

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

PRINTED: 04/01/2013
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 02/28/2013 |
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| NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217 |
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| F 000 | INITIAL COMMENTS AMENDED 04/01/13 A standard health survey was conducted 02/26/13 through 02/28/13. A Life Safety Code survey was conducted on 02/27/13-02/28/13. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. | F 000 | <i>The preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</i> <i>As part of the facilities' ongoing process improvement program, all audit results will be reported to the Process Improvement Team with additional education as necessary.</i> | |
| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to provide equipment in good repair to enable residents to participate in activities to their fullest thus enhancing their dignity for one (1) of thirty (30) residents. Resident #19. The findings include: Review of the Resident Rights Policy, not dated, revealed each resident shall be treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs. Record review of Resident #19's record, revealed he/she was admitted on 09/28/11 with diagnoses | F 241 | F 241 It is the facility policy to provide care for the residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality. The facility has accomplished this intention for resident #19 by promoting and providing individual activity preferences during bingo and other activities of choice. Resident #19 is outspoken and determined in regards to her care and choice of activities. She is able to make her needs and wants known to staff. Resident #19 has been assigned permanent staff members who are familiar with not only her care, but also her personal preferences. Resident #19's bingo preferences include; choosing certain numbers, choosing a specific activity staff member to play and watch her bingo cards. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE *Administrator* (X6) DATE *4/4/13*

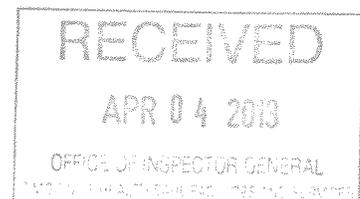
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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DIVISION OF HEALTH CARE REGULATION AND LICENSING

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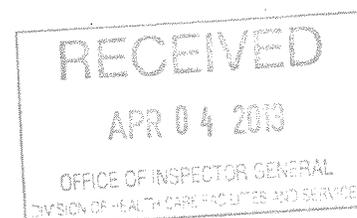
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| F 241 | <p>Continued From page 1</p> <p>of Aphasia (difficulty speaking), Symbolic Dysfunction (lack of ability to initiate or terminate a conversation), late effect Hemiplegia (late effects of cerebral vascular disease), Morbid Obesity, Depression, Cerebral Vascular Accident. Record review of Resident #19's quarterly assessment, dated 12/21/12, revealed a BIM score of 9, which meant the resident was interviewable.</p> <p>Observation of Resident #19 attending a Bingo activity, on 02/26/13 at 3:25 PM, revealed Resident #19 sitting in a Geri-chair, reclined back, unable to see the Bingo board or sit up to drink from a sippy cup. Observation of Certified Nursing Assistant (CNA) #1, on 02/26/13 at 3:25 PM, revealed CNA #1 informed another staff member that Resident #19's chair was broken and could not be fixed, so the resident would have to be reclined in the chair.</p> <p>Interview with Resident #19, on 02/26/13 at 3:25 PM, revealed he/she always needed help when playing Bingo and that he/she could not move the tabs by him/her self. Further interview with Resident #19, on 02/27/13 4:45 PM, revealed he/she remembered the chair being broken all day yesterday and including when he/she went to the activity room to play Bingo. Resident #19 stated he/she could not see the Bingo board at all and loved to see the board and get help from the staff to push the chips. Resident #19 further stated laying back in the Geri-chair made him/her feel sad and that it was not comfortable to sit like that.</p> <p>Interview with CNA #2, on 02/27/13 at 2:55 PM, revealed she pushed Resident #19 from the unit</p> | F 241 | <p>Continued from page 1</p> <p>Resident #19 has been a resident at Parkway since 3/25/2002. During the survey it was identified resident #19's cardiac chair was reclined to a position less than a 15-degree difference from her normal reclining position. Maintaining proper body alignment in the cardiac chair for Resident #19 can be a challenge due to her bilateral amputations and her upper body obesity. Resident #19's communicated personal preference has been to recline with her head angled back to give her proper upper body alignment and overall balance.</p> <p>Resident #19 was placed in a new chair on 2/26/13.</p> <p>On 3/14/13, the therapy assistant checked all cardiac chairs. Any needed repair has been done or parts have been ordered. Parkway already has a well-developed system in place for mobile device inspections and repair. All residents using wheelchair/ cardiac chairs will be reviewed for proper positioning by Activities staff and Social Service staff and completed by 3/29/13.</p> <p>The RN/LPN Nursing Resource team will be responsible to assure all nursing, social service and activities</p> | | |



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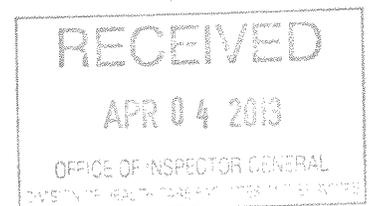
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| F 241 | <p>Continued From page 2</p> <p>to the Bingo activity. CNA #2 stated when she went to transport Resident #19 she noted Resident #19 was reclined and there was no neck brace or pillow present. CNA #2 stated when she got Resident #19 off the elevator she had to keep pushing the chair to an upright position and noticed it must have been broken. CNA #2 stated she went to get a neck brace and pillow because the resident's neck and head was not touching the chair. CNA #2 stated she did not follow up on the chair being broken. CNA #2 stated she would not want to play a game when she could not look at the board, it could be a dignity issue.</p> <p>Interview with CNA #1, on 02/27/13 at 2:42 PM, revealed once the resident arrived to the activity, she pushed Resident #19 to the activity table where they were sitting. CNA #1 stated that the chair was broken and staff made a phone call to get Resident #19 a pillow to prop his/her head up. CNA #1 stated the chair was affecting Resident #19's quality of life because Resident #19 loved to participate in Bingo. CNA #1 stated when Resident #19 was brought down from her hall by CNA #2 and another staff member they did not inform her that Resident #19's chair was broken. CNA #1 stated she would not like to sit in a chair where she would not be able to look at the game. CNA #1 stated she did not think to replace the chair.</p> <p>Interview with the Unit Manager on the 4th floor, on 02/28/13 at 9:37 AM, revealed the Activity Department should have brought Resident #19 immediately back up to the unit when they noticed the chair was broken. Resident #19 was very outspoken and gets really involved in Bingo. The Unit Manager stated trying to play Bingo while</p> | F 241 | <p>Continued from page 2</p> <p>staff watch a "Resident Dignity" video and be re-educated on the current mobile chair inspection and positioning packets developed by the Physical Therapist, and given a read & sign of acknowledgement to all nursing, social service, and activity staff to be completed and turned in to the RN Director of Nursing by 3/29/13.</p> <p>LPN Auditor, Activities staff, and Social Service staff will audit two scheduled activities to assess for staff competency in positioning and inspection of wheelchair/cardiac chairs during an activity per week for four weeks, then per month for two months, then two per quarter for three quarters. Discrepancies will be taken care of promptly and findings reported in the quarterly Performance Improvement meeting.</p> | March 30, 2013 | |



