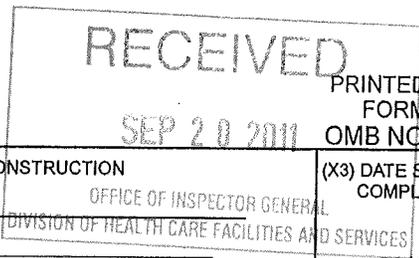


Addendum



PRINTED: 08/24/2011  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/11/2011
NAME OF PROVIDER OR SUPPLIER  GEORGETOWN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 900 GAGEL AVENUE LOUISVILLE, KY 40216	
(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 08/09/11 through 08/11/11 and a Life Safety Code survey was conducted on 08/10/11. Deficiencies were cited with the highest scope and severity of a "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.  An abbreviated survey was conducted 08/10/11 through 08/11/11 to investigate KY16789. KY16789 was found unsubstantiated with no deficiencies cited.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. The plan of correction constitutes our credible allegation of compliance.	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES  The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.  The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and	F 156	F 156 S/S=C  I. The sign is posted related to applying for Medicare and Medicaid benefits. The sign is posted in the lobby notifying the residents, employees and visitors, that a copy of the state inspection reports is available for review.  II.. The sign is posted related to applying for Medicare and Medicaid benefits. The sign is posted in the lobby notifying the residents, employees and visitors, that a copy of the state inspection reports is available for review.  III. Education has been provided on 8/12/2011 to the Social Service Director by Administrator on required posting of Medicare and Medicaid benefits and regarding availability/location of state inspections.	

continued

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

TITLE

(X6) DATE

*X. Knoch Bell*

*X Administrator*

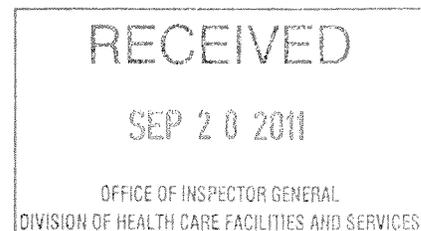
*8/19/20/2011*

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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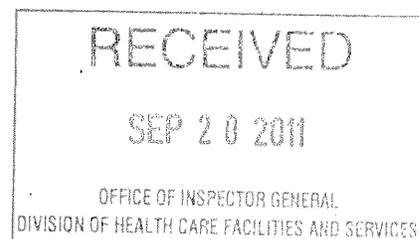
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F 156	<p>Continued From page 1</p> <p>the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and</p>	F 156	<p>IV. Social Director, Activity Director and/or Administrator will complete random audits or posting requirements on Medicare/Medicaid benefits and on required sign posting on availability/location of state inspections weekly for 4 weeks, then monthly for 2 months, then quarterly for 3 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.</p> <p>V. Completion Date:</p>	9/7/2011	



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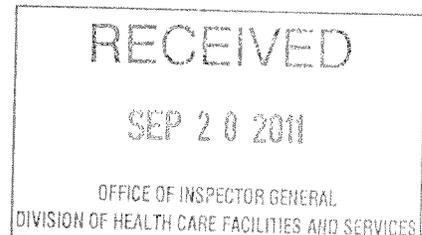
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F 156	<p>Continued From page 2</p> <p>misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to post the required signage related to applying for and how to receive Medicare and Medicaid benefits and the signage notifying residents, employees and visitors that a copy of the state inspection reports were</p>	F 156		



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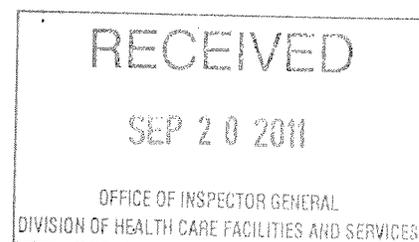
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F 156	Continued From page 3 available for review.  The findings include:  Observations during the environmental tour, on 08/11/11 at 9:00 AM, revealed the facility did not have the required signage available for residents, employees and visitors to view. There was no sign posted on how to apply for and receive benefits from Medicare and Medicaid. There also was no sign informing residents, employees and visitors that state law required state inspection reports on the facility to be made available upon request.  Interview with the Administrator, on 08/11/11 at 4:00 PM, revealed he thought all required signage was posted. He stated the survey results are available in the lobby but there is no sign. He also stated he was unaware of a requirement for a sign on Medicare and Medicaid.	F 156			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide services necessary to maintain a sanitary, orderly, and comfortable interior. Five (5) of eighty-eight (88) wheelchairs were in need of repair and twelve	F 253	F 253 S/S=E  I. Room 105, the light fixture was repaired. Room 106, the bathroom toilet was repaired. Room 109, repairs were made to the sink and is draining. Room 114, the toilet seat was replaced. Room 125, the bathroom was painted and repaired. Room 127 and 131, the walls have been repaired under the window. Room 130 and 135, the wall has been repaired and painted. Room 141, the cork board has been re-hung. Room 153, the sink has been caulked. Room 156, a new wax gasket seal was placed on the commode. Wheelchairs for Room 106B, 176 and 141B, the arm rests have been replaced. 155B and 123B, lap buddies were replaced. 123B, the wheelchair was replaced.  continued		



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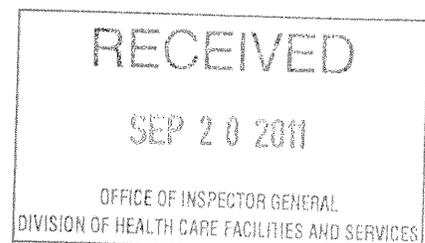
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F 253	<p>Continued From page 4 (12) of fifty-nine (59) resident rooms were in need of repair.</p> <p>The findings include:</p> <p>The facility failed to provide a Maintenance Policy.</p> <p>During the environmental tour of the facility 08/09/11-08/11/11, the following items were found in need of repair: Room 105 bathroom had a broken light fixture, Room 106 bathroom had a broken toilet seat, Room 109 sink was very slow to drain, Room 114 bathroom toilet seat was chipped and rough, Room 125 bathroom had chipping paint in the bathroom and the door to the bathroom was sticking and very hard to open, Room 127 and 131 had blistered paint under the window, Room 130 had paint chipping in the bathroom, Room 135 had holes in the wall beside a recliner, Room 141 had a cork board dangling off the wall, Room 153 did not have caulking around the sink, and Room 156 did not have caulking around the commode. In addition, five wheelchairs were found to be in need of repair: 106 B and 176 A wheelchair left arms were split and cracked open, 141 B right wheelchair arm was split and cracked open, 155 B and 123 B lap buddies were split and cracked open, and 123 B wheelchair back was cracked and split.</p> <p>Interview with Director of Maintenance (DM) on 08/11/11 at 1:45 PM revealed a maintenance log is kept at each nurse's station. He stated he checks those logs daily for maintenance requests and also conducts walk arounds to look for areas that may need repairs. The DM stated Central Service is responsible for maintenance of the</p>	F 253	<p>II. Resident rooms have been checked, for paint/repairs, sinks are draining and wheelchairs have been repaired/replaced as needed.</p> <p>III. Education on 8/12/2011 was provided to the Maintenance Director by Administrator on general repairs and maintenance of wheelchairs. Nursing has been re-educated on notifying Maintenance of wheelchairs in need of repair on 8/12/11 by Staff Development Coordinator.</p> <p>IV. The Maintenance Director, Maintenance Assistant and/or Administrator will complete random audits of resident rooms and wheelchairs weekly for 4 weeks, then monthly for 2 months, then quarterly for 3 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.</p> <p>V. Completion Date:</p>	9/7/2011	



