The Director of Nursing will monitor to ensure this is being done. The med pass audits will be continued to ensure that at minimum 4 staff is being audited for med pass on a quarterly basis, the results will be presented at the monthly QA meeting.</p>	
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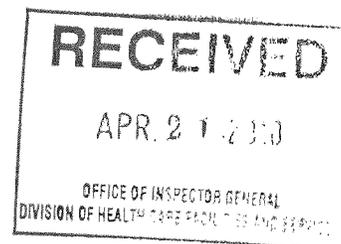
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{F 332}	Continued From page 38 requested. A pharmacy in-service was conducted on 10/27/09. There was no evidence of a repeat audit or counseling by the DON provided.	{F 332}		
{F 356} SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	{F 356}	No specific residents were cited. The Administrator had assigned a particular staff member to be responsible for posting the nurse staffing with the required information and this staff member failed to comply on the specific day noted by the surveyors. The Administrator counseled this staff member on February 18, 2010 and reinstructed her regarding the requirement for the nurse staffing posting requirement and policy. All residents have the potential to be affected. The Administrator developed a new policy for Nurse Staffing Posting. This was approved by the QA Committee on February 25, 2010. The new policy was reviewed by the DON, the Scheduler (staff member responsible for the daily posting), Wound-care nurse and MDS Coordinator. A post-test was completed to validate their knowledge of the policy.	4-1-10



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{F 356}	Continued From page 39 Based on observation, record review and interview it was determined the facility failed to post staffing notices with the required total numbers and actual hours worked by licensed and non-licensed staff per shift. The findings include: Observation of the facility postings on 02/16/10 at 1:55pm revealed it was not posted in the area as indicated by the nursing staff. However, the daily staffing sheet was posted. Interview with the Director of Nursing (DON) on 02/16/10 at 1:55pm revealed the required staffing was posted. However, observation by the DON confirmed the posting was not there. It should have been posted next to the staffing sheet for the day. Record review of the nurse staffing information revealed it lacked the facility's name, the total number and actual hours worked by the licensed and non-licensed nursing staff directly responsible for resident care per shift. Interview with the Administrator on 02/16/10 at 2:00pm revealed she was not aware the total hours had not been posted as required and there was no policy.	{F 356}	All nurses will be in-serviced by the Administrator on this policy by 3/31/10. The Administrator will monitor the compliance of proper posting beginning March 1 through March 15 and counsel the Scheduler if any discrepancies are noted. The Administrator will report to the QA Committee the compliance of the nurse staffing postings at the weekly QA meeting. This will be done weekly for one month and then reassessed for the continued need for monitoring by the QA Committee. A calendar will be used to monitor the nursing staffing postings ongoing to ensure the staffing postings are being done accurately.	
{F 371} SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	{F 371}	No specific residents were cited. All residents have the potential to be affected.	4-1-10



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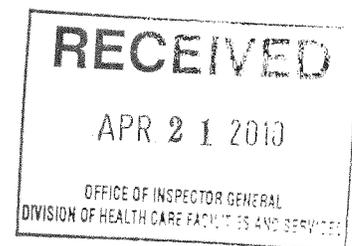
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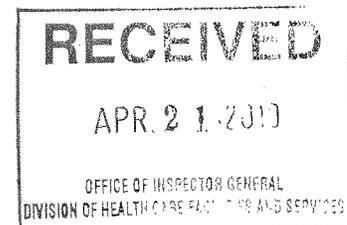
{F 371}	<p>Continued From page 40</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure foods were prepared and served in a sanitary manner. Dietary staff was observed to handle food with contaminated gloves.</p> <p>The findings include:</p> <p>A review of the facility's policy 9.3 Environmental Sanitation/Infection Control stated hands will be properly washed before and after touching anything that can be a source of contamination.</p> <p>Observation of the kitchen on 02/02/10 at 8:15am revealed Cook #1 picking up biscuits with gloved hand, splitting the biscuits, placing them on the plate, and then covering with gravy. Cook #1 was also observed picking up bacon and sausage with gloved hands and placing on plates. Cook #1 then proceeded to place bowls and plates on a tray, then picking up the tray and placing on the food cart. After food cart was full Cook #1 retrieved a large bag and covered the food cart. Cook #1 then returned to the tray line without changing gloves and proceeded to split biscuits with gloved hands and place on the plate and pick up bacon and sausage and place on a plate.</p> <p>Observation on 02/03/10 at 7:45am-8:45am revealed Cook #2 was placing bacon and toast on trays. Cook #2 was observed placing trays on the cart, leaning over the stove to retrieve a bowl of</p>	{F 371}	<p>The Dietary Manager will in-service 100% of dietary staff by April 1, 2010 on the following: when to wash hands, how to wash hands, where to wash hands, proper use of disposable gloves and when to wash hands and, how to serve biscuits, bacon, sausage, etc.</p> <p>The facility will monitor performance by 1. Dietary Manager will monitor employees to ensure proper handwashing occurs throughout the shifts, 2. Dietary Manager will document that proper handwashing and proper glove use occurred daily by monitoring meal preparation and tray line service 5 times per week for two weeks and then 2 times per week for two weeks, then atleast weekly for the next two months.</p> <p>Progress will be monitored in the weekly QA meeting.</p>	
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{F 371}	Continued From page 41 cereal, placed left hand on the stove hood, then proceeded to serve food on the tray line without changing gloves. Cook #2 was also observed wiping sweat from the forehead with the back of the gloved hand, wiping gloved hands on the apron, and then touching toast and bacon without changing gloves.	{F 371}		
{F 441} SS=F	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	{F 441}	The catheter bag for Resident #11 was positioned properly and covered for privacy when brought to the attention of the staff. Resident #11's care plan was updated on February 2, 2010, relating to care of the catheter. Proper care of the catheter for Resident #11 is being provided by staff. Catheter care was added to the resident's treatment record. The catheter was not listed on the MDS since it was not present during the assessment period. All residents have the potential to be affected. An infection control in-service was conducted for nursing staff on 3/18/10 and included education related to proper care of catheters, catheter tubing and bags. The facility did have Infection Control Policies and Procedures at the time of the survey. However, the nurse who had recently been appointed to manage	4-1-10



