

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

PRINTED: 05/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2014
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Standard Health survey was initiated on 04/29/14 and concluded on 05/01/14 with a deficiency cited at the highest scope and severity of an "F". A Life Safety Code survey was initiated and concluded on 04/30/14 with deficiencies cited at the highest scope and severity of an "F".	F 000	This plan of correction constitutes Mercy Sacred Heart's credible allegation of compliance for the cited deficiencies. Nothing in this plan of correction should be construed as admission by the facility of any violations of state or federal statutes, regulation, or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during an annual survey.	
F 371 SS=F	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 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to store, prepare, and serve food under sanitary conditions. A Dietary Aide was observed turning the water in the sink off with bare hands after washing them. There were multiple soiled and torn paper signs throughout the kitchen. A door leading to a dining	F 371	Corrective action for those residents found to have been affected by the deficient practice: 1. An in-service on hand washing with a return demonstration has been completed with 100% of Food Service employees. 2. All signs have been removed and retyped as needed. All signs needing to be reposted in a work area have been laminated for easy cleaning. 3. The closure on the door to the kitchen has been adjusted and does close fully now.	5/30/14

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

X Kim Thierman

TITLE

X Executive Director X

(X6) DATE

5/23/2014

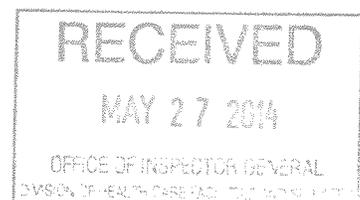
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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F 371	<p>Continued From page 1</p> <p>room did not close fully. Shelves under and above the steamtable were soiled with a dust-like substance. The tops of the plate warmer and the pullet warmer were soiled with black greasy substance and brown particles. There were areas of caked on food burned black on the top of the stove. Milk crates sitting directly on the floor in the storage room were used to store food items. A small cart, containing food items, was soiled on both shelves with black and brown particles. A black cart holding food items was soiled on both shelves with dust-like gray substance and brown particles. The walls in the food preparation area were soiled with brownish smears. Shelves by the ice machine were soiled with brown and white particles.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Sanitation, dated February 1999, revealed all kitchen areas were to be kept clean and free from litter. All shelves were to be kept clean.</p> <p>Observation of the kitchen, on 04/29/14 at 8:11 AM, revealed the door from a dining room into the kitchen would not fully close. Shelving next to the ice machine and under the steam table were soiled with dust-like substances and brown particles. Two (2) carts were in use with snack supplies and food items and both were soiled with brown particles, dried spills, and black marks. The bottom of clear plastic curtain in the doorway of the walk-in refrigerator revealed the bottom five (5) inches were brown in color. The floor under the curtain was soiled and brown in color.</p> <p>Observation of Dietary Aide #2 in the kitchen, on 04/30/14 at 12:07 PM, revealed she washed her</p>	F 371	<p>4. All shelves under and above the steam table and by the ice machine have been cleaned and sanitized.</p> <p>5. The plate warmer and pellet warmer have been cleaned and sanitized.</p> <p>6. The stove was checked for cleanliness. Grates were removed and washed after cooking as they are five to seven times per week.</p> <p>7. Milk crates will be removed in all storage areas. Dunage racks on casters have been ordered to store the additional food items on.</p> <p>8. All carts have been cleaned and sanitized.</p> <p>9. All walls in the food prep area have been scrubbed and cleaned.</p> <p>10. New air curtains have been installed in both the refrigerator and freezer walk ins.</p> <p>11. The storage room floor has been stripped and cleaned.</p> <p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <p>1. All meals are prepared from the same kitchen so all residents had the potential to be affected by this same practice.</p>