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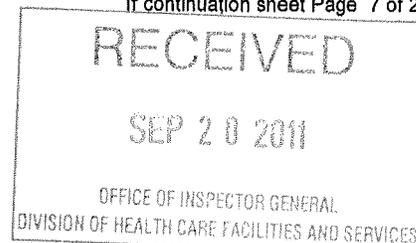
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F 253	Continued From page 5 wheelchairs, however, when there was an identified need maintenance did the repairs. He further stated he had no requests for repairs on any wheelchairs. The DM revealed the rough edges on the wheelchairs could cause skin tears on the residents. He stated he was unaware of the maintenance needs identified during the environmental tour.	F 253		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to follow physician orders for one (1) of twenty two (22) residents. Resident #12 had an order for a bowel protocol that was not followed.  The findings include:  The facility failed to provide a policy on following physician orders.  Interview with the Director of Nursing (DON), on 08/11/11 at 3:00 PM, revealed the nurses follow whatever the physician orders for a bowel protocol. The facility does not have a specific policy for a bowel protocol. Generally the	F 309	F 309 S/S=D  I. Resident #12 has been assessed and reports regular bowel movements. Bowel movements are being recorded on the ADL flow sheets.  II. Audits were completed of ADL flow sheets for bowel status. MD orders reviewed and medications are being provided as per orders.  III. Nursing staff has been re-educated on 8/12/2011 by Staff Development Coordinator on monitoring ADL flow sheets and following MD orders. Education was provided 8/12/11 by Staff Development Coordinator on asking residents that are independent with toileting, and documenting that information on the flow sheets as residents will comply.  IV. The Director of Nursing, Unit Manager and/or Staff Development Coordinator will complete random audits of ADL flow sheet weekly for 4 weeks, then monthly for 2 months, quarterly for 3 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.  V. Completion Date:	9/7/2011



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F 309	<p>Continued From page 6</p> <p>physicians order, after three days with no bowel movement, was to give medication for constipation relief as ordered.</p> <p>Record review revealed the facility admitted Resident #12 on 11/13/09 with diagnoses of Stroke, Congestive Heart Failure, Chronic Pain, Dementia and Hypertension. Resident #12 had physician orders for Lortab 7.5/500 mg to be given every four hours as needed for pain; Administer 30 cc of Milk of Magnesia daily if no bowel movement in three days; SMOG (Saline, Milk of Magnesia and Glycerin) Enema once daily for Constipation; and Monitor bowel movements every shift. The facility assessed Resident #12 via the MDS dated 06/24/11 as cognitively intact based on a score of 15.</p> <p>Record review for Resident #12 revealed the Care Plan listed a potential for episodes of constipation related to a diagnosis of constipation and use of medications as a problem. The careplan instructed the staff to: Administer stool softeners/laxatives as ordered; Document presence/absence of bowel movement each shift; and If no bowel movement in three days, begin as needed measures, document effectiveness and notify physician if not effective. The care plan was updated on 07/13/11 with the notation, no constipation noted. The CNA flow sheet listed Resident #12 as not having a bowel movement: July 1,2,3,4; July 10,11,12,13,14,15; July 17,18,19,20; and July 24,25,26,27,28 and 29. The Medication Administration Record (MAR) for Resident #12 revealed for the month of July there were no laxatives or enemas administered to Resident #12 as ordered.</p>	F 309			

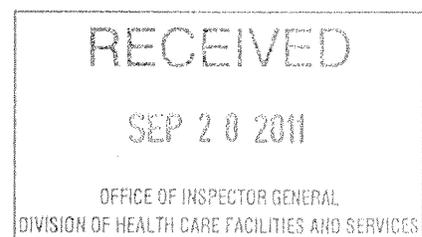


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F 309	Continued From page 7 Interview with LPN #1, on 08/11/11 at 10:15 AM, revealed the CNA's record a resident's bowel movements on the CNA flow sheet. If a resident has not had a bowel movement recorded in three days the CNA then lets the floor nurse know and the nurse would initiate the bowel protocol orders or if no orders are available, the nurse would call the physician for new orders. LPN #1 reported Resident #12 was taking medication that was known to cause constipation (Lortab) of which the facility administered 38 doses to the resident during the month of July. Based on the CNA flow sheets and the Medication Administration Record the physician orders were not followed related to Resident #12's bowel protocol.  Interview with Resident #12, on 08/11/11 at 10:30 AM, revealed the resident was continent of bowel most of the time. However, the CNA's only asked occasionally if he/she had a bowel movement.  Interview with the Director of Nursing (DON), on 08/11/11 at 3:00 PM, revealed the nurses follow whatever the physician orders for a bowel protocol. The facility does not have a specific policy for a bowel protocol. Generally the physicians order, after three days with no bowel movement, to give medication for constipation relief as ordered.	F 309			
F 371 SS=F	483.35(l) 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	F 371 S/S-F  I. Male employees are clean shaven and inspected by dietary manager.  II. Facial hair restraints are available and located in the dietary department, if needed.		