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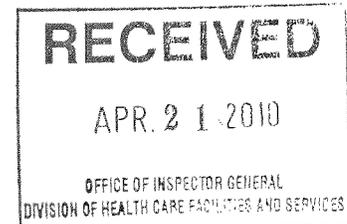
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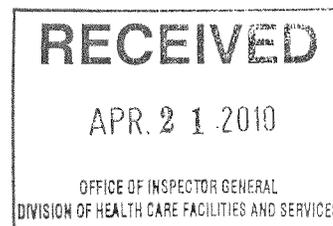
{F 441}	<p>Continued From page 42</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</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 record review, observation and interview it was determined the facility failed to ensure indwelling urinary catheters were protected and positioned in a manner that would reduce the risk of infection for one of the 40 sampled residents (#11). In addition, the facility failed to provide evidence of development, training, and implementation of policies and procedures for infection control to prevent the spread of infections.</p> <p>The findings include:</p> <p>Record review on 02/02/10 at 11:00am of Resident #11 revealed a re-admission date of 11/11/09 and diagnoses of Paraplegia secondary to Polio. The quarterly MDS assessment dated 11/10/09 indicated the resident was incontinent of bladder. There was no indication of an indwelling catheter utilized by the resident. The treatment records did not indicate there was a urinary catheter in use. The plan of care did not indicate the use of the urinary catheter.</p>	{F 441}	<p>the program was unaware of the location of them.</p> <p>The Administrator appointed a Registered Nurse to oversee the Infection Control Program.</p> <p>Charge nurses are responsible to monitor staff compliance with proper care of catheter tubing and bag. This will also be monitored during routine, established administrative rounds conducted by administrative staff. These documented rounds will be reviewed by the QA Committee and action taken as a result of the rounds.</p> <p>The Infection Control nurse will present an Infection Control report to the QA Committee at each QA meeting and the QA members will direct additional action as a result of the report.</p>	
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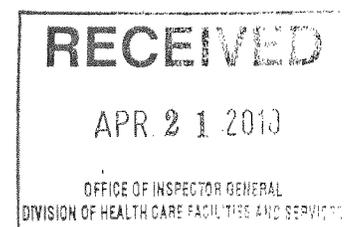
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{F 441}	Continued From page 43 Observation on 02/02/10 at 6:00am revealed Resident #11's indwelling catheter bag lying on the floor in the resident's room. Observation on 02/02/10 at 6:40am revealed CNA #1 coming out of Resident #11's room. Further observation revealed the urinary catheter bag lying on the floor. Observation on 02/02/10 at 8:10am revealed Resident #11 was up in a chair in the dining room for the breakfast meal. The urinary catheter bag was observed with the tubing lying on the floor and multiple staff members repositioning residents, talking with residents, and feeding residents in close proximity to Resident #11's urinary catheter tubing that was lying on the dining room floor. Interview with the Director of Nursing on 02/03/10 at 4:00pm revealed that neither the urinary drainage bag, nor the catheter tubing should be lying on the floor because this could cause an infection. Observation on 02/03/10 at 12:00pm revealed the resident sitting up in a Geri-chair in the resident's room with the urinary catheter bag lying on the floor uncovered. Interview with State Registered Nursing Assistant (SRNA) #6 on 02/03/10 at 5:00pm revealed the urinary catheters should be secured to the resident or onto the side of the bed, or the wheelchair and should not be lying on the floor; there are germs on the floor. Interview with the Quality Assurance Nurse on	{F 441}			



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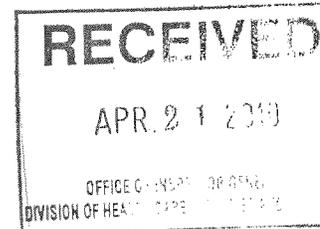
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{F 441}	<p>Continued From page 44</p> <p>02/04/10 at 9:30am revealed that she does not monitor anything with the urinary catheters; this is not part of her job.</p> <p>Interview via telephone with SRNA #7 on 02/04/10 at 2:00pm revealed they did not realize the urinary catheter bag was on the resident's floor, and that it should not have been on the floor, uncovered. They did not know why the catheter bag was on the floor, or why it was not covered.</p> <p>Interview with SRNA #12 on 02/04/10 at 4:00pm revealed that catheter tubing should be secured and not lying on the floor due to contamination.</p> <p>Interview with LPN #4 on 02/04/10 at 4:15pm revealed that urinary catheter bags and tubing should never be on the floor, and that the bag should always be placed in a privacy pouch. The LPN went on to state the Nurse is ultimately responsible to make sure patient care is carried out appropriately.</p> <p>Review of the facility's training records on 02/04/10 at 2:30pm revealed the facility was not able to provide a staff roster for training/education related to the care and management of urinary catheter bags.</p> <p>Record review of the facility's policy and procedures revealed there were no policy and procedures for the Infection Control program. However, the facility provided a one page statement titled Infection Control: to assure that nosocomial infections are prevented and monitored, i.e. 3) the facility has an established infection control program which has been designed to provide a safe, sanitary, and</p>	{F 441}		