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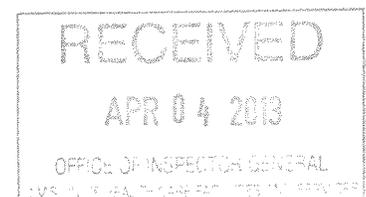
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| F 241 | Continued From page 3 reclined in the chair and not able to fully participate could be a dignity issue for this resident. Interview with the Activity Director, on 02/28/13 at 10:06 AM, revealed Bingo was Resident #19's favorite activity. Resident #19 was very engaged during Bingo and liked the cards that slide. The Activity Director stated denying Resident #19 Bingo would have been worse than sending him/her reclined back in the Geri-chair. The Activity Director stated she did not ask Resident #19 his/her thoughts on the chair being broken; however, Resident #19 should not have been reclined back in his/her Geri-chair. Interview with the Administrator, on 02/28/13 at 3:11 PM, revealed he was the supervisor for the Activity Department. The Administrator stated he was not aware of any problems with Resident #19 and could not speak to something he was not familiar with. | F 241 | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's | F 279 | F 279 It is facility policy to adhere to state and federal regulations, resident assessment guidelines, along with nursing policy and procedures when developing a comprehensive care plan. Resident #7 was re-evaluated for a bowel toileting program and one was initiated 2/28/13. Resident #7 had been admitted to the facility with confusion related to her UTI. This increased confusion had interfered with her ability to be continent. She was placed on a bowel and bladder toileting schedule initially to assist with regaining her continence. |



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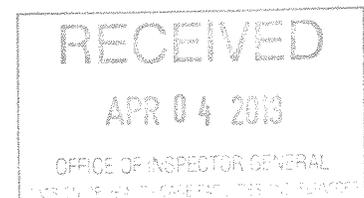
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| F 279 | <p>Continued From page 4</p> <p>highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to develop a care plan for one (1) of thirty (30) sampled residents. Resident #7 was identified by the facility to be incontinent of bowel and placed on a bowel program which was not addressed in the care plan.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Resident Assessment Instrument (RAI), revised 12/10, submitted as the care plan policy, revealed the components of the comprehensive care plan were a combination of the Kardex information, Certified Nursing Assistant (CNA) cards, the RAI care plan, Physician's orders, discipline assessments, interdisciplinary meetings and verbal reports.</p> <p>2. Review of the clinical record for Resident #7 revealed the facility admitted the resident on 11/22/12 with diagnoses of Congested Heart</p> | F 279 | <p>Continued from page 4</p> <p>The indwelling catheter was placed mid- February due to increased urinary retention and the bladder toileting schedule was correctly discontinued. The bowel program was inadvertently discontinued. By the time of the survey, Resident #7' s mentation had begun improving making her a better candidate for a bowel program. Resident #7's care plan was updated and completed on 02/28/13.</p> <p>New measures put in place since the survey includes: The RN/LPN Nursing Resource team will educate all nursing staff on the toileting door sheets, revised by the Director of Nursing. Two RN Managers produced a toileting assessment video. The RN/LPN Nursing Resource team will present this re-education video to all nursing staff. The RN Nursing Administration team instructed the RN/LPN nursing staff to read F-279. The RN/LPN Nursing Resource team and RN/LPN Managers will oversee the read and sign process. All education will be completed by 3/29/13. The LPN Auditor and RN/LPN Nursing Resource team will monitor the care plan process weekly for four weeks, then monthly for two months and then quarterly for three quarters.</p> | |



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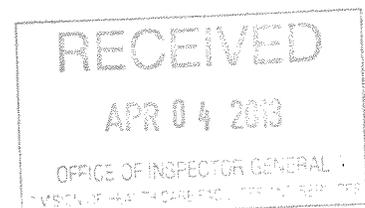
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| F 279 | <p>Continued From page 5</p> <p>Failure, Urinary Tract Infection and Pneumonia. The resident had a hospitalization and the facility readmitted the resident to the facility on 01/22/13. Review of the Minimum Data Set (MDS) comprehensive assessment, dated 01/26/13, revealed the facility assessed the resident to be incontinent of bowel and bladder and required total assistance with toileting needs. On 01/31/13, the resident's physician ordered the resident to be placed on a toileting program and was to be toileted upon rising, before meals and at hour of sleep (hs).</p> <p>Review of the comprehensive care plan, dated 01/31/13, revealed the resident's incontinence was identified as a new problem and stated the resident needed only minimal assistance with toileting. The care plan reflected the physician's order for toileting schedule. The care plan indicated Occupational Therapy would work with toileting techniques. However, there was no documented evidence therapy had developed any toileting techniques beside what the physician had ordered. Further review of the record revealed the toileting program had been discontinued on 02/16/13 when an indwelling catheter was inserted. The care plan was for urinary incontinence with no specific toileting program developed for bowel incontinence. A new care plan was developed on 02/27/13 for bowel incontinence after surveyor intervention.</p> <p>Review of the CNA care plan, undated, revealed the resident was continent and needed the bedpan; however, if the resident had to wait too long, she/he may soil. Review of the Intake and Output record, dated 01/31/13 through 02/16/13, revealed the resident was incontinent of bowel</p> | F 279 | <p>Continued from page 5</p> <p>Discrepancies will be taken care of promptly and findings reported in the quarterly Performance Improvement meetings.</p> | March 30, 2013 | |



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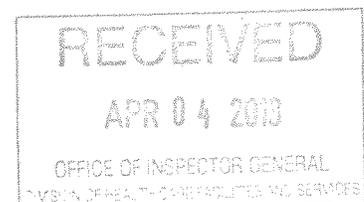
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| F 279 | Continued From page 6 and bladder with no documentation of bedpan use. On 02/16/13, an indwelling catheter was inserted related to urinary retention. Review of the Intake & Output sheet revealed the resident remained incontinent of bowel. Interview, on 02/27/13 at 10:00 AM, with CNA #6 revealed she was assigned to the resident that day. She stated the resident's toileting sheet for 02/27/13 was white which indicated the resident was a check and change only. Interview with the Director of Nursing (DON) with the Unit Manager present, on 02/28/13 at 4:15 PM, revealed she had contacted the nurse who had discontinued the toileting program for Resident #7, on 02/16/13, to question if the bedpan had been removed. The DON stated the nurse had removed the bedpan and the resident was placed on a check and change program. She indicated this had been a misunderstanding and and the resident should have remained on the toileting program for bowel function. Interview with Resident #7, on 2/27/13 at 9:40 AM, revealed the resident had never been offered the bedpan and was instructed by staff to just go in the brief. | F 279 | | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. | F 309 | F309 Resident #7, on admission 1/22/13, was placed on a toileting program, the patient developed retention and a Foley Catheter was inserted on 2/24/13. This disrupted the toileting program. This was an isolated event. | | |