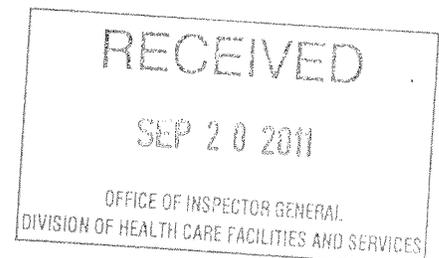
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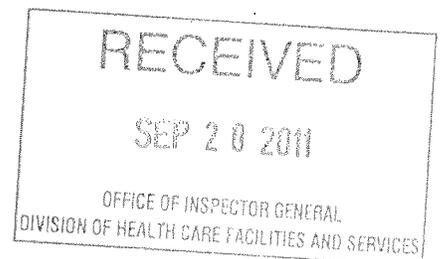
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F 371	Continued From page 8  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy on hair restraints the facility failed to serve, prepare, and distribute food under sanitary conditions as evidenced by two (2) of the two (2) male employees working on 08/10/11 were not wearing facial hair restraints while working in the kitchen.  The finding's include:  Review of the facility's policy for Hair Restraints in the Dietary Department, not dated, revealed no direction to staff for facial hair coverings or beard restraints.  Observation of the kitchen, on 08/10/11 at 11:00 AM, revealed hair restraints located on the back of the hallway entrance door. No beard restraints were observed readily available at kitchen entrances.  Observation, on 08/10/11 at 11:50 AM, revealed a male Dietary Aide with uncovered facial hair around the jaw line and extending down the neck. The male was observed transporting food and drinks around the kitchen and to the dining room, and transporting kitchen garbage.  Interview with the Dietary Aide, on 08/10/11 at 12:13 PM, revealed he was trained facial and neck hair was not allowed. However, if facial hair	F 371	III. Education has been provided on 8/23/2011 by Dietary Manager to the dietary staff on use and location of facial hair restraints.  IV. The Dietary Supervisor, Dietitian and/or Cook will complete random audits for facial hair weekly for 4 weeks, then monthly for 2 months, then quarterly for 3 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.  V. Completion Date:	9/7/2011	



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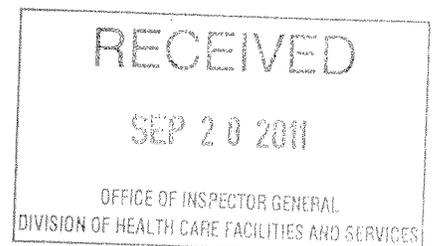
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F 371	<p>Continued From page 9</p> <p>was well groomed, then a facial hair restraint was not required. The Dietary Aide was not able to identify any potential concerns with not wearing facial hair restraints in the kitchen area.</p> <p>Observation, on 08/10/11 at 12:00 PM, revealed a male Dietary Cook with uncovered facial hair extending beyond the jaw line and down the neck. The Cook was observed washing and storing the dishes.</p> <p>Interview with the Dietary Cook, on 08/10/11 at 12:10 PM, revealed he was trained not to have alot of facial hair, but if they do, a beard or facial hair restraint should be utilized. He was aware his facial hair was too long, but did not consider the consequences of not wearing a facial hair restraint. Not wearing a facial hair restraint could cause hair to fall into the food or onto the dishes.</p> <p>Interview with the Dietary Manager, on 08/11/11 at 10:45 AM, revealed if the facial hair was a length that reached the chin line or was too long, then the person should wear a hair restraint. She revealed there may be a risk of something falling into the food if beard covers were not utilized. Her monitoring methods for facial hair restraints consisted of telling the employee to cover their beard if she noticed one not being used. She was not aware two (2) of her male employees had uncovered facial hair. When asked if there are beard restraints available for employees with facial hair, she stated they are located in the desk in her office. The current monitoring system was not working. The Dietary Manager revealed training was provided to the kitchen staff on hair restraints, but did not remember when the training had occurred. She was aware all facial hair</p>	F 371		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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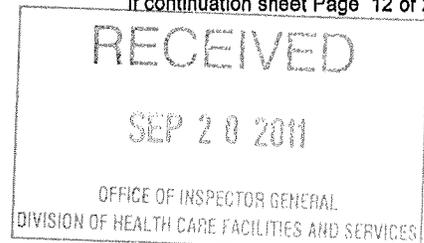
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F 371	Continued From page 10 should be coverd with a restraint, and stated ultimate responsibility for ensuring all employees have hair properly restrained was hers.	F 371			
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy titled Disposing of Trash Guidelines it was determined the facility failed to properly dispose of garbage and refuse to prevent the harborage and feeding of pests by not ensuring the dumpsters are maintained and sealed with a covering for one (1) of the three (3) dumpsters.  The findings include:  Review of the facility's policy titled Disposing of Trash Guidelines, not dated, revealed when taking trash to the dumpsters, take the cart to the south station and remove the trash with gloves on. Take the trash out the south east door to the dumpster. After putting the trash in the dumpster, close the dumpster doors.  Observation during the sanitation tour, on 08/10/11 at 8:35 AM, revealed the dumpster closest to the kitchen had a top lid which was	F 372	F 372 S/S=D  I. The dumpster with the broken lid was replaced by vendor on 8/11/11.  II.. Dumpsters are in good condition and are being closed between uses.  III. Education was provided to the Maintenance Director on 8/12/2011, by the Administrator on inspection of the dumpsters and for replacement if needed. Dietary staff was re-educated on 8/23/11 by Dietary Manager on closing the lid after use and notifying maintenance of repairs.  IV. The Director of Maintenance, Maintenance Assistant and/or Dietary Manager will complete random audits of the dumpsters weekly for 4 weeks, then monthly for 2 months, then quarterly for 3 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.  V. Completion Date:	9/7/2011	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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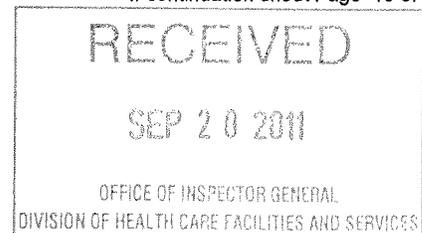
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F 372	<p>Continued From page 11</p> <p>cracked and broken with an eight (8) to twelve (12) inch strip collapsed into the dumpster leaving the contents exposed to the outside elements. The left side slide door of the dumpster was partially open.</p> <p>Observation of the dumpsters, on 08/11/11 at 10:30 AM, revealed the dumpster closest to the kitchen had the top lid completely caved into the dumpster leaving the contents completely exposed to the outdoor elements.</p> <p>Interview with the Dietary Manager, on 08/11/11 at 10:32 AM, revealed when the kitchen staff transports garbage to the dumpster, the dietary staff ensures the garbage was sealed and the doors were closed. The dietary staff checked to make sure the side doors were closed, but did not check to make sure the top lid was intact or closed. She was not aware of the condition of the dumpster lid. The maintenance department was responsible for the condition and upkeep of the dumpsters.</p> <p>Interview with the Maintenance Director, on 08/11/11 at 10:35 AM, revealed he did check the outside perimeter of the dumpsters and ensured the side doors were closed, but did not check the integrity of the top lid. He stated the current system of checking the perimeter of the dumpsters in not working. The Maintenance Director revealed there was a potential for animals and rodents to get into the dumpsters with the current condition of the dumpster lid. The Maintenance Director stated he was responsible for the condition and integrity of the dumpsters.</p>	F 372			