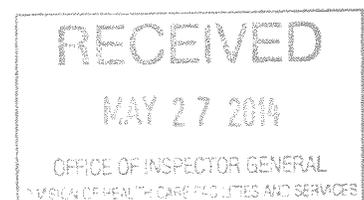
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F 371	<p>Continued From page 2</p> <p>hands in the sink then turned the water faucet off using her bare hands.</p> <p>Interview with Dietary Aide #2, on 04/30/14 at 12:25 PM, revealed she had received training on handwashing. She stated she forgot to use the paper towel to turn the water off. She stated washing her hands incorrectly could lead to residents becoming sick from bacteria on the food.</p> <p>Observation of the kitchen, on 05/01/14 at 9:40 AM, revealed shelving next to the ice machine, and shelving under and over the steam table continued to be soiled with dust-like substances and brown particles. Two (2) carts were in use with snack supplies and food items and both were soiled with brown particles and dried spills as observed on 04/29/14. The door to a dining room did not fully close. There were areas of burnt food on the stove. Milk crates were used in the food storage room as platforms to store boxes of bananas and other food items. These milk crates were soiled and sat directly on the floor. The floor in the food storage room was scuffed with black and brown marks.</p> <p>Review of the cleaning schedule for the kitchen, revealed staff were signing off on the schedule to indicate the cleaning tasks were completed by that person.</p> <p>Interview with the Dietary Manager, on 04/29/14 at 8:15 AM, revealed the kitchen door leading to a dining room usually closed without problems. He stated a maintenance request had not been sent to repair the door.</p>	F 371	<p>Measures put into place or systemic changes made to ensure the deficient practice will not recur:</p> <ol style="list-style-type: none"> 1. An in-service on hand washing will be completed with all new hires during orientation in the department. 2. An annual in-service will be completed with all Food Service employees. 3. All signs will be approved by the Director of Food Service or one of the cooks. 4. All signs will be laminated or made of plastic for easy cleaning in the work area. 5. Cleaning of the shelves under and above the steam table and by the ice machine has been added to the daily cleaning checklist. (Attachment A). 6. Cleaning of the plate warmer and pellet warmer have been added to the weekly cleaning checklist. (Attachment A). 7. Cooks have been instructed to continue to run stove grates through the dish washer when soiled and to spot clean after cooking is complete. 	



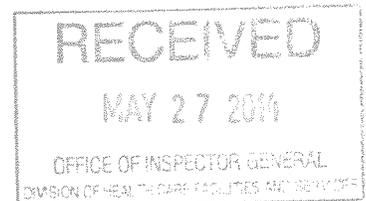
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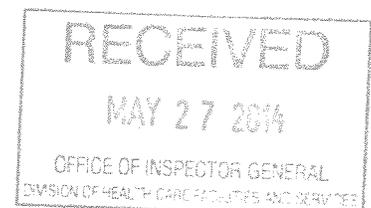
F 371	Continued From page 3 Interview with Dietary Aide #1, on 04/30/14 at 12:30 PM, revealed each person had an area to clean. He stated at times cleaning was not completed or was not done thoroughly. He stated everyone had been trained on cleaning. He stated dirty areas in the kitchen could cause germs to be spread to the residents and they could get sick. Interview with the Dietary Manager, on 05/01/14 at 11:40 AM, revealed the maintenance person was in the process of adjusting the closer of the kitchen door to ensure the door closed fully as it was supposed to do. He stated the kitchen staff were assigned cleaning tasks and he supervised to ensure the cleaning was completed. He stated cleaning was not monitored every day and that bacteria from soiled equipment could be a cause of resident illness. He stated the expectation was that the kitchen would be clean.	F 371	8. Milk crates will be stored in a separate area for vendor pick up. 9. Cleaning of all carts has been added to the daily cleaning checklist (Attachment A). 10. All walls in the kitchen will be cleaned monthly. 11. The kitchen floor will be mopped each shift. 12. Cleaning schedules have all been reviewed and revised (Attachment A). 13. The "Cleaning and Sanitation of Food Service Area" and "Storage of Food" policies have been reviewed and revised (Attachment B). 14. All employees have been in-serviced on the "Cleaning and Sanitation of Food Service Area" and "Storage of Food" policies as well as the revisions to the cleaning checklists.	
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1999, 2008</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Protected.</p> <p>SMOKE COMPARTMENTS: Ten (10) smoke compartments.</p> <p>FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic sprinkler systems. Dry System in the attic space and exterior and a Wet System in the interior.</p> <p>GENERATOR: Two (2) Type II generators. Fuel source is diesel.</p> <p>A standard Life Safety Code Survey was conducted on 04/30/14. The facility was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate</p>	K 000	<p>This plan of correction constitutes Mercy Sacred Heart's credible allegation of compliance for the cited deficiencies. Nothing in this plan of correction should be construed as admission by the facility of any violations of state or federal statutes, regulation, or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during an annual survey.</p>	
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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