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{F 441}	Continued From page 45 comfortable environment and to help prevent the development and transmission of disease and infection; however, these policy and procedures were not provided for review. Interview with the Administrator on 02/16/10 at 3:50pm revealed the Infection Control program could not be found in the facility. The only thing that was available was the Infection Control statement attached to the Flu and Pneumonia vaccine consent and procedure forms. The Administrator indicated there was a program but could not locate it.	{F 441}		
{F 490} SS=E	(Refer to F371 and TB0005) 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Not Corrected Based on interview and record review it was determined the facility failed to be administered in a manner to attain the highest practicable well-being of each resident. The administration of the facility failed to have a system to ensure the facility had documented evidence of the completion of audits, interviews, and monitoring to ensure correction of deficient practice.	{F 490}	All residents have the potential to be affected. There were no specific residents cited. The facility has a system in place to ensure that all employees have completed the employee questionnaire to verify knowledge of policies and procedures related to resident to resident incidents in the facility. The employee test are discussed at the weekly QA meeting to ensure that all newly hired staff have completed the employee questionnaire.	4-1-10



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{F 490}	Continued From page 46 The findings include: 1. (Cross refer F323) The facility had not completed employee questionnaires to verify knowledge of policies and procedures related to resident to resident incidents in the facility. In addition, the facility was unable to provide evidence of compliance rounds (audits) made by unit manager/supervisors/charge nurses to monitor staff knowledge and compliance with behavior interventions on resident ' s care plans. 2. Review of the facility's letter of credible allegation revealed the Administrator and key members of the Quality Assurance Committee led the corrections listed in the letter. Included in the letter was the following: "The Unit Managers/Supervisors/Charge Nurses are responsible to make rounds and supervise staff to monitor their compliance with behavioral interventions as listed on each individuals' care plan. The unit Managers/Supervisors/Charge Nurses take immediate action to correct any con-compliance by staff members. The Director of Nursing is made aware of any serious non-compliance as soon as possible." Interview with LPN # 10, a unit manager, on 03/25/10 at 5:45 PM revealed she interviewed two (2) CNAs three (3) or four (4) days ago about their knowledge of care plans for residents with whom they worked who had behavioral interventions. Interview with LPN # 8, a unit manager, on 03/23/10 at 5:55 PM revealed she interviewed three (3) CNA staff at random with general questions about knowledge of abuse policies. She did not interview staff about specific resident behavior plans. While these	{F 490}	Although the Unit Managers were already making rounds and documenting evidence of these rounds they were in-serviced on ⁴⁻¹⁻¹⁰ 4/20/10 by the Director of Nursing and Administrator on completing rounds with staff to ensure that behavior interventions are being followed as listed on the resident's care plan. This in-service included how these rounds are to be documented and specific questions to be asked. The Unit Managers /supervisors are making rounds to monitor staffs knowledge and compliance with behavior interventions on resident's care plans. The Unit Managers/supervisors are documenting their rounds and are turning their completed rounds into the Nursing Administrative Assistance that list the staff name of who was interviewed. These rounds are discussed in the weekly Quality Assurance Committee meeting.	

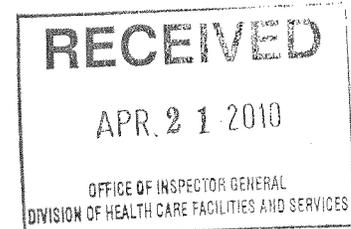
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 490}	<p>Continued From page 47</p> <p>staff were conducting interviews per the facility's allegation of compliance neither could provide documented evidence of who they interviewed, what questions were asked whether it was regarding abuse policy and procedures or staff knowledge of resident's care planned behavioral interventions. Interview with LPN #8 revealed that she did not conduct interviews regarding specific resident behavior plans. Furthermore, interview with the facility's Nurse Consultant on 03/25/10 at 6:30 PM revealed she had conducted random CNA staff interviews regarding assignment sheets and thirty-one (31) residents' behavior plans; however, the consultant's documentation did not identify staff names that were interviewed.</p> <p>Interview with the Director of Nursing (DON) on 03/25/10 at 5:50 PM revealed she could provide no evidence of rounds made by facility unit managers, supervisors, or charge nurses. While she detailed the rounds were being done, she "...didn't think to tell them" to document.</p> <p>The facility was unable to provide evidence that they had developed a system to ensure that staff conducting interviews were knowledgeable about what questions they were to ask, what they were looking for, and how they were to document the results and the completion of the interviews. The facility could not provide evidence of how they were monitoring and assuring rounds and interviews were completed or how they were reviewing the results of the rounds and interviews to ensure completion of the allegation of compliance and progress towards compliance.</p>	{F 490}		