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

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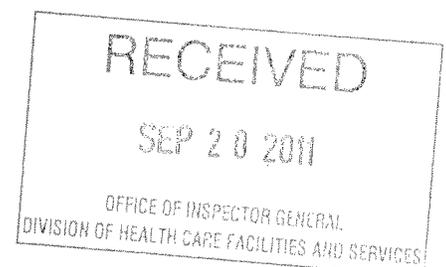
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F 372	Continued From page 12 Interview with the Administrator, on 08/11/11 at 3:10 PM, revealed he was personally responsible for monitoring the dumpsters. He watched the dumpsters from his office and made rounds on the dumpsters to ensure all of the lids were closed and there was no garbage on the outside of the dumpster. He was not aware of the condition of the dumpster lid and stated there was a potential for odor and the harborage of animals or rodents. The Administrator stated he was ultimately responsible for monitoring the condition and integrity of the dumpsters.	F 372			
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked,	F 431	F 431 S/S=F  I. Medication carts have been cleaned and checked for loose medications in the bottoms. Pharmacy will now be sealing the medication packages with a stronger seal. Medication refrigerators are maintained in temperature range of 35-46 degrees, and have been defrosted. Narcotic medications are being documented on the Narcotic count sheet as medications are pulled and on the MAR after ingestion.  II. Medications are stored to meet guidelines. Medication refrigerators are maintained in temperature range of 35-46 degrees. The freezers have been checked and are defrosted. Narcotic medication records are being documented to meet requirements.  continued		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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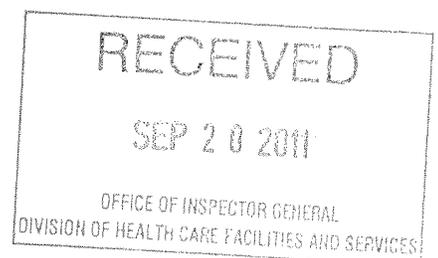
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F 431	<p>Continued From page 13</p> <p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain medications in the original packaging with a pharmaceutical label, and failed to ensure each resident received all prescribed medications as two (2) of four (4) medication carts sampled had multiple unlabeled and loose medications stored in the bottom of the drawers. The facility failed to maintain medication refrigerators in optimal condition, as one (1) of two (2) sampled medication refrigerators had an accumulation of ice around the freezer compartment, directly above stored vials of medication, and staff documented temperatures below thirty-five (35) degrees. The facility failed to maintain account of all controlled drugs as a narcotic count of one (1) of four (4) sampled medication carts revealed narcotics for five (5) residents were not documented when administered.</p> <p>The findings include:</p> <p>1. Record review of the Medication Administration Policy was requested, but the facility was unable to provide a copy.</p>	F 431	<p>III. Nurse #11 has been re-educated on signing of narcotics on 8/12/2011 by Staff Development Coordinator. Pharmacy has completed a medication pass audit with Nurse #11 on 8/26/2011. Nursing staff has been re-educated on 8/12/2011 by the Staff Development Coordinator on monitoring for dislodged medications in drawers, to notify Director of Nursing and/or Maintenance for refrigerator temperatures not in range, refrigerator defrosting and on documenting Narcotic medications.</p> <p>IV. The Director of Nursing, Unit Manager and/or Staff Development Coordinator will complete random audits of medication carts, medication refrigerators and temperature logs weekly for 4 weeks, then monthly for 2 months, then quarterly for 3 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.</p> <p>V. Completion Date:</p>	9/7/2011	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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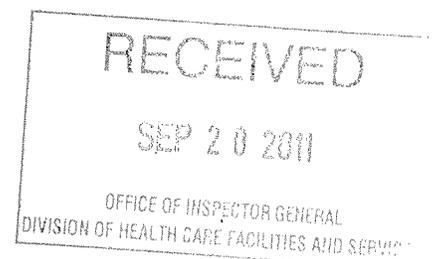
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F 431	<p>Continued From page 14</p> <p>Interview, on 08/11/11 at 3:15 PM, with the Director of Nursing (DON) revealed the contracted pharmacy service performed an audit on 08/03/11 of all medication carts, and did not report any finding of loose medications on the carts. The DON stated the pharmacy service audits the medication carts on a monthly basis. The DON stated staff are not trained to administer medications from the blister cards in any certain way, because it was not necessary, due to all nurses adhere to the five (5) rights of medication administration. The DON did not believe the loose and unlabeled medications found in the medication cart drawers would have any impact on resident care because a nurse would know if the medication dropped into the drawer or on the floor.</p> <p>Observation, on 08/11/11 at 1:55 PM, of the southeast medication cart revealed fifteen (15) whole medications and eleven (11) halves and pieces of medications unlabeled and unpackaged, stored in the bottoms of the medication drawers. Observation, on 08/11/11 at 2:15 PM, of the northeast medication cart revealed five (5) whole medications which were unlabeled and unpackaged, stored in the bottom of the medication drawers.</p> <p>Interview, on 08/11/11 at 1:55 PM, with the House Manager revealed staff were trained to administer medications by removing the blister card from the cart, and to hold the card over the medication cup and push the medication into the cup. The medications found loose in the drawer were a result of medications that fell into the drawer during medication administration, and said the</p>	F 431		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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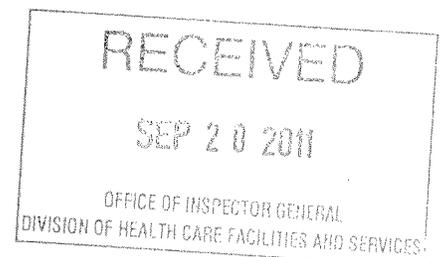
