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

PRINTED: 04/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185310		03/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME	7504 WESTPORT ROAD LOUISVILLE, KY 40222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Standard Health Survey was initiated on 03/18/14 and concluded on 03/20/14 with deficiencies cited at the highest scope and severity of an "E". A Life Safety Code survey was initiated and concluded on 03/18/14 with no deficiencies cited.	F 000	Corrective action corrected by 4.15.2014. The specific measures used to correct the violation include:	4/15/14
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to ensure the care plan was followed for one (1) of twenty-three (23) sampled residents, Resident #6. The facility care planned a sensor pad to the wheelchair of Resident #6 to prevent falls. The findings include: Policy review of the Minimum Data Set (MDS) 3.0 Section 4, page 4.6, revealed the Interdisciplinary Team (IDT) were to identify specific, individualized steps or approaches that would be taken to help the resident achieve his or her goals. These approaches would serve as instructions for resident care and provide for the continuity of care by all staff. Precise and concise instructions would help staff understand and implement interventions.	F 282	A determination of the residents currently using the sensor pad was conducted on each neighborhood by the nurse mangers and Director of Clinical Services- Donna Watson RN, Megan Wesselman RN and Kathy Shireman RN with completion on 4/8/14. Each resident's SRNA assignment sheet and care plan was reviewed to ensure sensor pad use was incorporated with completion on 4/9/14 by those same individuals. The use of the sensor pad has been included on the 24 hour report form to provide ready visualization to the nurses of who needed to have one. Completion was achieved on 4/11/14 on Morton by Christy Smith RN and 4/10/14 on Clingman by Kathy Shireman RN, and Shauna Riggs LPN and on Marmion on 4/11/14 by Bea Kiger LPN. Reeducation of the staff on the use of sensor pads in use and how they connect, their roles in checking/ observing to ensure are properly connected and functional, and the need for inclusion of the sensor pad in all reporting was completed on 4/14/14. Training was conducted by Kathy Shireman RN, Tameshia Walker RN, Rhonda Day RN, Jacquelyn Flynn RN, Tom Valerius RN,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
x Anne Hrenko RN, LNHA	x CEO	x 4/25/14

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 282	Continued From page 1 Review of Resident #6's clinical record, revealed the facility admitted the resident on 02/25/13 with diagnoses of Multiple Therapies, Difficulty walking, Seizure Disorder, Symbolic Dysfunction, Prostate Cancer Metastasis to the bone and History of Falls. Review of Resident #6's Risk for Injury: Nursing Care Plan, revealed the problem was related to weakness, diagnosis of seizures and history of falls. The intervention, dated 02/22/14, revealed Resident #6 was to have a chair sensor pad underneath him/her at all times for safety. Review of the Certified Nursing Assistant (CNA) care plan, revealed Resident #6 was a fall risk and was to have a sensor pad at all times. Observations of Resident #6 during a birthday activity, on 03/18/14 at 4:36 PM and 4:52 PM, revealed Resident #6 was sitting in his/her motorized wheelchair, with no sensor pad alarm attached to his/her wheelchair. Interview with CNA #1, on 03/20/14 at 2:35 PM, revealed Resident #6 had a censor alarm because he/she would attempt to self transfer. CNA #1 stated he remembered Resident #6 having one fall before, but could not remember when. Interview with Licensed Practical Nurse (LPN) #1, on 03/20/14 at 2:45 PM, revealed nursing staff could initiate and update care plans. LPN #1 stated that Resident #6 was changed from a tab alarm to a sensor pad because he/she would like to take the tab alarm off. The sensor pad would ensure that the resident was not able to remove	F 282	Megan Wesselman RN and Donna Watson RN from 4/5-4/14/14. Letters were sent to those not on schedule, not completing or not returning calls for training notices by Jacquelyn Flynn RN. Counseling was done of the individual SRNAs on 4/12 and 4/14 for day and evening shifts by Kathy Shireman RN. The counseling was done to ensure a clear understanding of performance expectations. The measures utilized to ensure the violation will not reoccur are as follows. Sensor pad use will be incorporated into training about the falls prevention program in new hire orientation. Jacquelyn Flynn has incorporated the content into the curriculum. An observational style Quality Assurance program has been devised by Kathy Shireman RN and includes a documentation tool to identify compliance with sensor pad use or the lack thereof. Observations are planned for the dining areas, activities, and rooms on a rotating basis of once weekly in an activity, dining area, and on the neighborhood either in the room or community area. Nurses, Aides and Activities Professionals have been asked to observe and notify the nurses of any issues noted. Observations will be conducted by the Nurse Managers/ Supervisors, Staff Nurses, Activities Coordinators during an activity, and SRNA's. Initially, until it is determined that compliance is consistently achieved; weekly will be done then reduced	