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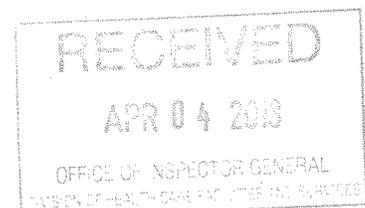
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| F 309 | Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determine the facility failed to provide care and services for one (1) of thirty (30) sampled residents. Resident #7's bowel program did not address the resident's individual toileting needs to maintain or improve the bowel incontinence. The findings include: Review of the facility's policy titled Continnence Program, revised 03/06, revealed the purpose of the policy was to maintain and restore continence for all residents whenever possible. In addition, the facility was to manage incontinent episodes, and preserve the resident's dignity. 1. Observation of Resident #7, on 02/27/13 at 09:40 AM, revealed the resident was laying in the bed and stated she had to have a bowel movement to the wound treatment staff, Licensed Practical Nurse (LPN) #8 and Certified Nursing Assistant (CNA) #10. Continued observation revealed the wound treatment staff had to wait for CNA #6 to determine how the resident was to be toileted. Interview with the resident (while waiting for CNA #6), on 2/27/13 at 9:40 AM, revealed the resident had never been offered the bedpan and was instructed by staff to just go in the brief. At 9:43 AM, observation revealed a bedpan was brought to Resident #7's room and placed under | F 309 | Continued from page 7 Resident #7 was re-evaluated for a bowel toileting program during the survey, a new toileting program was initiated and orders were revised on 02/28/13. All residents with a Foley Catheter who are incontinent of bowels, care plans are being reviewed and revised by RN/LPN Unit Managers, and RN / LPN RAI Coordinators, and will be completed by 3/29/13. The RN Nursing Administration team revised the toileting sheets to reflect improved bowel tracking. The RN/LPN Nursing Resource team and RN/LPN Unit Managers will educate all nursing staff on the revised toileting doors sheets. Two RN Managers produced a toileting assessment and implementation video on 3/15/13. The RN/LPN Nursing Resource team will present this re-education video to all nursing staff. All education will be completed on 3/29/13. The LPN Auditor and RN/LPN Nursing Resource team will monitor implementation and documentation of bowel toileting programs weekly for four weeks, then monthly for two months, and then quarterly for three quarters. Discrepancies will be taken care of when they are found and findings will be reported to the quarterly Performance Improvement Meetings. | March 30, 2013 |



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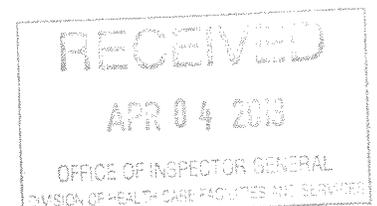
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| F 309 | <p>Continued From page 8</p> <p>the resident. Continued observation revealed the resident toileted successfully in the bedpan.</p> <p>Record review revealed the facility admitted the resident on 11/22/12 with diagnoses of Congested Heart Failure, Urinary Tract Infection and Pneumonia. Review of the Admission Minimum Data Set (MDS), dated 01/26/13, revealed the facility assessed the resident to be interviewable with a Brief Interview Mental Status (BIMS) score of an 11. A physician order, dated 01/31/13, instructed the facility to place the resident on a toileting program and was to be toileted upon rising, before meals and at hour of sleep (hs).</p> <p>Review of the comprehensive care plan, dated 01/31/13, revealed the resident's incontinence was identified as a new problem and stated the resident needed only minimal assistance with toileting. The care plan reflected the physician's ordered toileting schedule. Review of the CNA care plan, undated, revealed the resident was continent and utilized the bedpan; however, if the resident had to wait too long, he/she may soil. Review of the Intake and Output record, dated 01/31/13 through 02/16/13, revealed the resident was incontinent of bowel and bladder with no documentation of the bedpan use. On 02/16/13, an indwelling catheter was inserted related to Urinary Retention. Review of the Intake & Output sheet revealed the resident remained incontinent of bowel.</p> <p>On 02/27/13 at 11:15 AM, interview with Resident #7's family, revealed the resident had lived with the family prior to admission to the nursing facility and was continent of bowel and bladder. The</p> | F 309 | | | |



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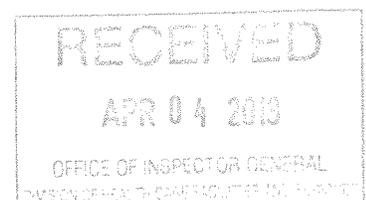
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| F 309 | <p>Continued From page 9</p> <p>family stated the resident's discharge goal was to return home after the resident had returned to his/her previous functional status.</p> <p>Interview, on 02/27/13 at 10 AM, with CNA #6 revealed she was assigned to the resident that day. She further stated the resident had a indwelling catheter and was offered the bedpan for other toileting needs. She stated each resident that was on a toileting program had a specific colored form to complete. She revealed Resident #7 had a yellow sheet that indicated the resident was on a toileting program. However, she then stated the resident's toileting sheet for 02/27/13 was white which indicated the resident was a check and change only.</p> <p>Interview, on 02/28/13 at 8:25 AM, with CNA #8 revealed the toileting program was for residents that are at risk for falls or frequent urination. She further stated she would identify if a resident was on a toileting program by the color of the form. She stated a blue colored form represented a five (5) day initial assessment, a yellow form represented a toileting program and a white form indicated the resident was on a check and change program. She said she had questioned why the resident was on a toileting program with a catheter verses being a check and change.</p> <p>Interview with the Director of Nursing (DON) with the Unit Manager present, on 02/28/13 at 4:15 PM, revealed she had contacted the nurse, who had discontinued the toileting program for Resident #7 on 02/16/13, to question if the bedpan had been removed. The DON stated the nurse had removed the bedpan and the resident was placed on a check and change program. She</p> | F 309 | | | |



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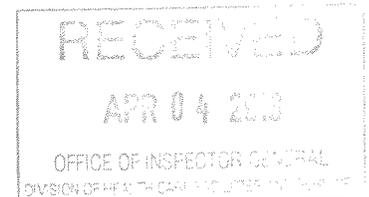
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| F 309 | Continued From page 10 indicated this had been a misunderstanding and and the resident should have remained on the toileting program for bowel function. | F 309 | | |
| F 371 SS=D | 483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The 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 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the kitchen cleaning schedule and policy, it was determined the facility failed to clean the metal barrier between the deep fryer and stove with a heavy build up of grease splatters. The findings include: Review of the facility's policy regarding Cleaning Schedule, dated 2007, revealed the cleaning schedule would be posted and checked daily for completion and thoroughness. The policy stated to refer to the Cleaning Schedule. Review of the mandatory cleaning schedule, for the dates of February 11-13, 2013, revealed the barrier beside the deep fryer was to be cleaned on 01/19/13 and 02/13/13. This portion of the cleaning schedule was not initialed as completed. | F 371 F371 | The facility does procure food from sources approved or considered satisfactory by Federal, State or local authorities, and stores, prepares, distributes and serves food under sanitary conditions. The metal barrier between the deep fryer and stove with build-up of grease splatters and the surrounding area was cleaned thoroughly by a Dietary Aide and inspected by the Nutrition Services Director on 2/27/13. On 2/27/13, the Nutrition Services Director did a thorough inspection of all other areas to ensure no further cleaning tasks were needed. On 3/4/13, the AM and PM Supervisor's Daily Critical Control Checklist was updated to include daily inspection of the deep fryer, splashguard, and surrounding areas. The Critical Control Checklist is signed daily by the AM and PM Supervisors to ensure all areas in need of cleaning have been performed. In addition, the Registered Dietician's Monthly Sanitation Checklist was updated on 3/4/13 to include the deep fryer, | |