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K 000	INITIAL COMMENTS A state Life Safety Code survey was conducted on 02/16 -17/2010 for compliance with Title 42, Code of Federal Regulations, 483.70 (a) (Life Safety from fire, requirements for Long Term Care Facilities)NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency identified at an "F".	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor doors were being	K 018	The Maintenance Director made rounds throughout the entire facility on February 17, 2010 and removed all devices including door wedges, and trashcans that were being used to hold doors open. The Maintenance Director and his full time assistant were in-serviced on March 4, 2010 at 7 pm by the Administrator on not propping doors open with any objects including door wedges.	3/31/10

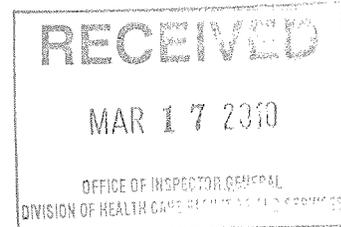
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Stephanie L. Mathis* TITLE Administrator (X6) DATE 3-17-2010

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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K 018	Continued From page 1 held open by approved devices. The findings include: During the Life Safety Code tour on 02-16-10 between 2:00pm and 5:30pm and on 02-17-10 between 7:30am and 2:00pm, multiple observations through out the facility revealed door wedges were used to hold open the doors. An interview with the Maintenance Director on 02-16-10 at 2:00pm, revealed the Maintenance Director was aware that corridor doors should not be held open in this manner. Observations of doors inappropriately held open continued during the survey, and the facility's corridor closet doors to resident rooms were noted to be held open with unapproved devices as well. Reference: NFPA 101 (2000 Edition). 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches 19.3.6.3.4 Door-closing devices shall not be required on doors in corridor wall openings other than those serving required exits, smoke barriers, or enclosures of vertical openings and hazardous areas.	K 018	100% of facility staff will be in-serviced by the Maintenance Director on not propping doors open by March 31, 2010. The Maintenance Director and his full time assistant will make rounds in the facility Monday-Friday to check for doors propped open beginning March 8, 2010. The results of this audit will be reported to the QA Committee in the weekly QA meeting.	



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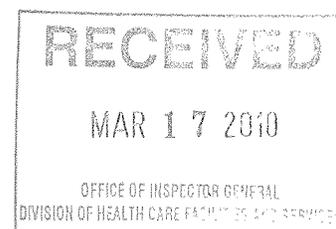
K 038 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to assure the delayed egress doors in the building were working properly.</p> <p>The findings include:</p> <p>1. Observations during the Life Safety Code Inspection on 02-17-10 between 9:00am and 2:00pm revealed the emergency egress doors on b,c,d,e,f,and g halls, and all emergency egress doors from the facility were not approved with locks and alarm devices that meet NFPA regulations.</p> <p>2. Observations revealed on 02-17-10 between 9:00am and 2:00pm revealed all emergency egress doors had lever handle door knobs and key pad push button locks. In addition, all emergency egress exit doors had a second key pad lock on the wall that also needed a number code in order for staff to exit the facility. All of these locks needed two different sets of numbers for each lock in order to exit the facility. However, when the Fire Alarm System was activated, all doors released upon activation.</p>	K 038	<p>On 2/16/10 the Administrator instructed the Director of Maintenance to contact life safety vendors to get the emergency egress doors on B, C, D, E, F, and G halls and all emergency egress doors in the facility with approved locks and alarm devised that meet NFPA regulations.</p> <p>The facility changed the code lock on the exit doors on 2/17/10 so that only one code on each door has to be used to exit the facility.</p> <p>The egress doors will be equipped with the approved locks and alarm by March 31, 2010.</p> <p>The progress of the egress doors being brought to code will be discussed in the weekly QA meeting.</p>	3/31/10
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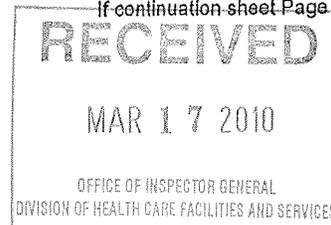
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K 038	Continued From page 3 Interview with the Maintenance Director and the Administrator on 02-17-10 at 1:00pm revealed the Maintenance Director and the Administrator said they were not aware the doors were not operating according to NFPA regulation. NFPA: 101, 2000 7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to	K 038	Qualified vendors are scheduled to upgrade the egress doors the week of March 14, 2010, and these upgrades will be completed no later than March 31, 2010. These upgrades will include all aspects for meeting the requirements for NFPA: 101, 2000, including the irreversible process that will release the lock within 15 seconds upon application of a force to the release device. When completed, a readily visible, durable sign will be placed on the door adjacent to the release device. When completed, a readily visible, durable sign will be placed on the door adjacent to the release device that reads "Push Until Alarm Sounds Door Can Be Opened in 15 Seconds" in accordance with NFPA: 101, 2000 (7.2.1.6.1).	