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F 431	<p>Continued From page 15</p> <p>loose medications should have been wasted. She did not think the number of loose medications in the drawer would raise a concern that residents might not have received all of the medications as ordered, because if a medication dropped into the drawer the nurse would be aware and replace the medication.</p> <p>Interview, on 08/11/11 at 2:30 PM, with LPN #7 revealed staff were trained to hold the blister card over the medication cup and push the medication into the cup. She was trained to sit the cup on top of the cart to ensure the medication goes into the cup. She had found loose and unlabeled medications in the bottom of the drawers on medication carts in the past. She was not aware of any regular staff audit of the medication carts or drawers. If the proper procedure for administration of medications from the blister cards was not followed it would be possible for a medication to drop into the drawer without the nurse being aware which could result in missed dose for a resident.</p> <p>2. Record review of the facility policy for cleaning of refrigerators revealed medication refrigerators should be cleaned with the temperature recorded daily. The medication refrigerators should maintain a range of thirty-five (35) to forty-six (46) degrees, and variances of temperature should be reported to Maintenance immediately.</p> <p>Record review of the Medication Refrigeration Temperature Log for the North Hall, dated August, 2011 revealed no documented temperature for 08/08/11. The Medication Refrigeration Temperature Log for the North Hall, dated July, 2011 revealed on 07/06/11 the</p>	F 431		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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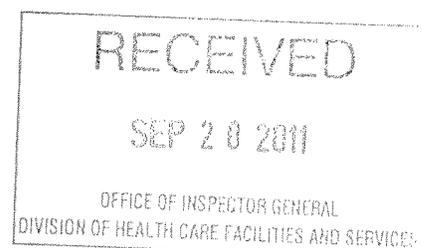
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F 431	<p>Continued From page 16</p> <p>recorded temperature was thirty-two (32) degrees, on 07/07/11 the recorded temperature was thirty-four (34) degrees, and on 07/22/11 the recorded temperature was thirty-two (32) degrees, and no recorded temperature was documented on 07/08/11.</p> <p>Observation, on 08/11/11 at 2:25 PM, of the North medication refrigerator revealed a build-up of ice formation surrounding the freezer compartment which was directly above medication vials stored in the refrigerator.</p> <p>Interview, on 08/11/11 at 10:40 AM, with LPN #9 revealed the medication refrigerator should be defrosted when the ice builds up around the freezer compartment. When it looks like this it is time to defrost the freezer, but was uncertain if there was a schedule for defrosting or how often this should be done. The ice accumulation could cause the medications stored directly below to freeze which would impact the effectiveness of the drug.</p> <p>Interview, on 08/11/11 at 2:30 PM, with the North Unit Manager (UM) revealed she was not sure how often or when the refrigerator should be defrosted. She was not aware of the variances reported from the Medication Refrigeration Temperature Log, or if any variances were reported to Maintenance. The North UM did not think medications stored in the refrigerator would be affected by temperatures below thirty-five (35) degrees.</p> <p>Interview, on 08/11/11 at 3:15 PM, with the DON revealed the medication refrigerators are supposed to be defrosted nightly on third shift,</p>	F 431			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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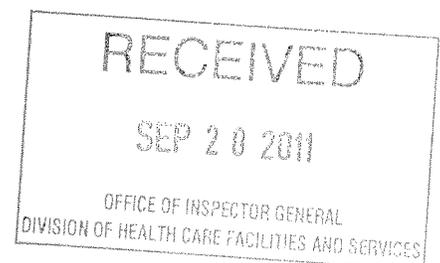
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F 431	<p>Continued From page 17 and stated that medications should not be stored in the refrigerator below thirty-five (35) degrees as this could have a negative impact on the function of the drug.</p> <p>3. Record review of the facility policy for administration of narcotic medications revealed no facility policy.</p> <p>Interview with the Director of Nursing (DON), on 08/11/11 at 3:15 PM, revealed all narcotics and medications should be signed as given on the narcotic sheet and medication administration record when given.</p> <p>Observation, on 08/11/11 at 2:15 PM, of the North medication cart with the North UM revealed the narcotic count was incorrect in relation to two (2) sampled residents (Resident #2 and Resident #12), and three (3) unsampled residents. Narcotic medications were signed as given by LPN #11 on the Medication Administration Record on the morning of 08/11/11, and were not signed as given on the Narcotic Sheet which was the source of the discrepancy.</p> <p>Interview, on 08/11/11 at 2:25 PM, with LPN #11 revealed she did not sign narcotic medications out for five (5) residents which had been administered earlier in the morning. She documented the narcotics when they were administered on the Medication Administration Record, but had been busy and neglected to sign the narcotic sheets. She had been trained to sign the narcotic sheet when the medications were administered.</p> <p>Interview on 08/11/11 at 2:25 PM with the North</p>	F 431			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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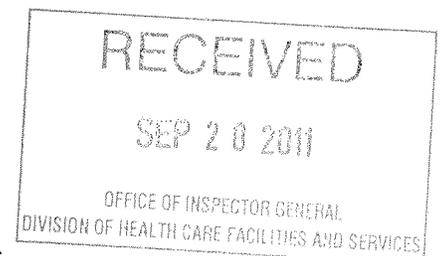
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F 431	Continued From page 18 UM revealed all staff are trained and expected to sign the narcotic sheets when narcotics are administered. The North UM stated LPN #11 should have completed the narcotic log and could have requested assistance if needed.  Continued interview, on 08/11/11 at 3:15 PM with the DON, revealed she was told of the variance in the narcotic count which occurred on the northeast cart earlier involving LPN #11 and stated the appropriate procedure would be addressed with LPN #11. The DON said the lack of documentation of narcotic medications was "a problem" which required her immediate attention.	F 431		
F 441 SS=E	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.	F 441	F 441 S/S=E  I. LPN #11, wound nurse and CNAs #1, 2, and 3 are washing their hands per infection control guidelines. Bedpans used in Rooms 109 and 111 are being stored in individual plastic bags.  II. Nursing staff is washing hands and/or using a sanitizing gel per infection control guidelines. Bedpans are being stored in plastic bags.  III. Staff has been re-educated on 8/12/2011 by Staff Development Coordinator on hand washing procedures per infection control guidelines and on storage of bedpans.  IV. The Director of Nursing, Staff Development Coordinator and/or Unit Managers will complete random audits of hand washing and storage of bedpans weekly for 4 weeks, then monthly for 2 months, then quarterly for 3 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.  V. Completion Date:	9/7/2011