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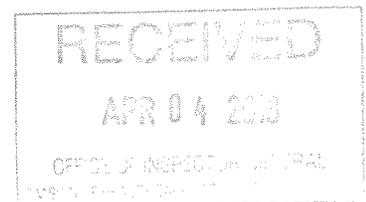
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| F 371 | <p>Continued From page 11</p> <p>Observation, on 02/26/13 at 7:55 AM, during the initial tour of the kitchen, revealed the metal barrier between the deep fryer and the gas stove (splatter guard) had a heavy build up of grease splatters. In addition, the floor under the deep fryer had food debris under the fryer.</p> <p>On 02/27/13 at 7:45 AM, observation of the deep fryer's splatter guard between the deep fryer and the stove/range revealed the splatter guard still had a large build-up of grease and the floor under the deep fryer was dirty with food debris.</p> <p>Interview with the Director of Nutrition Services, on 02/27/13 at 8:25 AM, revealed there was a cleaning schedule for the deep fryer splatter guard (weekly); however, she provided a copy of the cleaning schedule and review of this schedule revealed the cleaning of the deep fryer splatter guard had not been cleaned in the last 2 weeks. She stated it was the responsibility of the AM Kitchen Supervisor to ensure staff cleaned this area. She stated she had two Supervisors (AM and PM) to oversee the operation of the kitchen. They were the first line of ensuring kitchen tasks were completed and then it was ultimately her responsibility to oversee those tasks were done. She stated she had failed to review the cleaning schedule and realized multiple tasks had not been initialed as completed. She said the staff was suppose to initial the cleaning schedule when a specific task was completed.</p> <p>Interview with the AM Kitchen Supervisor, on 02/27/13 at 12:15 PM, revealed she normally walked around the kitchen to look at the kitchen equipment for cleanliness early in the morning</p> | F 371 | <p>Continued from page 11</p> <p>splashguard and surrounding areas. The Nutrition Service Director will inservice all Nutrition Services staff on the importance of cleanliness in all areas of the Dietary Department by 3/29/13. The Nutrition Services Director or the Assistant Nutrition Services Director will review and initial each Supervisor's checklist to ensure completion and will visually inspect the Dietary Department for areas in need of additional cleaning weekly for one month, then quarterly for two quarters. A written report will be reported at the quarterly Performance Improvement meetings.</p> | March 30, 2013 | |



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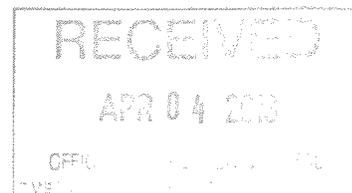
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| F 371 | Continued From page 12 and before she left for the day. She stated sometimes the kitchen staff would forget to initial the cleaning schedule whenever the task was completed. However, she did not know when the last time the deep fryer splatter guard was cleaned. She revealed she was off the 26th and did not review the cleaning schedule to ensure the cleaning tasks had been completed. | F 371 | | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which | F 441 | F 441 The facility does have in place an effective evidence-based infection control program that is referenced by state and federal regulations, CDC, and APIC. Foley catheter care guidelines are taught during certified nursing training and in orientation. Additionally, this information is found in certified nursing assistant manuals located on each unit and in the classroom and are available at all times. Resident #4 has no active infection or signs and symptoms of an active infection. The RN Unit Manager was made aware of the survey finding during survey on 02/27/13 and it was corrected immediately. Staff was re-educated by the RN Unit Manager 02/27/13 on the proper positioning of a Foley Catheter bag. This event was an isolated event and no actual harm came to the resident. During survey, RN Unit Managers reviewed all Foley Catheter bags and all were found to comply with F-441. | | |



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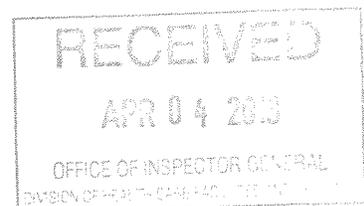
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| F 441 | <p>Continued From page 13 hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to prevent indwelling catheter bags from potential contamination when laying on the floor for one (1) of thirty (30) residents. Resident #4's indwelling catheter bag was found laying on the floor on 02/26/13 and 02/27/13.</p> <p>The findings include: The facility did not provided a policy regarding catheter care.</p> <p>Record review of Resident #4's record revealed he/she was ordered to use an indwelling catheter, on 01/25/13 for wound healing.</p> <p>Observations of Resident #4's indwelling catheter bag, on 02/26/13 at 11:46 AM, 2:16 PM, and 3:13 PM and on 02/27/13 on 8:12 AM, revealed Resident #4's indwelling catheter bag was laying on the floor.</p> <p>Interview with Certified Nursing Assistant (CNA) #4, on 02/28/13 at 8:39 AM, revealed when attaching an indwelling catheter to the bed, staff</p> | F 441 | <p>Continued from page 13</p> <p>New Measures put in place: RN/LPN Nursing Resource team created a poster board identifying the proper placement and covering of a Foley Catheter bag, and a test of knowledge of proper infection control procedure regarding the placement and covering of a Foley Catheter bag to acknowledge understanding. The LPN/RN Nursing Resource Team and RN/LPN House Supervisors will oversee that all nursing staff review the poster board, complete the test, and sign signature log. The LPN Auditor and RN/LPN Nursing Resource Team will monitor the placement of Foley Catheter bags weekly for four weeks, and then monthly for two months, then quarterly for three quarters. Discrepancies will be taken care of promptly and findings will be reported to the quarterly Performance Improvement meetings.</p> | March 30, 2013 | |



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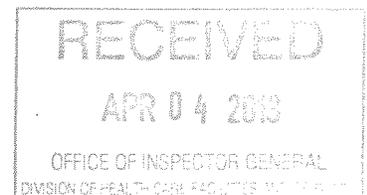
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| F 441 | Continued From page 14 were to make sure the catheter was below the bladder, hooked on the bed and not the bed rails. CNA #4 stated the indwelling catheter bag should never touch the floor because contamination could possibly occur. Interview with CNA #5, on 02/28/13 at 8:47 AM, revealed catheter bags should not be touching the floor; but should be off the floor because it can cause infections. Interview with Licensed Practical Nurse (LPN) #3, on 02/28/13 at 9:07 AM, revealed the catheter bag should not be on the floor. LPN #3 stated she had noticed the catheter bag on the floor. Normally when she saw an indwelling catheter bag on the floor, she picked up the catheter bag and places it up off of the floor. LPN #3 stated the catheter bag should not be on the floor because it could become contaminated. Interview with the 5th floor Unit Manager, on 02/28/13 at 9:23 AM, revealed the catheter bag should not be on the floor due to infection reasons. The Unit Manager stated she did not note any infections for Resident #4. Interview with the Director of Nursing (DON), on 02/28/13 at 2:38 PM, revealed the catheter bag should be placed on the bed frame and not touch the floor. The DON further stated the catheter bag laying on the floor could be an infection issue. | F 441 | | | |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each | F 514 | | | |