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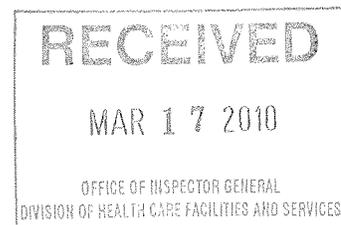
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K 038	Continued From page 4 the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted	K 038		



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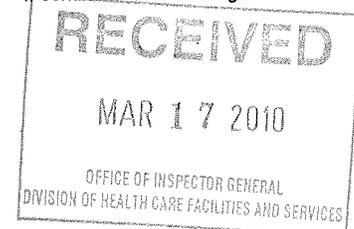
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K 038	Continued From page 5 to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations. 7.2.1.6.2 Access-Controlled Egress Doors. Where permitted in Chapters 11 through 42, doors in the means of egress shall be permitted to be equipped with an approved entrance and egress access control system, provided that the following criteria are met. (a) A sensor shall be provided on the egress side and arranged to detect an occupant approaching the doors, and the doors shall be arranged to unlock in the direction of egress upon detection of an approaching occupant or loss of power to the sensor. (b) Loss of power to the part of the access control system that locks the doors shall automatically unlock the doors in the direction of egress. (c) The doors shall be arranged to unlock in the direction of egress from a manual release device located 40 in. to 48 in. (102 cm to 122 cm) vertically above the floor and within 5 ft (1.5 m) of the secured doors. The manual release device shall be readily accessible and clearly identified by a sign that reads as follows: PUSH TO EXIT When operated, the manual release device shall result in direct interruption of power to the lock -	K 038		



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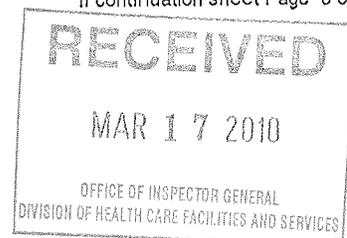
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K 038	Continued From page 6 independent of the access control system electronics - and the doors shall remain unlocked for not less than 30 seconds. (d) Activation of the building fire-protective signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. (e) Activation of the building automatic sprinkler or fire detection system, if provided, shall automatically unlock the doors in the direction of egress and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process	K 038		



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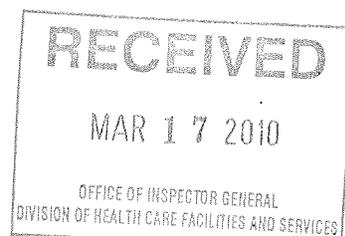
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K 038	Continued From page 7 shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 050 SS=E	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review; it was determined the facility failed to conduct fire drills as required. The facility did not ensure that staff were prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness, and this failure affected all residents and staff in the facility.	K 050	Fire Drills were conducted at least quarterly on each shift at the facility. The Maintenance Director stated that he was aware that Fire Drills had to be conducted at least quarterly on each shift. However, the Maintenance Director was re in-serviced on the requirement of at least quarterly fire drills on each shift on March 4, 2010 by the Administrator. The full time maintenance assistant was also in-serviced on this requirement on March 4, 2010 by the Administrator.	3/3/10



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K 050	Continued From page 8 The findings include: During the Life Safety Code survey on 02-17-10 at 9:00am, with the Director of Maintenance, a records review revealed the facility had not been performing fire drills at unexpected times and varying conditions on all shifts. An interview with the Director of Maintenance on 02-17-10, at 9:00am, revealed the Director of Maintenance was not aware of this requirement.	K 050	100% of facility staff will be in-serviced by the Maintenance Director on the Fire Drill Policy and Fire Safety by March 31, 2010. The Administrator will sign off on all fire drills.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the building's Fire Alarm System as required by the National Fire Protection Association (NFPA) Standard 72. This deficient practice affected all residents and staff. The findings include:	K 052	The results of the fire drills will be reported to the QA Committee in the monthly QA meeting. An automatic smoke detection system was installed in the electrical room on 2/22/10. The Maintenance Director contacted the fire alarm vendor on March 9, 2010 to come to facility to do an audit and advise facility where additional smoke detection systems need to be located if any.	3/31/10



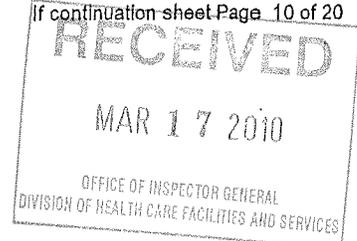
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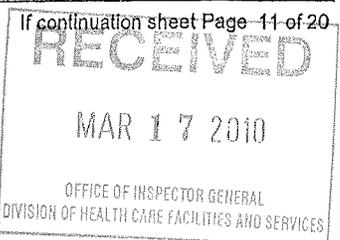
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K 052	Continued From page 9 During the Life Safety Code tour conducted on 02-16-10 at 1:59pm, a test of the Fire Alarm System was conducted. The Fire Alarm System was located in the electrical room. Observation revealed no automatic smoke detection was provided for the fire alarm system. Interview with the Maintenance Director on 02-16-10 at 1:59am revealed the Maintenance Director was not aware a smoke detector was needed for the fire alarm system. NFPA: 72, 1999 Actual NFPA standard: In areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit(s) to provide notification of fire at that location. NFPA 72 section 1-5.6.	K 052	The Maintenance Director was given a copy of the Life Safety 101, 2000 Edition on 2/25/10. The Maintenance Director and his full time assistant were in-serviced on this requirement by a life safety vendor on March 4, 2010. The results of the smoke detection audit by the fire alarm vendor will be reported to the QA Committee in the monthly QA meeting.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	A sprinkler was installed in the family room closet that has an opening at the top on 3/5/10. The Maintenance Director and his full time assistant were educated on March 4, 2010 by the vendor that	3/31/10