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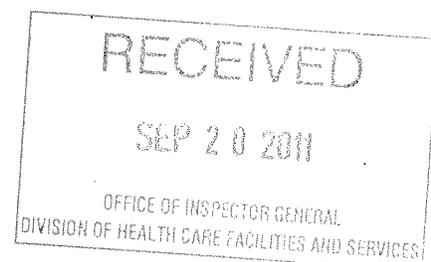
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F 441	<p>Continued From page 19</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility 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 observation, interview and facility policy review it was determined the facility failed to ensure infection control policies were implemented and followed by staff. The facility staff failed to perform proper handwashing for three (3) of twenty two (22) residents, Residents # 1,2, and 5. Two CNAs did not wash their hands after disposing of trash. There was improper storage of a bedpan in one (1) of thirty two (32) bathrooms.</p> <p>The findings include:</p> <p>1. Review of the Lippincott Manual of Nursing Practice 9th Edition, the Fundamentals of Standard Precautions - Hand Hygiene revealed: Cleaning hands with soap, warm water, and friction for 15 seconds or alcohol-based waterless hand rubs as promptly and thoroughly as possible</p>	F 441		



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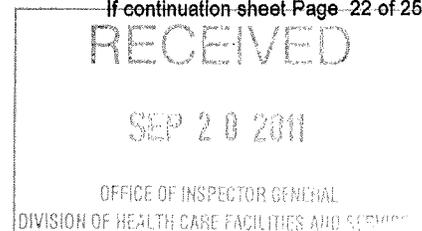
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/11/2011	
NAME OF PROVIDER OR SUPPLIER  GEORGETOWN MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 900 GAGEL AVENUE LOUISVILLE, KY 40216		
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F 441	<p>Continued From page 20</p> <p>between patient contacts; after contact with blood, body fluids, secretions, excretions, and contaminated equipment or articles; and after gloves are removed is vital for infection control.</p> <p>Interview with the Director of Nursing (DON), on 08/11/11 at 3:00 PM, revealed the facility used the Lippincott Manual of Nursing Practice for nursing procedures.</p> <p>Review of the facilities Quality Indicator: Bloodborne Pathogens/Standard Precautions #6 stated: Employees wash their hands with soap and water in between contact with residents and after removing gloves and before leaving resident rooms.</p> <p>Observation of a dressing change for Resident #1, on 08/09/11 at 11:45 AM, revealed LPN #11 followed aseptic technique during the dressing change. However, after completing the dressing change she did not wash her hands after removing her gloves. LPN #11 then left the room, reached into the medication cart, obtained a stethoscope and blood pressure cuff, returned to Resident #1's room and took his/her blood pressure. She then proceeded back out to the hallway and continued on with her next task. She did not wash her hands.</p> <p>Observation of a dressing change for Resident #2, on 08/09/11 at 2:40 PM, revealed the Wound Care Nurse (WCN) did not perform dressing change per facility protocol. The Wound Care Nurse washed her hands, gathered supplies, positioned the resident, put on gloves, removed the dressing from the coccyx, cleaned the rectal area with a wash cloth, rinsed the wash cloth out</p>	F 441		



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

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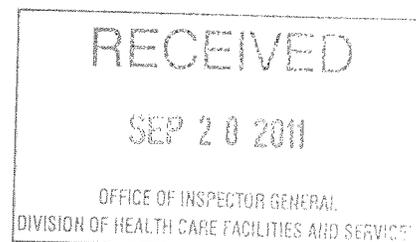
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F 441	<p>Continued From page 21</p> <p>and used same wash cloth to clean the vaginal area. She then changed gloves without washing her hands and applied a new dressing to the coccyx area. After the dressing was applied the WCN cleaned the area around the resident, disposed of the trash, removed her gloves and washed her hands.</p> <p>Observation of a dressing change for Resident #2, on 08/10/11 at 9:10 AM, revealed LPN #11 washed her hands, donned gloves, removed the gauze pad and packing from the open abdominal wound. She then packed the wound with a saline soaked gauze, without changing gloves, covered the gauze with an abdominal pad, removed her gloves and did not wash her hands. She then left the room and went to the medication cart and retrieved a medicated cream. She returned to the room, donned gloves, applied the cream to the resident's left foot, then took the dressing off the right foot and applied cream to the right foot. She then replaced the dressing on the right foot and removed her gloves. LPN #11 then, without washing her hands, administered oral medication to Resident #2, donned new gloves and laced straps on the abdomen to hold the abdominal dressing in place. She then removed her gloves and did not wash her hands. LPN #11 returned her supplies to the medication cart and continued passing medication to the other residents without washing her hands.</p> <p>Interview with the Wound Care Nurse (WCN), on 08/11/11 at 10:10 AM, revealed the proper procedure for dressing change was to wash hands, put on gloves, remove old dressing, remove gloves, wash hands, put on new gloves. She stated the expectation was to wash hands</p>	F 441		



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

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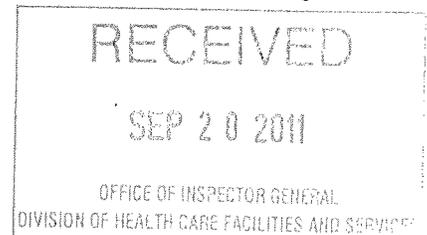
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F 441	<p>Continued From page 22</p> <p>each time gloves are removed. She stated it was very important to wash hands properly to avoid transmitting infections from one resident to another as well as resident to staff transmission. The WCN stated all staff received education on hand hygiene by the Staff Development Coordinator and sometimes by the manufacturer representatives. She further stated if she witnessed poor technique she would also provide education.</p> <p>2. Observation during the initial tour, on 08/09/11 and again during the environmental tour on 08/11/11, revealed a bedpan sitting on the floor in the bathroom shared by four residents in Rooms 109 and 111.</p> <p>Interview with the LPN #1, on 08/11/11 at 1:20 PM, revealed bedpans are supposed to be stored in bags in the bathrooms. If bedpans are left sitting on the floor there could be an infection control issue. She further stated that if the bedpans are not marked there could be cross contamination between residents.</p> <p>Continued interview with the Director of Nursing, on 08/11/11 at 3:00 PM, revealed bed pans are supposed to be stored individually in plastic bags and then hung up in the bathroom and are never to be sat on the floor. The DON stated there was an infection control issue to have bedpans sitting on the floor.</p> <p>3. Observation of CNA #1, on 08/10/11 at 9:15 AM, revealed CNA #1 entered Resident #5's room to assist LPN #3. CNA #1 applied gloves to assist with Resident #5, then removed her gloves</p>	F 441			



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

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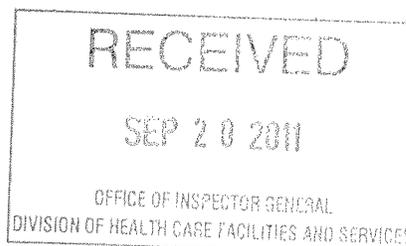
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F 441	<p>Continued From page 23 and exited the room without washing her hands.</p> <p>Observation of CNA #3, on 08/11/11 at 1:35 PM, revealed CNA #3 entered the soiled utility room carrying a clear, plastic bag of trash. She removed the lid and placed the clear, plastic trash bag into a hard shell plastic container, exited the soiled utility room and proceeded to room 170 without washing her hands.</p> <p>Observation of CNA #2, on 08/11/11 at 1:40 PM, revealed CNA #2 entered the soiled utility room carrying a clear, plastic bag of trash. She removed the lid and placed the clear, trash bag in the hard shell, plastic container. She then exited the soiled utility room and proceeded to room 170 without washing her hands.</p> <p>Interview with CNA #1, on 08/11/11 at 1:30 PM, revealed she was trained on infection control and cross contamination. CNA #1 further revealed by not washing her hands between residents germs would be spread.</p> <p>Interview with CNA #3, on 08/11/11 at 1:35 PM, outside the soiled utility room, revealed she was trained on infection control and cross contamination. She was trained to wash hands between residents and whenever touching something dirty. She stated by not washing her hands germs could be transferred to residents.</p> <p>Interview with CNA #2, on 08/11/11 at 1:40 PM, outside the soiled utility room, revealed she was trained on infection control and cross contamination. She normally used hand sanitizer between residents and whenever touching something dirty. She stated the importance of</p>	F 441		