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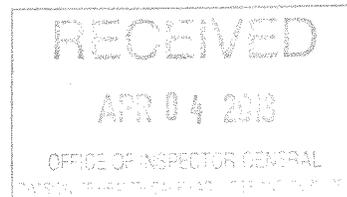
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| F 514 | <p>Continued From page 15</p> <p>resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to transcribe an order for a tray cushion that was on the re-admission orders and failed to clarify a physician's order for padded side rails and a seat belt for two (2) of thirty (30) sampled residents. Resident #5's physician orders did not reflect the use of a tray cushion. Resident #8 continued to utilize padded side rails and seat belt although the order stated to discontinue.</p> <p>The findings include:</p> <p>Review of the facility's admission policy titled, Admission of Patient to Unit, Reviewed/Revised 10/09/08, revealed upon admission the nurse would notify the resident's physician to verify unsigned orders. Based on the nurse's initial assessment of the resident, review of the history and physical, and the discharge summary/transfer report, he/she would discuss anticipated problems and seek appropriate</p> | F 514 | <p>F514</p> <p>Residents #5 and #8 care interventions were carried out per physicians' orders. Person-centered and individualized care for both residents #5 and #8 continued without disruption during these survey findings with no actual harm to the residents. Resident #5 had a history of CVA. Due to the above, the knee amputation and late effects of CVA, a tray cushion was ordered on 11/30/12 to enhance positioning while seated in the wheelchair. Resident #5 went out to the hospital and returned on 1/22/13 and all ancillary orders were to be resumed. The specific order for tray cushion was carried over to the ancillary orders when identified during survey by the RN Unit Manager. The RN Unit Manager and the Unit Nurses were re-educated on 2/27/13 by RN Nursing Administration team. Resident #8 had an original order for padded side rails for seizure precautions and wheelchair seatbelt for safety. Resident #8 's padded side rails and safety belt continued to be utilized as ordered. The RN Unit Manager discontinued the order only to remove it from being auto printed on the wrong form. The RN Unit Manager clarified the order upon the surveyor identifying it and was re- educated by the surveyor and RN Nursing Administration team. Residents #5 and #8 had restraint/ enabler orders correctly stated on the physician orders.</p> | |



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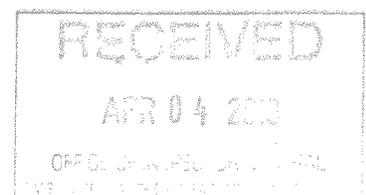
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| F 514 | <p>Continued From page 16</p> <p>orders. In addition, the Unit Manager would assess the resident, review the medical record, and identify unmet needs and unclear orders.</p> <p>1. Review of the Admission Review/Feedback Form, Revised 10/2012, completed by the 3rd floor Clinical Manager, revealed he checked to assure the admission orders were verified with the physician, and that they were transcribed onto the Medication Administration Record (MAR), Treatment Administration Record (TAR), and the Accu-Check Book, exactly as written.</p> <p>Review of the clinical record for Resident #5 revealed the facility admitted the resident on 02/20/2011 with diagnoses of Hypertension (HTN), Benign Prostatic Hypertrophy (BPH), Cerebral Vascular Accident (CVA), a history of Deep Vein Thrombosis (DVT), Neuropathy, Depression, Dysphasia, and Dementia. Resident #5 also had a history of an Above the Knee Amputation of the left leg.</p> <p>Continued review of the record revealed placement of a tray cushion had been ordered on 11/30/12 for Resident #5 whenever he/she was seated in the wheelchair. Resident #5 was transferred to the hospital for evaluation of gastrointestinal bleeding on 01/13/13 and readmitted to the facility on 01/22/13. However, the readmission orders did not include an order for the tray cushion.</p> <p>Review of the Comprehensive Care Plan and the Certified Nursing Assistant (CNA) Care Card for Resident #5 revealed the tray cushion was to be in place when Resident #5 was in the wheelchair to elevate the resident's hands related to edema.</p> | F 514 | <p>Continued from page 16</p> <p>RN/LPN Unit Managers, Unit Secretaries, and RN Nursing Administration team will review and revise or clarify, as needed, all ancillary restraint/ enabler orders for correct transcription by 3/29/13. The RN/LPN Nursing Resource team will generate the transcription order video inservice mandatory to all nurses, unit secretaries, and Certified Medication Aides (CMT's) The RN Nursing Administration team revised the admission/re-admission review feedback form and the admission/re-admission report form to reflect an additional check system from shift to shift after an admission/ readmission with an instruction sheet as a read and sign. RN/LPN Unit Managers, and the RN Nursing Administration team will provide education for all nurses and CMT's on the above stated procedures and the revised forms and expectations. All to be completed and documented by 3/29/13. RN/LPN Nursing Resource team and LPN Auditor will review admission/re-admission review feedback and report forms revision section and perform five audits on admission/re-admission ancillary orders for transcription accuracy.</p> | |



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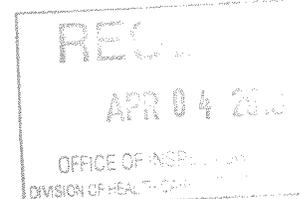
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 514 | Continued From page 17 Observations, on 02/26/13 at 11:55 AM, 12:45 PM, 1:55 PM and 2:25 PM, revealed Resident #5 was seated in a wheelchair with a tray cushion attached to the chair with Velcro straps. Interview, on 02/27/13 at 2:40 PM, with Licensed Practical Nurse (LPN) #2 revealed the tray cushion was placed every time Resident #5 sat in the wheelchair. According to LPN #2, the cushion was ordered and care planned for Resident #5 prior to his/her hospitalization in January, but the order for the cushion was not transcribed upon his/her readmission to the facility on 01/22/13. Interview, on 02/28/13 at 10:40 AM, with the 3rd Floor Clinical Director revealed the nurse admitting the resident was responsible for contacting the resident's physician to review/verify orders from the discharge/transfer summary and obtain any new physician's orders. In addition, the Clinical Director stated he or the House Supervisor on duty was responsible for reviewing and verifying admission orders for accuracy. He further stated his number one concern with incomplete or omitted orders would be a potential for a negative outcome for Resident #5. Interview, on 02/28/13 at 10:50 AM, with the Director Nursing (DON) revealed the Admission/Review Feedback Form completed by the Unit's Clinical Director or the House Supervisor provided a check and balance for review of the admission orders. 2. Review of Resident #8's physician orders, revealed on 02/04/13 at 12:00 PM an order to | F 514 | Continued from page 17 The reviews and audits will be done weekly for four weeks, monthly for two months, then quarterly for three quarters. Discrepancies will be taken care of promptly and findings reported to the quarterly Process Improvement meetings. | March 30, 2013 | |