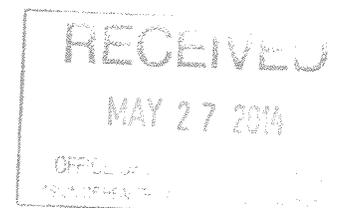
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Kim Threlman* TITLE: *Executive Director* (X6) DATE: *5/23/2014*

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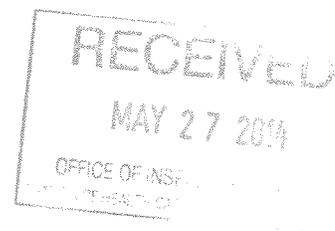
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K 000	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at F level.	K 000	K 029 Corrective action for those residents found to have been affected by the deficient practice:		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of ten (10) smoke compartments, approximately twenty (20) residents, staff and visitors. The facility had one-hundred and twenty-one (121) certified beds and the census was ninety-four (94) on the day of the survey. The findings include:	K 029	1. The opening in the drywall below the main electrical panel in the 300 Hall Storage Room has been patched and sealed with a rated sealant to assure the wall is capable of resisting the passage of smoke in the event of an emergency. How the facility identified other residents having the potential to be affected by the same deficient practice: 1. All storage closets, mechanical rooms and areas above the ceiling have been checked and noted to be without any penetrations in the smoke walls or ceilings. All items against the walls were moved so that walls could be checked as well. No other openings found. No other residents were affected by this practice.	<i>5/28/2014</i>	



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K 029	<p>Continued From page 2</p> <p>Observation, on 04/30/14 at 10:17 AM, with the Maintenance Director revealed the 300 Hall Storage Room had a three (3) inch by eighteen (18) inch opening cut out of the interior drywall, below the main electrical panel. The opening had not been patched and sealed with a rated sealant and was not capable of resisting the passage of smoke in the event of an emergency.</p> <p>Interview, on 04/30/14 at 10:19 AM, with the Maintenance Director revealed he was not aware of the opening cut out of the interior drywall and not being patched and sealed with a rated sealant. He acknowledged the room was not smoke-tight and able to resist the passage of smoke in the event of an emergency.</p> <p>The census of ninety-four (94) was verified by the Administrator, on 04/30/14 at 3:22 PM. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/30/14.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions</p>	K 029	<p>Measures put into place or systemic changes made to ensure the deficient practice will not recur:</p> <ol style="list-style-type: none"> 1. The maintenance employees have been in-serviced on NFPA 101 standards regarding the need for all smoke resisting partitions and doors to be sealed smoke tight and be without penetrations. 2. Maintenance will follow-up on all vendor work in which smoke barriers may have been affected upon the vendor's departure from the work area. 3. A new form has been developed for vendors to sign when doing any overhead or through the wall work stating they will use fire rated caulk and repair any damage done. (Attachment C).



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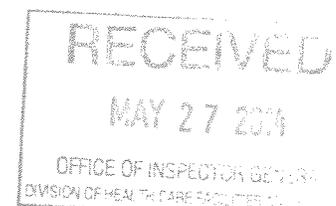
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K 029	Continued From page 3 and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029	How the facility plans to monitor its performance to ensure that solutions are sustained: 1. The Director of Maintenance or assigned Maintenance Tech will check for smoke tight seals in the storage rooms, mechanical rooms and ceilings monthly for three months and then quarterly for the remainder of the year. 2. The Director of Maintenance or assigned Maintenance Tech will check that all smoke barrier walls are sealed after any vendor work is completed for one year. 3. All findings will be reviewed and analyzed then reported to the CQI Committee.	
K 045 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were	K 045		