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

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FORM APPROVED  
OMB NO. 0938-0391

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F 441	Continued From page 24 hand washing was to prevent the spread of germs.  Interview with the Staff Development Coordinator (SDC), on 08/11/11 at 10:25 AM, revealed the staff was provided with education on handwashing and universal precautions as well as having a skills check off on hand washing. The staff are instructed to change gloves per protocols and to wash hands when removing gloves. The SDC reported the most important part of infection control was proper hand washing. She stated it kept the spread of infection down from resident to resident, resident to staff as well as prevents the staff from carrying infections home to their families.  Continued interview with Director of Nursing (DON), on 08/11/11 at 3:00 PM, revealed she personally washed her hands when removing gloves but is not sure if that was stated in the protocol. She stated that by not washing hands after removing gloves it could be an infection control problem.	F 441			



# Addendum

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  <b>GEORGETOWN MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>900 GAGEL AVENUE LOUISVILLE, KY 40216</b>	
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<b>K 000</b>	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1968</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II generator installed in 2006. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 08/10/11. The facility was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one-hundred and twenty (120) beds and the census was one-hundred and four (104) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	<b>K 000</b>	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. The plan of correction constitutes our credible allegation of compliance.</p> <div style="text-align: center; border: 1px solid black; padding: 10px; margin: 20px auto; width: fit-content;"> <p><b>RECEIVED</b></p> <p><b>SEP 20 2011</b></p> <p>OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES</p> </div>

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

TITLE

(X6) DATE

*X* Edward Bell

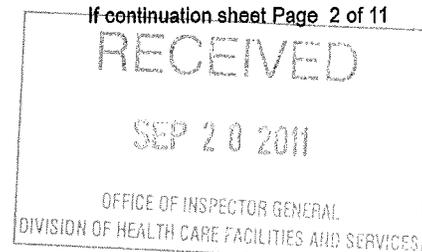
*X* Administrator *X* 9/20/2011

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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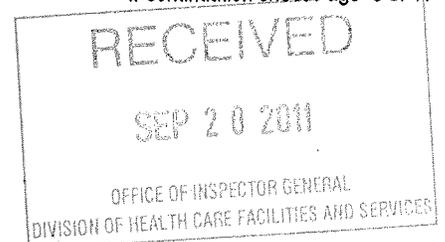
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K 000	Continued From page 1	K 000		
K 018 SS=F	<p>Deficiencies were cited with the highest deficiency identified at F level. CFR: 42 CFR 483.70(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required 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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and Interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, according to NFPA standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, residents, staff and visitors. The facility is</p>	K 018	<p>K 018 SS=F</p> <p>I. The corridor doors to resident rooms 127, 129, 130, 132 and 179 have been repaired and latch when closed.</p> <p>II. Resident doors have been checked and are closing properly and latching.</p> <p>III. Education has been provided to the Maintenance Director on 8/29/2011 by Administrator regarding resident corridor doors closing properly and latching when closed.</p> <p>IV. The Maintenance Director will complete random audits of the corridor doors to resident rooms for properly closing and latching monthly for 2 months, then quarterly for 3 quarters. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed.</p> <p>V. Completion Date:</p>	9/7/2011



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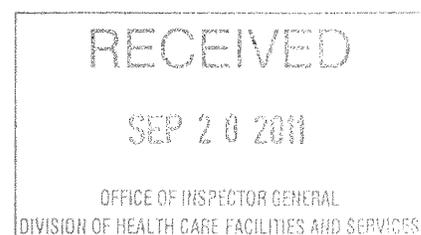
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K 018	<p>Continued From page 2</p> <p>licensed for one-hundred and twenty (120) beds and the census was one-hundred and four (104) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 08/10/11 between 8:30 AM and 10:00 AM, with the Maintenance Supervisor revealed the corridor doors to resident rooms 127, 129, 130, 132 and 179 would not latch when tested.</p> <p>Interview, on 08/10/11 at 8:30 AM, with the Maintenance Supervisor verified all observations that the corridor doors did not latch when closed, and did not resist the passage of smoke.</p> <p>Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar</p>	K 018		



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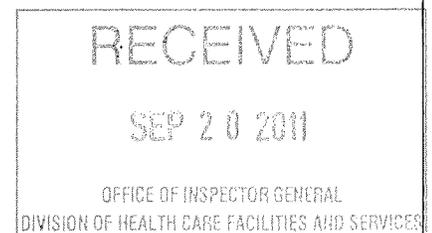
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K 018	Continued From page 3 auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.  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. Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or	K 018		



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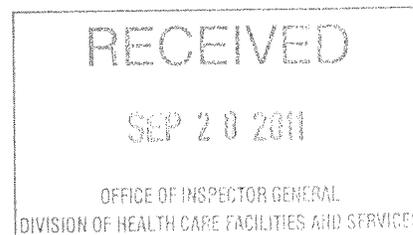
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K 018	Continued From page 4 plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
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 of Protection of Hazards, per NFPA Standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and twenty (120) beds and the census was one-hundred and four (104) on the day of the survey.  The findings include:  Observation, on 08/10/11 at 10:00 AM, with the	K 029 SS=D	I. Maintenance Director installed a self closing device on the oxygen storage room door on 8/10/2011.  II. Doors requiring self closing devices were checked.  III..Education was provided to the Maintenance Director on 8/29/2011 by Administrator on doors requiring self closing devices.  IV. The Maintenance Director, Maintenance Assistant and/or Administrator will complete random audits of the doors with self closing devices monthly for 2 months, then quarterly for 3 quarters. Results of the audits will be reviewed at the Quality Assurance meeting for revision as needed.  V. Completion Date:	9/7/2011



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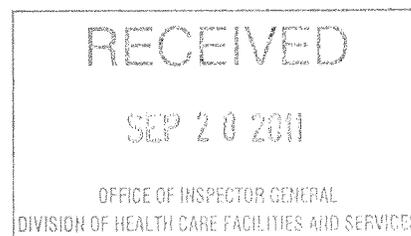
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  08/10/2011
NAME OF PROVIDER OR SUPPLIER  GEORGETOWN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 900 GAGEL AVENUE LOUISVILLE, KY 40216	
(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 029	<p>Continued From page 5</p> <p>Maintenance Supervisor revealed the door to the Medical Gas Storage Room did not have a self closing device installed on the door.</p> <p>Interview, on 08/10/11 at 10:00 AM, with the Maintenance Supervisor revealed he was unaware the door to the Medical Gas Storage Room was required to be self-closing.</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 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</p>	K 029		