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

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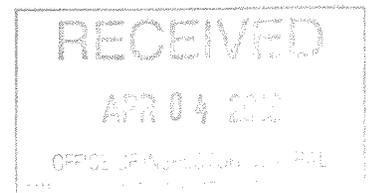
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 02/28/2013 |
|---|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217 | | |
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| F 514 | <p>Continued From page 18</p> <p>discontinue the seat belt on the wheelchair for safety, and discontinue the padded side rail for seizure precautions and safety prevention.</p> <p>Observations, on 02/26/13 at 11:49 AM and on 02/27/12 at 7:57 AM and 9:14 AM, revealed padding to the left side rail on Resident #8's bed. Observations, on 02/26/13 at 12:20 PM, revealed Resident #8 was sitting in his/her motorized wheelchair with a seat belt attached and holding the resident's cup between the belt and the resident's stomach.</p> <p>Review of the CNA care plan, revealed Resident #8 was to have a left padded side rail related to seizure precautions and a thermos cup with a lid and was to carry it between the seat belt and the belly.</p> <p>Interview with CNA #5, on 02/28/13 at 8:47 AM, revealed she was not aware of an order that stated Resident #8 should not have a pad to his/her bed rail. CNA #5 stated as far as she was aware Resident #8 always had a pad to his/her bed rail.</p> <p>Interview with LPN #3, on 02/28/13 at 9:07 AM, revealed the padding on Resident #8's bed had been there for awhile. LPN #3 stated the Unit Manager wrote the orders and the Unit Secretary took off the orders. The Unit Manager also checked to ensure the orders were taken off properly.</p> <p>Interview with the Unit Secretary, on 02/28/13 9:17 AM, revealed it was her responsibility to take physician orders off. The Unit Secretary stated when she took an order off, she transcribes them</p> | F 514 | | |



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| NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217 | |
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| F 514 | <p>Continued From page 19</p> <p>and flags the order for the nurse to note whether the order was transcribed properly. The Unit Secretary stated the order to discontinue the padded side rails and discontinue the seatbelt was written the wrong way. The Unit Manager wrote the order so the seat belt and the padded rails would be removed from the restorative card not the physician orders.</p> <p>Interview with the Unit Manager, on 02/28/13 at 9:23 AM, revealed when orders are sent to the pharmacy, the pharmacy was sending the order back, printed on the CNA card and the restorative card. The Unit Manager stated she was wanting the order to only be reflected on the CNA card. The Unit Manager stated she still wanted the order for the seat belt and pad to be in place. She stated she should have written the order better and clarified the order.</p> <p>Interview with the Director of Nursing (DON), on 02/28/13 at 2:38 PM, revealed the facility had been having issues with the pharmacy printing orders and medication orders on the restorative card and the treatment administration record. She indicted the physician wanted Resident #8 to have the padded rails and the seat belt. The DON stated she was not sure what the physician reviewed during the visit, but the physician did sign off on all the orders. The DON stated she had met with pharmacy and was working on fixing the medication records first then the ancillaries. The DON stated the discontinuation of the padded rails and seat belt were physician orders and had to be followed.</p> | F 514 | | |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 -MAIN BUILDING 01 B. WING | (X3) DATE SURVEY COMPLETED 02/28/2013 |
| NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217 | |
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| K 000 | <p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1973</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: seven (7) stories, Type II (222)</p> <p>SMOKE COMPARTMENTS: fourteen (14) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was initiated on 02/27/13 and concluded on 02/28/13. Parkway Medical Center was found to be not 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). The facility is certified for two hundred fifty two (252) beds with a census of two hundred twenty eight (228) on the day of the survey.</p> <p>The findings that follow demonstrate</p> | K000 | | |

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

ADMINISTRATOR

4/2/2013

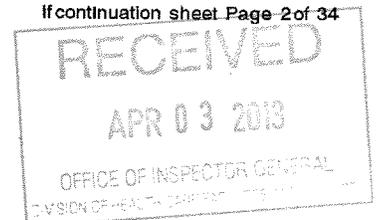
A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

OFFICE OF SUPERVISOR GENERAL
STATE OF MISSOURI
If continuation sheet Page 1 of 34

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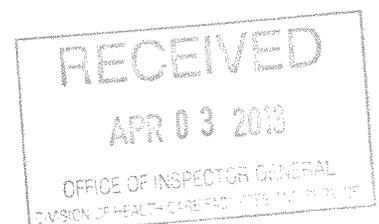
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01-MAIN BUILDING 01 B. WING | (X3) DATE SURVEY COMPLETED 02/28/2013 |
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| NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217 | |
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| K000 | Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). | K000 | | |
| K027 SS=D | Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/2-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for two hundred fifty two (252) beds with a census of two hundred twenty eight (228) on the day of the survey. The findings include: Observation, on 02/28/13 at 11:31 AM, with the Director of Facility Management revealed the two | K027 | K027 Self-closing automatic door closures were installed and astragal brushes were adjusted on the two sets of cross-corridor doors on the 4th floor 3/11/2013. The other 12 sets of corridor doors were inspected 3/11-3/15/2013 and the facility replaced all hinge-type closures with self-closing closures to assure self-closing hinges do not become weak. Astragal brushes were ordered and installed on 3/18/13 on cross-corridor doors whenever gaps larger than 1/8 inch are found. All cross-corridor doors will be inspected monthly by maintenance personnel to assure corridor doors are self-closing and there are no gaps larger than 1/8 inch. Facility Management Director has added cross-corridor door inspection to the monthly Preventive Maintenance Inspection Log. The Facility Management Director provided an inservice for all maintenance staff on how to check self-closing automatic door closures and to inspect for potential gaps on 3/26/13. | |



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| NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217 | |
| (X4) 1D PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | 10 PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| K027 | <p>Continued From page 2</p> <p>(2) sets of cross corridor doors located on the 4th Floor had a gap too large and would not resist the passage of smoke. The doors were equipped with self-closing hinges that had become too weak to ensure proper closer of the doors.</p> <p>Interview, on 2/28/13 at 11:31 AM, with the Director of Facility Management revealed she was not aware the door had developed a gap that was too large to resist smoke.</p> <p>Interview, on 2/28/13 at 3:30 PM, with the Administrator revealed he was not aware the door had developed a gap that was too large to resist smoke.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.4.1 Doors in smoke barriers shall close the opening leaving Only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors. NFPA 101 LIFE SAFETY CODE STANDARD</p> | K029 | <p>Continued from page 2</p> <p>The Facility Management Director will inspect cross-corridor doors on the 4th floor to assure doors are in compliance with expectations of K 027. Inspections will be done quarterly for two quarters. Written reports will be submitted to the Performance Improvement committee for review.</p> <p>K 029</p> <p>The doors found not self-closing with hazardous amounts of combustible Storage:</p> <ol style="list-style-type: none"> Administrators Office Conference area closet Administrators Office closet did not have a door or closer | March 30, 2013 |
| K029 SS D | <p>One hour fire rated construction (with % 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</p> | | | |