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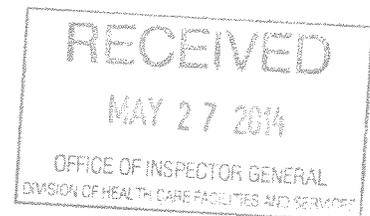
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K 045	Continued From page 4 equipped with emergency lighting in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the ten (10) smoke compartments, residents, staff and visitors. The facility has one-hundred and twenty-one (121) certified beds and the census was ninety-four (94) on the day of the survey. The facility failed to provide the required level of illumination outside an exit for discharge. The findings include: 1. Observation, on 04/30/14 at 9:45 AM, with the Maintenance Director revealed the 300 Hall exit near Room 308, did not have exterior egress lighting to provide the required level of illumination at the exit discharges. The exit was equipped with a light fixture containing one bulb. Interview, on 04/30/14 at 9:47 AM, with the Maintenance Director revealed he was not aware of the requirement that exterior light fixtures required for egress were to have two (2) bulbs. 2. Observation, on 04/30/14 at 9:58 AM, with the Maintenance Director revealed the 300 Hall exit near Room 318, did not have exterior egress lighting to provide the required level of illumination at the exit discharges. The exit was equipped with a light fixture containing one bulb. Interview, on 04/30/14 at 10:00 AM, with the Maintenance Director revealed he was not aware of the requirement that exterior light fixtures required for egress were to have two (2) bulbs. 3. Observation, on 04/30/14 at 10:27 AM, with the Maintenance Director revealed the 400 Hall	K 045	K 045 Corrective action for those residents found to have been affected by the deficient practice: 1. The eight exits identified (300 Hall exit near Room 308, 300 Hall exit near Room 318, 400 Hall exit near room 406, 400 Hall exit near the Admissions Office, Rehab entrance/exit, 600 Hall exit near Room 623, and 500 Hall exit near Room 516) have been equipped with a light fixture containing two bulbs required at exterior egress to provide the required level of illumination at the exit.	5/23/2014	



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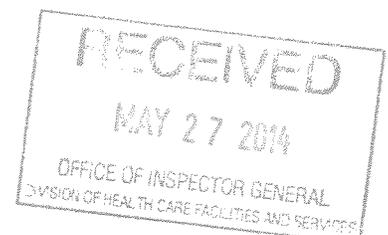
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K 045	<p>Continued From page 5</p> <p>exit near Room406, did not have exterior egress lighting to provide the required level of illumination at the exit discharges. The exit was equipped with a light fixture containing one bulb.</p> <p>Interview, on 04/30/14 at 10:29 AM, with the Maintenance Director revealed he was not aware of the requirement that exterior light fixtures required for egress were to have two (2) bulbs.</p> <p>4. Observation, on 04/30/14 at 10:36 AM, with the Maintenance Director revealed the 400 Hall exit near Room 416, did not have exterior egress lighting to provide the required level of illumination at the exit discharges. The exit was equipped with a light fixture containing one bulb.</p> <p>Interview, on 04/30/14 at 10:38 AM, with the Maintenance Director revealed he was not aware of the requirement that exterior light fixtures required for egress were to have two (2) bulbs.</p> <p>5. Observation, on 04/30/14 at 10:51 AM, with the Maintenance Director revealed the 400 Hall exit near the Admissions Office, did not have exterior egress lighting to provide the required level of illumination at the exit discharges. The exit was equipped with a light fixture containing one bulb.</p> <p>Interview, on 04/30/14 at 10:53 AM, with the Maintenance Director revealed he was not aware of the requirement that exterior light fixtures required for egress were to have two (2) bulbs.</p> <p>6. Observation, on 04/30/14 at 11:02 AM, with the Maintenance Director revealed the Rehab entrance/ exit, did not have exterior egress lighting to provide the required level of</p>	K 045	<p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <p>1. All exits have been checked for a light fixture containing two bulbs. Six additional exits were found in need of a fixture containing two bulbs. These six exits have been equipped with a light fixture containing two bulbs required at exterior egress to provide the required level of illumination at the exit. All residents had the potential to be affected by this practice.</p> <p>Measures put into place or systemic changes made to ensure the deficient practice will not recur:</p> <p>1. All exit lights will be tested monthly to assure both bulbs are working.</p> <p>2. The required ninety minute testing of all exterior lights will be completed annually.</p>