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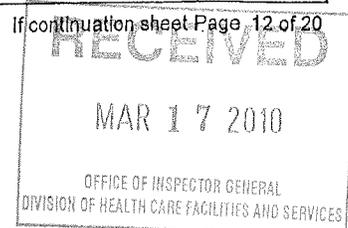
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185448	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 02/17/2010
NAME OF PROVIDER OR SUPPLIER JAMES S TAYLOR MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 W MAGAZINE STREET LOUISVILLE, KY 40203	
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K 056	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation and Interview, the facility failed to provide complete coverage for all portions of the building by the automatic sprinkler system. The findings include: Observations during the Life Safety Code inspection conducted on 02-16-10 at 12:55pm revealed the family room located on the a-wing closet area was not provided with sprinkler coverage. Interview with the Maintenance Director on 02-16-10 at 12:55pm revealed the Maintenance Director was not aware sprinkler coverage was needed in that location. NFPA 13 2002 Chapter 8 8.5 Position, Location, Spacing, and Use of Sprinklers. 8.5.1 General. 8.5.1.1 Sprinklers shall be located, spaced, and positioned in accordance with the requirements of Section 8.5. 8.5.1.2 Sprinklers shall be positioned to provide protection of the area consistent with the overall objectives of this standard by controlling the positioning and allowable area of coverage for each sprinkler.	K 056	provides sprinkler services to the facility. The Maintenance Director was given a copy of the Life Safety 101, 2000 Edition on 2/25/10. The Maintenance Director contacted the facility sprinkler vendor on March 9, 2010 to come to facility to do an audit and advise facility where additional sprinklers need to be located if any. The results of the sprinkler audit by the facility sprinkler vendor will be reported to the QA Committee in the monthly QA meeting.	
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:	K 066	The facility ordered additional metal containers with self-closing cover devices into which ashtrays can be emptied. These ashtrays were placed in the gated outside smoking area on March 1, 2010.	3/31/10



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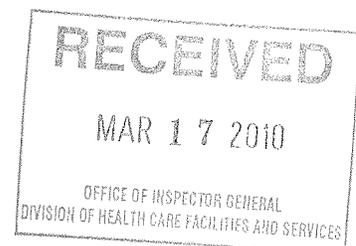
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K 066	<p>Continued From page 11</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to assure the smoking area met minimum requirements as established in NFPA Standard 101.</p> <p>The findings include:</p> <p>Observation during the Life Safety Code tour on 02-16-10, at 3:45pm, revealed the smoking area outside the dining area court yard failed to have Metal Containers with self-closing cover devices into which ashtrays can be emptied.</p> <p>Interview on 02-16-10 at 3:45pm, revealed the</p>	K 066	<p>The Maintenance Director removed all other ashtrays on the facility property on February 17, 2010.</p> <p>The Maintenance Director was given a copy of the Life Safety 101, 2000 Edition on 2/25/10.</p> <p>The Maintenance Director will audit the facility smoking area 5 days a week for 2 weeks beginning March 8, 2010 to ensure that the approved metal containers with self-closing cover devices are being used which ashtrays can be emptied, the audit will be conducted 3 days a week for 2 weeks, and then once a week.</p> <p>The results of this audit will be reported to the QA Committee at the weekly QA meeting.</p>	



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K 066	Continued From page 12 Maintenance Director was not aware of the requirements regarding these containers. Actual NFPA Standard: 19.7.4 Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. In accordance with NFPA 19.7.4 Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation, record review and	K 067	The Maintenance Director contacted a vendor to get the steel roller door that divide the kitchen from the dining room inspected on 2/17/10. The steel roller door was looked at on 3/4/10 by a local door service company; however they stated they would have to come back because further work needed to be done. The facility Maintenance Director contacted the door vendor again on	3/31/10