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F 282	Continued From page 2 the device and must be placed by a CNA or nurse. Resident #6 was to have a sensor pad to prevent him/her from falling. LPN #1 stated staff were expected to follow the care plan as outlined. Interview with the Director of Nursing (DON), on 03/20/14 at 3:05 PM, revealed she presumed Resident #6 was to have a sensor pad alarm to alert staff for falls. The DON stated that she expected the staff to follow the care plan, unless the intervention placed the resident at risk.	F 282	to monthly. Findings will be reviewed by the neighborhood Nurse Manager and Director of Clinical Services monthly, discussed with the neighborhood staff for problem solving, if needed, and then the outcomes presented at the QAPI meeting which is generally held monthly. Completion Date: 4/15/14	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to ensure water temperatures were within 100 to 110 degrees Fahrenheit (F), as evidenced by water temperatures in excess of 118 degrees (F) on three (3) of three (3) halls, Hall A, C and D. The findings include: Review of the Water Temperature Checks Policy, dated 10/26/05, revealed the minimum water temperature was to be 100 degrees Farenheit (F) and the maximum water temperature was to be	F 323		

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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F 323	Continued From page 3 110 degrees (F). Observations of water temperatures, (using a digital thermometer that did not have to be calibrated), on 03/19/14 at 11:20 AM, revealed rooms C-25, C-18 and C-13 had temperatures as high as 117 degrees (F). Room C-6 had a temperature of 118 degrees (F). Observations of Rooms D-12 and D-27 revealed a water temperature of 114 degrees (F) and Room D-18 had a temperature as high as 116 degrees (F). Observations of Rooms A-18 revealed a temperature as high as 112 degrees (F). Review of the temperature logs for the months of January, February and March 2014, revealed all the temperatures were recorded in the normal range of 100 - 110 degrees (F). Interview with the Director of Maintenance, on 03/19/14 at 11:20 AM, revealed the water supply runs centrally from the basement up to Halls C and B, then Halls A and D and back to the basement. The Director of Maintenance stated that he was not aware the water temperatures were high and that the water should be between 100 to 110 degrees (F). The Maintenance Director stated if there was a discrepancy with the water temperatures, the maintenance staff would have to inform the Supervisor and make the necessary adjustments. The maintenance staff would not have to inform him of the discrepancy. Interview with the Maintenance Technician (MT), on 03/19/14 at 4:00 PM, revealed the water temperatures should range between 100 to 110 degrees (F). The MT stated that if the water temperatures were high he would report the findings to his Supervisor. The MT stated that	F 323	and Marmion Neighborhood (D wing) have the potential to be affected by elevated water temperatures. 3 – Measures or systemic changes that which been put into place are; The water temperature log sheet was revised and put into force on April 8, 2014 with the addition of columns for monitoring building supply and return temperatures, log sheet is attached. 4 – The facility will monitor the performance of the solutions by; Maintenance staff measuring water temperatures will report immediately to the Director of Facilities, or his charge, any elevated water temperature. They will document the time and date of the observation on the water temperature log. The roles of Administrator, DON, and the House Supervisor will also be informed. All affected neighborhoods will receive a written notice of the existing condition(s) and any action(s) necessary. Log sheets are to be reviewed monthly by the Director of Facilities and reported to QAPI. Maintenance staff was in-serviced in the change of water temperature policy on April 8, 2014. 5 – The date of the corrective action is; Date of correction April 9, 2014.	