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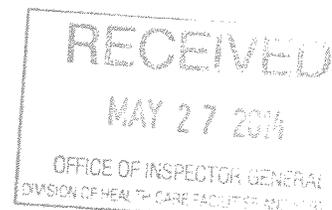
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K 045	<p>Continued From page 6</p> <p>illumination at the exit discharges. The exit was equipped with a light fixture containing one bulb.</p> <p>Interview, on 04/30/14 at 11:04 AM, with the Maintenance Director revealed he was not aware of the requirement that exterior light fixtures required for egress were to have two (2) bulbs.</p> <p>7. Observation, on 04/30/14 at 11:34 AM, with the Maintenance Director revealed the 600 Hall exit near Room 623, did not have exterior egress lighting to provide the required level of illumination at the exit discharges. The exit was equipped with a light fixture containing one bulb.</p> <p>Interview, on 04/30/14 at 11:36 AM, with the Maintenance Director revealed he was not aware of the requirement that exterior light fixtures required for egress were to have two (2) bulbs.</p> <p>8. Observation, on 04/30/14 at 11:38 AM, with the Maintenance Director revealed the 500 Hall exit near Room 516, did not have exterior egress lighting to provide the required level of illumination at the exit discharges. The exit was equipped with a light fixture containing one bulb.</p> <p>Interview, on 04/30/14 at 11:40 AM, with the Maintenance Director revealed he was not aware of the requirement that exterior light fixtures required for egress were to have two (2) bulbs.</p> <p>The census of ninety-four (94) was verified by the Administrator, on 04/30/14 at 3:13 PM. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/30/14.</p> <p>Reference NFPA 101 (2000 edition)</p>	K 045	<p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <ol style="list-style-type: none"> 1. The Director of Maintenance or assigned Maintenance Tech will check all exterior lights to assure they are working monthly for three months and then quarterly for the remainder of the year. 2. All findings will be reviewed and analyzed then reported to the CQI Committee.



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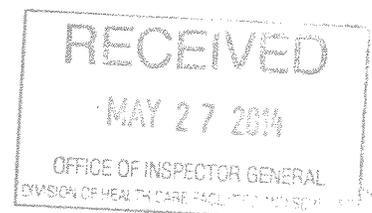
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K 045	<p>Continued From page 7</p> <p>19.2.8 Illumination of Means of Egress.</p> <p>Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>7.8 ILLUMINATION OF MEANS OF EGRESS</p> <p>7.8.1 General.</p> <p>7.8.1.1*</p> <p>Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way.</p> <p>7.8.1.2</p> <p>Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units.</p> <p>7.8.1.3*</p> <p>The floors and other walking surfaces within an exit and within the portions of the exit access and</p>	K 045		



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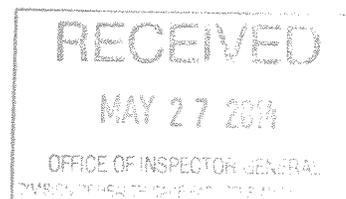
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K 045	Continued From page 8 exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide battery-powered emergency lighting at the generator transfer switch in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the ten (10) smoke compartments, residents, staff and visitors. The facility has one-hundred and twenty-one (121) certified beds and the census was ninety-four (94) on the day of the survey. The findings include: Observation, on 04/30/14 at 11:22 AM, with the	K 045	K 046 Corrective action for those residents found to have been affected by the deficient practice: 1. A battery powered emergency light fixture has been installed in the 600 Hall Electrical Room in which the emergency generator transfer switch is located.	5/23/2014