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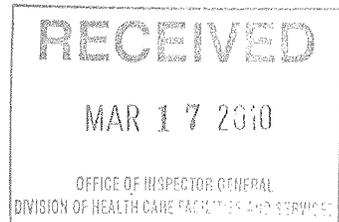
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K 067	<p>Continued From page 13</p> <p>interview it was determined the facility failed to have an effective system in place to maintain building equipment, i.e. water mixing valves to ensure the facility residents received water at a safe temperature. The deficient practice has the potential to affect all residents in the facility.</p> <p>The findings include:</p> <p>1. Observation during the Health Survey on 02-03-10 by surveyors revealed while checking the water that was available for the residents' use, the water thermometer registered temperatures of 118-126 degrees Fahrenheit for various locations tested.</p> <p>Interview with the Maintenance Director on 02-17-10 at 9:00am revealed he had to adjust the water mixing valves frequently to achieve a water temperature of 120 degrees Fahrenheit. The only corrective action he had previously taken was continued adjustment of the mixing valves. The Maintenance Director stated he thought 120 degrees was "ok" for the water temperature.</p> <p>2. Observation on 02-17-10 at 9:00am revealed the steel roller door that divide the kitchen from the dining room was not inspected and maintained according to NFPA.</p> <p>Interview with the Maintenance Director on 02-17-10 revealed he was not aware the roller door needed to be inspected and maintained.</p> <p>NFPA 101, 2000</p>	K 067	<p>3/9/10 to see when they would be back to inspect the steel roller door. The local door service company tested the steel roller door on 3/15/10 and the steel roller door passed the inspection. This inspection included the door fusible link being inspected and certified in accordance with NFPA.</p> <p>No individual residents cited. All residents have the potential to be affected. The Administrator took immediate action when it was brought to her attention that the inconsistent water temperature (above 110 degrees on all four halls at times) caused an unsafe situation and constituted a concern for resident safety. Immediately upon learning of the increased water temperature on February 2, the Maintenance Director adjusted the mixing valve of the boiler and ran hot water to reduce the temperature. The Administrator directed staff to post signs (which they did) in each resident room, shower rooms and other areas that contained hot and cold water sinks. The Maintenance Director removed hot water handles from sinks in residents' rooms, shower rooms, restorative restroom and general staff, and resident restrooms so that hot water could not be used.</p> <p>Calls were made to three plumbing companies to assess the situation. The first, did not respond. The second stated they did not work on boiler</p>	
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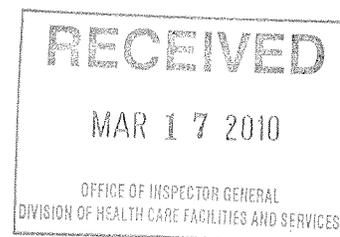
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K 067	Continued From page 14 Chapter. 4 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 4.6.12.2* Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. 4.6.12.3 Equipment requiring periodic testing or operation to ensure its maintenance shall be tested or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. 4.6.12.4 Maintenance and testing shall be under the supervision of a responsible person who shall ensure that testing and maintenance are made at specified intervals in accordance with applicable NFPA standards or as directed by the authority having jurisdiction.	K 067	systems. The third stated they would dispatch a service person within the hour. At 6:00 pm. the plumber from the third company evaluated the situation and stated the boiler may need a new mixing valve or check valve and would return between 7:00am and 8:00am to repair. Nursing staff were provided individual hand sanitizers and extra cleaning wipes for care of the residents. Nursing staff were instructed regarding the situation with the water temperatures and informed to alert their supervisor if they felt the water was too hot or if any resident complained of water being too hot. This information was added to the nurse agency information book and will be added to the orientation program. Temperatures were checked every hour in alternating resident rooms (at least six per wing) and common areas throughout the night by nursing staff. The Maintenance Director instructed them on how to check temperatures. K067 Plan of correction continued on back page 15 of 20 on the 2567.	
K 135 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids are constructed in accordance with NFPA 30,	K 135	The Maintenance Director made rounds throughout the facility and disposed or placed in safety fire proof cabinet all flammable and combustible liquids being used in the facility on February 16, 2010.	3/31/10



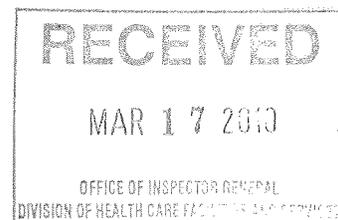
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K 135	<p>Continued From page 15</p> <p>Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure flammable materials were stored safely in the event of a fire.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation during the Life Safety Code Inspection on 02-16-10 at 3:45pm revealed eight (8) cans of aerosols containing butane, propane were stored in the dry goods area located in the Kitchen. 2. Observation of the Basement revealed the laundry room door was held open with a five gallon can of polyurethane, which is a Flammable product. <p>Interview with the Maintenance Director on 02-17-10 at 8:50am revealed he was unaware the aerosols contained the flammable ingredients. The Maintenance Director was not aware the five gallon can of polyurethane was being used for a door stop. The Maintenance Director said the polyurethane is a combustible liquid and should not be stored in the building.</p> <p>NFPA 2000 8.4 SPECIAL HAZARD PROTECTION 8.4.1 General:</p>	K 135	<p>The Maintenance Director and his full time assistant were educated on March 4, 2010 on how and where to store all flammable material and liquid.</p> <p>All facility staff will be in-serviced on the proper storage of flammable and combustible liquids by March 31, 2010.</p> <p>The Maintenance Director will audit the facility 5 days a week for 2 weeks beginning March 8, 2010 to ensure that all flammable and combustibles are stored properly, this audit will be conducted 3 days a week for 2 weeks, and then once a week.</p> <p>The results of this audit will be reported to the QA committee at the weekly QA meeting.</p>	