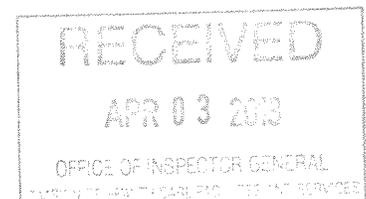


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| NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217 | |

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| K 029 | <p>Continued From page 3</p> <p>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</p> <p>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 in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for two hundred fifty two (252) beds with a census of two hundred twenty eight (228) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/28/13 between 9:00AM and 3:00 PM, with the Director of Facility Management revealed doors to hazardous rooms or rooms with hazardous amounts of combustible storage did not have a self-closing device. The doors are located in the following areas:</p> <ol style="list-style-type: none"> 1) Administrators Office Conference area closet. 2) Administrators Office closet did not have a door or closer. 3) Closet located in the Accounting Office. 4) Copy Room closet. | K029 | <p>Continued from page 3</p> <ol style="list-style-type: none"> 3. Closet located in the Accounting Office 4. Copy Room closet 5. Social Services Office closet 6. 1st floor Clean Linen room <p>had positive self-closing devices installed on 3/19/13. Administrator's closet door was installed with self-closing device on 3/22/13.</p> <p>The Maintenance staff has inspected all other areas that are considered hazardous storage and found all in compliance with K 029 on 3/22/13. Facility Maintenance Director added inspection of combustible storage areas that need self-closure doors to the monthly Preventive Maintenance Inspection Log. The Facility Management Director provided an inservice to all maintenance staff on areas that are considered hazardous combustible areas on 3/26/13.</p> <p>The Facility Management Director will inspect hazardous combustible storage areas to assure self-closing devices comply with K 029 expectations for two quarters. A written report will be submitted to the Performance Improvement committee for review.</p> | March 30, 2013 |



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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

185122

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01-MAIN BUILDING 01

B. WING

(X3) DATE SURVEY
COMPLETED

02/28/2013

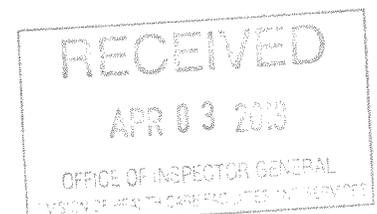
NAME OF PROVIDER OR SUPPLIER

PARKWAY MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

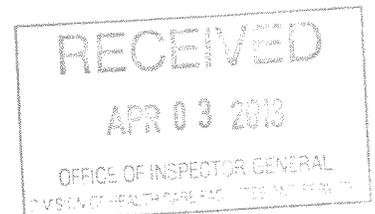
1155 EASTERN PARKWAY
LOUISVILLE, KY 40217

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| K 029 | <p>Continued From page 4</p> <p>5) Social Services Office closet.</p> <p>6) 1st Floor Clean Linen Room.</p> <p>Interview, on 02/28/13 between 9:00AM and 3:00 PM, with the Director of Facility Management revealed she was not aware the doors to rooms with hazardous amounts of combustible storage were required to be self-closing.</p> <p>Interview, on 02/28/13 at 3:30PM, with the Administrator revealed he was not aware the rooms were required to have self-closing doors.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>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:</p> <p>(1) Boiler and fuel-fired heater rooms</p> <p>(2) Central/bulk laundries larger than 100112 (9.3 m2)</p> <p>(3) Paintshops</p> <p>(4) Repair shops</p> <p>(5) Soiled linen rooms</p> | K029 | | |



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| K 029 | Continued From page 5 (6) Trash collection rooms (7) Rooms or spaces larger than 50 1/2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD | K029 | | |
| K 045 ss D | llumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for two hundred fifty two (252) beds with a census of two hundred twenty eight (228) on the day of the survey. The findings include: | K045 | K045 The east exit on the 1st floor had two light fixtures installed to provide required illumination for exit discharge on 3/18/2013. The facility maintenance personnel inspected the other 3 exit areas for required illumination on 3/11/13 and all are in compliance. The Facility Management Director provided an inservice for all maintenance staff on K 045 and the inspection of all exit areas to assure required illumination on 3/26/13. Facility Management Director will inspect exit discharges for required illumination for two quarters assuring compliance with K 045. A written report will be submitted to the Performance Improvement committee for review. | March 30, 2013 |



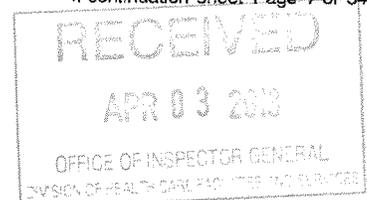
FOR

PRINTED: 03/13/2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
& MEDICAID SERVICES

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| K045 | <p>Continued From page 6</p> <p>Observation, on 02/28/13 at 2:08PM, with the Director of Facility Management revealed the East Exit on the 1st Floor did not have a light installed outside to provide the required illumination for exit discharge.</p> <p>Interview, on 02/28/13 at 2:08PM, with the Director of Facility Management revealed she was not aware the exit did not have the required illumination for egress lighting.</p> <p>Interview, on 02/28/13 at 3:30PM, with the Administrator revealed he was not aware the exit did not have the required illumination for egress lighting.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.U. Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps,</p> | K045 | |



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES
 AND PLAN OF CORRECTION

(XI) PROVIDER/SUPPLIER/CLIA
 IDENTIFICATION NUMBER:

185122

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01

B. WING

(X3) DATE SURVEY
 COMPLETED

02/28/2013

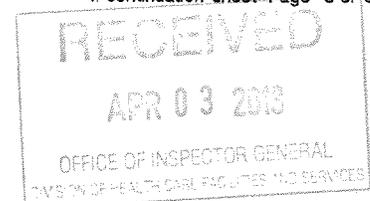
NAME OF PROVIDER OR SUPPLIER

PARKWAY MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1155 EASTERN PARKWAY
 LOUISVILLE, KY 40217

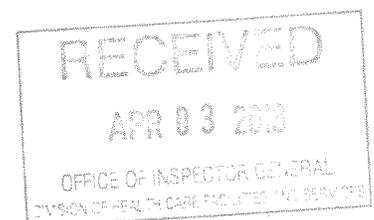
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| K045 | <p>Continued From page 7 escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 5-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3. The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4. Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.</p> | K045 | <p>K046 The annual 90-minute emergency lighting test was conducted and documented on 3/22/13.</p> | |
| K 046 | NFPA 101 LIFE SAFETY CODE STANDARD | K046 | | |