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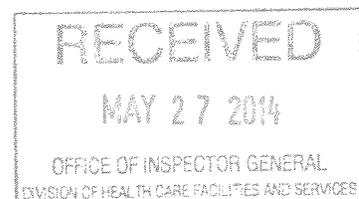
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K 046	<p>Continued From page 9</p> <p>Maintenance Director revealed in the 600 Hall Electric Room, the facility did not have a battery-powered emergency light fixture located at the emergency generator transfer switch.</p> <p>Interview, on 04/30/14 at 1:24 AM, with the Maintenance Director revealed he was not aware of the 600 Hall Electric Room where the emergency generator transfer switch is located, did not battery-powered emergency light fixture located at the emergency generator transfer switch. The Director was unaware that emergency battery-operated lighting was required to be at the generator and transfer switch locations. This type of lighting provided lighting to maintenance personnel at the generator set and transfer switch locations in case the generator failed to start during a power failure.</p> <p>The census of ninety-four (94) was verified by the Administrator, on 04/30/14 at 3:13 PM. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/30/14.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every</p>	K 046	<p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <p>1. All electrical closets have been checked. All closets have a battery powered emergency light fixture. No other residents had the potential to be affected by this practice.</p> <p>Measures put into place or systemic changes made to ensure the deficient practice will not recur:</p> <p>1. All battery powered emergency lights will be tested for thirty seconds monthly and replaced as needed.</p> <p>2. Monthly check list for battery powered emergency lights has been updated to include the 600 Hall Electrical Room.</p>



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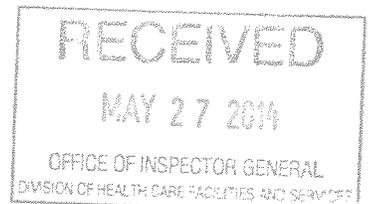
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K 046	Continued From page 10 required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046	How the facility plans to monitor its performance to ensure that solutions are sustained: 1. The Director of Maintenance or assigned Maintenance Tech will check all battery powered emergency lights to assure they are working monthly for three months and then quarterly for the remainder of the year. 2. All findings will be reviewed and analyzed then reported to the CQI Committee.	
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2	K 143	K 143 Corrective action for those residents found to have been affected by the deficient practice: 1. The light switch and the variable speed switch for the PA system have been mounted at the required height of five feet above the floor in the oxygen storage room used to transfer oxygen on the 600 Hall.	5/23/2014



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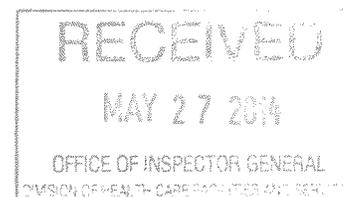
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K 143	<p>Continued From page 11</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the oxygen storage room was protected in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the ten (10) smoke compartments, residents, staff and visitors. The facility has one-hundred and twenty-one (121) certified beds and the census was ninety-four (94) on the day of the survey. The facility failed to ensure the room used for transferring oxygen did not have any electrical devices mounted less than five (5) feet above the floor.</p> <p>The findings include:</p> <p>Observation, on 04/30/14 at 11:16 AM, with the Maintenance Director revealed the storage room used to transfer oxygen had a light switch and a variable speed switch for the PA system installed below five (5) feet from the floor.</p> <p>Interview, on 04/30/14 at 11:18 AM, with the Maintenance Director revealed he was unaware the wall mounted electrical devices could not be installed below five feet from the floor if the storage room was used to transfer oxygen. The room had been previously used to store oxygen cylinders and not used for transfer filling.</p> <p>The census of ninety-four (94) was verified by the Administrator on 04/30/14 at 3:22 PM. The findings were acknowledged by the Administrator</p>	K 143	<p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <ol style="list-style-type: none"> 1. No other residents had the potential to be affected by this practice as this is our only oxygen transfer room at this time. 2. The one other room that was used in the past to transfer oxygen was checked and found to meet all height requirements. <p>Measures put into place or systemic changes made to ensure the deficient practice will not recur:</p> <ol style="list-style-type: none"> 1. If a new storage room is identified for oxygen transfer in the future, the Maintenance Director will review all requirements with the Executive Director and both will sign off for meeting requirements prior to use of room for oxygen transfer. 	