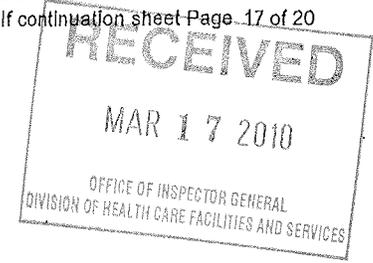
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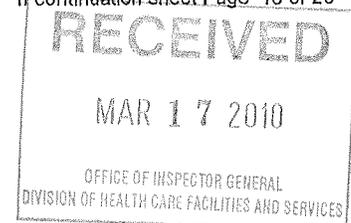
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K 135	Continued From page 16 8.4.1.1* Protection from any area having a degree of hazard greater than that normal to the general occupancy of the building or structure shall be provided by one of the following means: (1) Enclose the area with a fire barrier without windows that has a 1-hour fire resistance rating in accordance with Section 8.2. (2) Protect the area with automatic extinguishing systems in accordance with Section 9.7. (3) Apply both 8.4.1.1(1) and (2) where the hazard is severe or where otherwise specified by Chapters 12 through 42. NFPA 99, 10-7.2.1* Flammable and Combustible liquids shall be used from and stored in approved containers in accordance with , NFPA 30- 4.3.3 Storage cabinets that meet at least one of the following sets of requirements shall be acceptable for storage of liquids: (a) Storage cabinets that are designed and constructed to limit the internal temperature at the center of the cabinet and 1 in. (25 mm) from the top of the cabinet to not more than 325°F (162.8°C), when subjected to a 10-minute fire test that simulates the fire exposure of the standard time-temperature curve specified in NFPA 251, Standard Methods of Tests of Fire Endurance of Building Construction and Materials, shall be acceptable. All joints and seams shall remain tight and the door shall remain securely closed during the test.	K 135		
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	The Maintenance Director made rounds throughout the facility on February 16, 2010 and removed the extension cord in the MDS office, removed the extension cord	3/31/10



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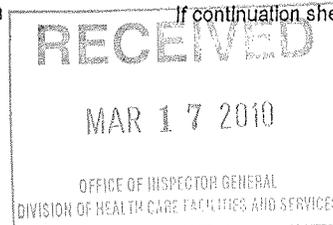
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K 147	<p>Continued From page 17</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure residents were supplied a safe and reliable source of electrical power to prevent circuit overload and a possible fire. In addition, the facility failed to ensure there were no extension cords in use in the building.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation during the Life Safety Code Inspection on 02-16-10 at 3:15pm revealed the Minimum Data Set assessment office was using an extension cord to supply energy to the computer. 2. Observation on 02-16-10 at 3:15pm revealed, in room #11 an extension cord was plugged into a radio. 3. Observation on 02-16-10 at 3:15am revealed, in room #12 a concentrator, easy air oxygen, and pumps, all medical equipment, were plugged into a power strip. <p>Interview with the Maintenance Director on 02-16-10 at 3:15pm revealed he was unaware of staff using the extension cords. The Maintenance Director stated facility policy does not allow extension cords to be used.</p> <p>NFPA 70 400-8 (Extensions Cords) Uses Not Permitted.</p>	K 147	<p>in room # 11 that a radio was plugged into. The Director of Nursing and the Maintenance Director removed the power strip from room #12 and plugged in all equipment in to the wall electrical outlet.</p> <p>The Maintenance Director and his full time assistant were in-serviced on March 4, 2010 on the use of extension cords and power strips in the facility by the Administrator.</p> <p>The Maintenance Director was given a copy of the Life Safety 101, 2000 Edition on 2/25/10.</p> <p>All staff will be in-serviced on the use of extension cords and power strips in the facility by March 31, 2010. This in-service will be conducted by the Maintenance Director.</p>	



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K 147	Continued From page 18 Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces National Electric Code, relating to ground fault protection for electric outlets near sinks in resident rooms. NFPA: 70 210.8 Receptacles installed under the exceptions to 210.8(A)(5) shall not be considered as meeting the requirements of 210.52(G). (6) Kitchens - where the receptacles are installed to serve the countertop surfaces (7) Wet bar sinks - where the receptacles are installed to serve the countertop surfaces and are located within 1.8 m (6 ft) of the outside edge of the wet bar sink.	K 147		
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8	K 155	All residents have the potential to be affected. The facility has implemented a fire watch policy and	3/31/10



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FORM APPROVED
OMB NO. 0938-0391
MAR 1 2010
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE SERVICES
DATE SURVEY COMPLETED
02/17/2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185448	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 02/17/2010
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NAME OF PROVIDER OR SUPPLIER JAMES S TAYLOR MEMORIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 W MAGAZINE STREET LOUISVILLE, KY 40203
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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
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K 155	Continued From page 19 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to provide in writing, a procedure to implement in case the fire alarm system was out of service for more than 4 hours in a 24- hour period. NFPA 9.6.1.8 The findings include: Observation made during Life Safety Code Inspection tour on 02-16-10 at 2:30pm revealed the facility could not provide in writing when the fire alarm system was out of service for more than 4 hours in a 24-hour period in 01-26-10 and 07-15-09. Interview with the Administrator on 02-16-10 at 2:30pm revealed the Administrator could not provide in writing a procedure in case the fire alarm system was out of service for more than 4 hours in a 24-hour period.	K 155	procedure that addresses the fire alarm watch when the system is down for more than 4 hours. The Maintenance Director and his assistant were in-serviced on this policy and procedure on March 4, 2010 by the Administrator. All staff will be in-serviced by the Maintenance Director on this policy and procedure by March 31, 2010. The Maintenance Director will report to the QA Committee when the fire alarm system is down for more than 4 hours and the QA Committee will monitor to see that the fire watch was done when required as stated in facility policy.	
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