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F 323	Continued From page 4 most of the time, another Technician checked the water temperatures, but that MT was out and he had to check the water temperatures. The MT stated he did not have any discrepancies in the water temperatures that morning. The MT stated he had checked the water that morning between the hours of 7:30 AM and 8:30 AM. The MT stated he utilized a thermometer, but did not calibrate the thermometer before he used it. He stated that when he became aware of the high water temperatures, he calibrated his thermometer and found the thermometer was two degrees off. So instead of the calibrated thermometer reading 32 degrees (F), it read 30 degrees (F), which meant the MT would had to of added two (2) degrees to each reading. With this finding none of the morning temperatures were above 110 degrees (F). The MT stated that he calibrated his thermometer every three (3) months and did not document his calibrations. The MT stated that he thought temperatures as high at 118 degrees (F) could potentially burn a resident's hand if the resident had utilized his/her sink to wash his/her hands. The MT stated that it could be possible that the mixing valve had gotten stuck, but he was not sure. Interview with the Director of Nursing (DON), on 03/19/14 at 3:57 PM, revealed the Maintenance Director had informed her around 2:00 PM the same day, that the water temperatures were as high as 117 degrees (F). The DON stated she instructed the staff to check the tub rooms when giving baths. The DON stated she did not inform the staff to monitor the sink use in the resident rooms. The DON stated the Maintenance Director lead her to believe the water temperatures would be readily resolved.	F 323		

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DIVISION OF HEALTH CARE FACILITIES INSPECTIONS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 5 Observations of C and D hall, on 03/19/14 at 2:10 PM, revealed no signage to inform the residents, staff and visitors of elevated temperatures. Interview with CNA #1, on 03/19/14 at 2:05 PM, revealed he was not aware the water temperatures were running high. Interview with CNA #5, on 03/19/14 at 2:10 PM, revealed she was not informed of the hot water temperatures. CNA #5 stated when she gave baths she ensured the water did not get over 98 degrees (F). Interview with the Maintenance Director, on 03/19/14 at 3:00 PM, revealed he had attempted to cool down the pipes to ensure the water temperatures dropped. The Maintenance Director stated that this cooling down process would take about two (2) hours. The Maintenance Director stated that the mixing valve was working appropriately. The Maintenance Director stated he thought the elevated water temperatures occurred because the output water was checked at 117 degrees F. Further interview with the Maintenance Director, on 03/19/14 at 3:40 PM, revealed he lowered the water temperature on the water output mechanism. The Maintenance Director stated that no one checked the water output mechanism unless there was a concern. The Maintenance Director stated he informed the DON as an FYI (For Your Information). The Maintenance Director stated the DON did not respond and there was no discussion about informing the nursing staff on the halls. The Maintenance Director stated temperatures ranging as high as 117 to 118 degrees (F) could not scald a resident unless the	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 6 resident was exposed for a long time. Further interview with the DON, on 03/19/14 at 3:57 PM, revealed she was not sure if water temperatures at 118 degrees (F) could cause any harm. Interview with the Administrator, on 03/20/14 at 2:20 PM, revealed the DON informed her about the water temperatures. The Administrator stated Hall A, B, C and D were all on the same water system. She stated she was not aware of any past water elevations and there had been no burns or harm from elevated water temperatures. She specified water temperatures should be between 100 to 110 degrees (F) and the staff should inform her right away if the water was found to be elevated. The Administrator stated who ever found the water to be too hot should inform the Maintenance Department immediately. The Administrator stated she liked to keep the water temperatures within range to ensure resident safety.	F 323		

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HEALTH AND HUMAN SERVICES

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	(X3) DATE SURVEY COMPLETED
	185310		**03/18/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1975, 1986 SURVEY UNDER: 2000 Existing FACILITY TYPE: S/NF DP TYPE OF STRUCTURE: One (1) story, Type III Unprotected. SMOKE COMPARTMENTS: Eight (8) smoke compartments. FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system. GENERATOR: Type II, 60KW generator. Fuel source is diesel. An abbreviated, Short Form, Life Safety Code survey was conducted on 03/18/14. Episcopal Church Home was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anne Haw RN, LNHA	CEO Adm	4/14/14

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