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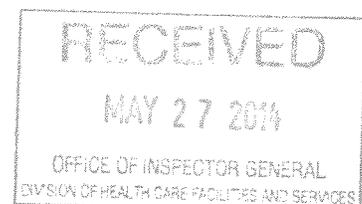
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K 143	Continued From page 12 and verified by the Maintenance Director at the exit interview on 04/30/14. Reference: NFPA 99 (1999 edition). 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a) * Nonflammable Gases (Any Quantity, In-Storage, Connected, or Both) 1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin. 2. * Enclosures shall be p for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations. Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose. 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary	K 143	How the facility plans to monitor its performance to ensure that solutions are sustained: 1. The Director of Maintenance will review for changes in oxygen transferring rooms used quarterly for one year. 2. All findings will be reviewed and analyzed then reported to the CQI Committee.		



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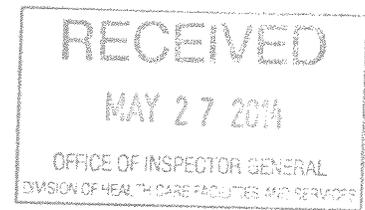
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K 143	Continued From page 13 locations. Electric wall fixtures, switches and receptacles shall be installed in fixed locations not less than 152 cm (5 feet) above the floor as a precaution against their physical damage. 5. Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials [also 4-3.1.1.2(a) 7]. 6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat. 7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage. Exception: Shipping crates or storage cartons for cylinders. 8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use. 9. Containers shall not be stored in a tightly closed space such as a closet [8-2.1.2.3(c)]. 10. Location of Supply Systems. a. Except as permitted by 4-3.1.1.2(a) 10c, supply systems for medical gases or mixtures of these gases having total capacities (connected and in storage) not exceeding the quantities specified in 4-3.1.1.2(b) 1 and 2 shall be located outdoors in an enclosure used only for this purpose or in a room or enclosure used only for this purpose situated within a building used for other purposes. b. Storage facilities that are outside, but adjacent to a building wall, shall be in accordance with NFPA 50, Standard for Bulk Oxygen Systems at Consumer Sites.	K 143		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014	
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 143	<p>Continued From page 14</p> <p>c. Locations for supply systems shall not be used for storage purposes other than for containers of nonflammable gases. Storage of full or empty containers shall be permitted. Other nonflammable medical gas supply systems or storage locations shall be permitted to be in the same location with oxygen or nitrous oxide or both. However, care shall be taken to provide adequate ventilation to dissipate such other gases in order to prevent the development of oxygen-deficient atmospheres in the event of functioning of cylinder or manifold pressure-relief devices.</p> <p>d. Air compressors and vacuum pumps shall be located separately from cylinder patient gas systems or cylinder storage enclosures. Air compressors shall be installed in a designated mechanical equipment area, adequately ventilated and with required services.</p> <p>a. Walls, floors, ceilings, roofs, doors, interior finish, shelves, racks, and supports of and in the locations cited in 4-3.1.1.2(a) 10a shall be constructed of noncombustible or limited-combustible materials.</p> <p>b. Locations for supply systems for oxygen, nitrous oxide, or mixtures of these gases shall not communicate with anesthetizing locations or storage locations for flammable anesthetizing agents.</p> <p>c. Enclosures for supply systems shall be provided with doors or gates that can be locked.</p> <p>d. Ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than 5ft (1.5 m) above the floor to avoid physical damage.</p> <p>e. Where enclosures (interior or exterior) for supply systems are located near sources of heat, such as furnaces, incinerators, or boiler rooms,</p>	K 143		



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

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K 143	Continued From page 15 they shall be of construction that protects cylinders from reaching temperatures exceeding 130°F (54°C). Open electrical conductors and transformers shall not be located in close proximity to enclosures. Such enclosures shall not be located adjacent to storage tanks for flammable or combustible liquids. f. Smoking shall be prohibited in supply system enclosures.	K 143		