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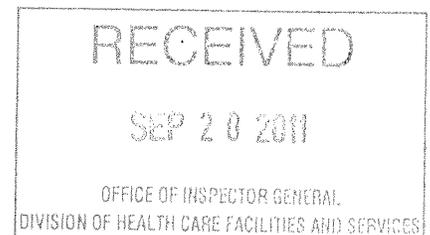
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K 029	Continued From page 6 and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: 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		
K 047 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained according to NFPA standards. Exit signs must be maintained to ensure exits are identifiable in an emergency. The deficiency affected all staff in the basement area.  The findings include:  Observation, on 08/10/11 at 10:30 AM, with the Maintenance Supervisor revealed egress paths to exits from the basement were not identified with directional and exit signage.  Interview, on 08/10/11 at 10:30 AM, with the Maintenance Supervisor revealed the basement area was used by staff only, and evacuation	K 047	K 047 SS=F  I. Maintenance Director installed additional exit signage in the basement on 8/29/2011. Installed were 6 right arrows, 6 left arrows and 1 double arrow directional exit signage.  II. Maintenance Director inspected the facility for proper exit signage that meet NFPA standards.  III. Education was provided to the Maintenance Director on 8/29/2011 on required exit signage and on required directional signage in the basement.  IV, The Maintenance Director, Maintenance Assistant and/or Administrator will conduct random audits of directional exit signage in the basement monthly for 2 months, then quarterly for 3 quarters. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed.  V. Completion Date:	9/7/2011



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

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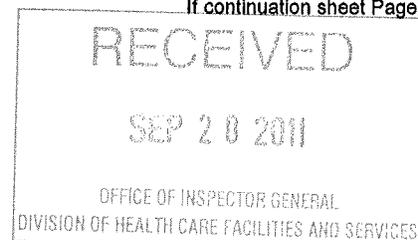
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K 047	Continued From page 7 routes are posted on the wall. He stated in the event of an emergency, evacuation could be confusing without approved directional and exit signage.  Reference: NFPA 101 (2000 edition)  7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The deficiency had the potential to affect the staff working in the basement area.  The Findings Include:  Observation, on 08/10/11 at 10:37 AM, with the Maintenance Supervisor revealed the sprinkler heads within the laundry room, located in the	K 062	K 062 SS=D  I. The lint in the sprinkler heads in the laundry room were cleaned on 8/10/2011.  II. The maintenance staff cleaned the sprinkler heads in the facility  III. Education was provided to the Maintenance Director on 8/29/2011 by Administrator on preventative maintenance for the sprinkler heads.  IV. The Maintenance Director, Maintenance Assistant and/or Administrator will complete random audits of the sprinkler heads in the laundry room monthly for 2 months, then quarterly for 3 quarters. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed.  V. Completion Date	9/7/2011



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

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K 062	Continued From page 8 basement, were obstructed with an accumulation of dust and lint.  Interview, on 08/10/11 at 10:37 AM, with the Maintenance Director verified the observation.  Reference: NFPA 25 (1999 Edition).  2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062			
K 130 SS=E	NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress, per NFPA standards. This deficiency had the potential to affect the basement area and one (1) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for one-hundred and twenty (120) beds, with a census of one-hundred and four (104) on the day of the survey.	K 130	K 130 SS=E  I. The slide bolt type lock to the elevator access room was removed on 8/10/11. The padlock was removed on the egress side of the doors to the laundry room, central supply room and storage room doors in basement.  II. Maintenance inspected the basement area and those that had padlocks or bolt type locks were removed.  continued		



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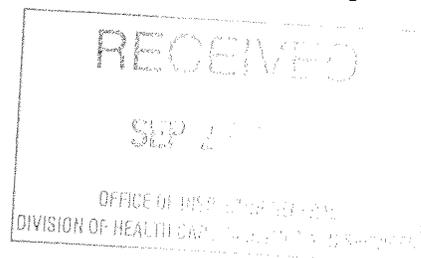
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K 130	<p>Continued From page 9 The findings include:</p> <p>Observations, on 08/10/11 between 9:20 AM and 10:50 AM, with the Maintenance Supervisor revealed an unapproved lock (slide bolt type) was installed on the egress side of the door to the elevator access room on the ground floor. A padlock was installed on the egress side of the doors to the laundry room in the basement. A padlock was installed on the door to the central supply room located in the basement, and a padlock was installed on the door to the storage room located next to the garage door in the basement.</p> <p>Interviews, on 08/10/11 between 9:20 AM and 10:50 AM, with the Maintenance Supervisor revealed he was aware of the locks, but not aware they were prohibited.</p> <p>Reference: NFPA 101 (2000 Edition) 19.2.2.2.4</p> <p>Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.</p>	K 130	<p>III. Education was provided to the Maintenance Director on 8/29/2011 by Administrator on not utilizing unapproved slide bolt type locks or padlocks in the facility.</p> <p>IV. Maintenance Director, Maintenance Assistant and/or Administrator will complete random audits of doors in the basement monthly for 2 months, then quarterly for 3 quarters. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed,</p> <p>V. Completion Date:</p>	9/7/2011
K 147 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical</p>	K 147	<p>K 147 SS=F</p> <p>I. The electrical panels on resident corridors are locked.</p> <p>II. Electrical panels in resident corridors have been inspected and are locked on 8/14/2011.</p> <p>continued</p>	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 147	<p>Continued From page 10</p> <p>panels were maintained according to NFPA standards. The deficiency had the potential to affect five (5) of seven (7) smoke compartments, all residents, staff and visitors. The facility is licensed for one-hundred and twenty (120) beds and the census was one-hundred and four (104) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 08/10/11 between 8:30 AM and 10:00 AM, with the Maintenance Supervisor revealed all electrical panels located in the resident's corridors were unlocked.</p> <p>Interview, on 08/10/11 at 8:30 AM, with the Maintenance Supervisor revealed he was unaware the electrical panels located in resident corridors were required to be locked to prohibit unauthorized access.</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>110-26. Space About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p>	K 147	<p>III. Education was provided to the Maintenance Director on 8/29/2011 by Administrator regarding resident corridor electrical panels being locked.</p> <p>IV. Maintenance Director, Maintenance Assistant and/or Administrator will complete random audit of corridor electrical panels being locked monthly for 2 months, then quarterly for 3 quarter. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed.</p> <p>V. Completion Date:</p>	9/7/2011	