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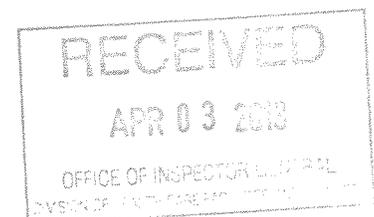
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| NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217 | |
| (X4) 10 PREFIX TA | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |
| K046 Continued From page 8 SS=F Emergency lighting of at least 1 1/2 hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation, and interview it was determined the facility failed to test emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect fourteen (14) of fourteen (14) smoke compartments, residents, stall and visitors. The facility is certified for two hundred fifty two (252) beds with a census of two hundred twenty eight (228) on the day of the survey. The facility failed to conduct the required annual ninety minute emergency battery light test. The findings include: Observation, on 02/27/13 at 2:20 PM, with the Director of Facility Management revealed the facility did not have documentation for the annual testing of emergency battery lighting located in the facility. Interview, on 02/27/13 at 2:20PM, with the Director of Facility Management revealed she was not aware of the annual testing requirements. Interview, on 02/28/13 at 3:30PM, with the Administrator revealed he was not aware of the requirement for emergency battery light testing. Reference: NFPA 101 (2000 edition) 7.9.2.1" Emergency illumination shall be provided | K046 | Continued from page 8 On 3/20/13 all areas requiring emergency lighting were identified and were included in the annual 90-minute emergency battery light test performed on 3/22/13. The inspection documents will indicate annual test. Maintenance personnel will conduct annual testing and document annual results. The Facility Management Director has placed the 90-minute emergency battery light test on the annual calendar. The Facility Management Director provided an inservice for all maintenance personnel on how to test emergency lighting on 3/22/13. Facility Management Director will report completion of the 90-minute annual test to the Performance Improvement committee. The Facility Management Director will be responsible to assure the annual 90-minute test is completed timely in 2014, and thereafter. | (X5) COMPLETION DATE March 30, 2013 |



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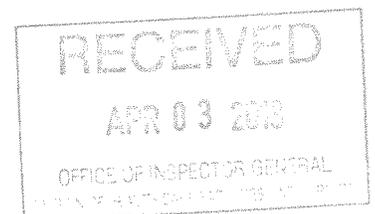
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| K046 | Continued From page 9 for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals. | K046 | | |
| K047 ss D | NFPA 101 LIFESAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous | K047 | K047 The exit doors in the Nutritional Service Kitchen had illuminated exit signs | |



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| K047 | <p>Continued From page 10 illumination also served by the emergency lighting system. 19.2.10.1</p> <p>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 in accordance with NFPA standards. The deficiency had the potential to affect one (1) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for two hundred fifty two (252) beds with a census of two hundred twenty eight (228) on the day of the survey. The facility failed to ensure exits were clearly recognizable with proper exit signage.</p> <p>The findings include:</p> <p>Observation, on 02/28/13 at 2:47PM, with the Director of Facility Management revealed the exit doors located in the Kitchen did not have an exit sign above the door making the path of egress clearly recognizable.</p> <p>Interview, on 02/28/13 at 2:47 PM, with the Director of Facility Management revealed she was not aware the exits did not have proper signage.</p> <p>Interview, on 02/28/13 at 3:00PM, with the Administrator revealed he was not aware the exits did not have proper signage.</p> | K047 | <p>Continued from page 10</p> <p>installed over each exit area, making the path of egress recognizable 3/7-3/11/2013.</p> <p>The facility was inspected by maintenance staff to identify all exit areas covered by K 047 on 3/6/2013. Maintenance staff will inspect monthly all exit areas to assure exit areas in the facility have illuminated exit signs. The Facility Management Director provided an inservice for all maintenance staff to inspect exit lighting in Nutrition Service and all areas requiring illuminated exit signs. On 3/26/13, the Director of Facility Management added monthly inspections of exit signs on the preventive maintenance log. The Facility Management Director will inspect Nutrition Service exit lights to assure they are working properly. This will be done for two quarters and a written report will be submitted to the Performance Improvement committee.</p> | March 30, 2013 |



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| K 047 | Continued From page 11 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. NFPA 101 LIFE SAFETY CODE STANDARD | K047 | | |
| K 050 SS F | Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect fourteen (14) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for two hundred fifty two (252) beds with a census of two hundred twenty eight (228) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times on all shifts. | K050 | K050 After the survey, the facility found documentation that a 3 rd shift fire drill was conducted in the 4th quarter. Fire drills will continue to be conducted under varying conditions and varying times on each shift. Maintenance staff will conduct fire drills and document. Parkway provides fire inservices for all personnel at orientation and semi-annually. On 3/26/13 the Facility Management Director reviewed and revised the facility process for conducting fire drills at varying times which includes an annual fire drill calendar. The Facility Management Director conducted an inservice for all maintenance staff on conducting quarterly fire drills at varying times and on each shift on 3/26/13. Facility Management Director will conduct fire drills with maintenance staff for two quarters and submit a written report to the Performance Improvement committee. | March 30, 2013 |



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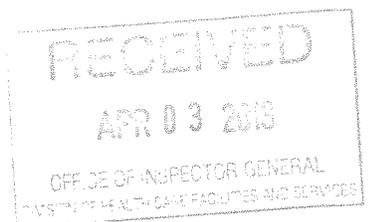
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| K 050 | <p>Continued From page 12</p> <p>The findings include:</p> <p>Fire Drill review, on 02/27/13 at 2:15PM, with the Director of Facility Management revealed the facility failed to conduct fire drills at unexpected times on all shifts. Further review revealed the facility failed to conduct a fire drill in the fourth quarter of 2012 on third (3rd) shift.</p> <p>Interview, on 02/27/13 at 2:15PM, with the Director of Facility Management revealed she was not aware the fire drills were not being conducted as required. Further interview revealed she was not aware the fire drill in the fourth quarter of 2012 on third shift had been missed.</p> <p>Interview, on 02/27/13 at 3:30PM, with the Administrator revealed he was aware of the requirements for fire drills, but not aware the fire drills were not being conducted as required.</p> <p>Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p> <p>Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7.0 OPERATING FEATURES 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to</p> | KOSO | | |



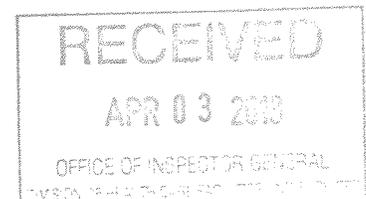
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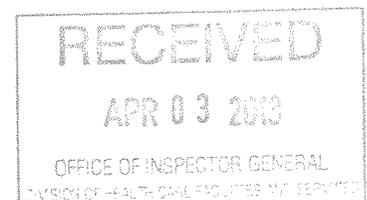
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| K 050 | Continued From page 13 all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2. Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00p.m. (2100 hours) and 6:00a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. | KOSO | | |
| K 056 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water | K056 | K056 Landmark Sprinkler will install sprinklers in two-hundred-fifty-two resident closets throughout the facility. The work plan is to complete 10 rooms per day per work week. This contracted service may require up to May 3, 2013 to complete. Work began on 3/18/13. (See attachment #1) | |



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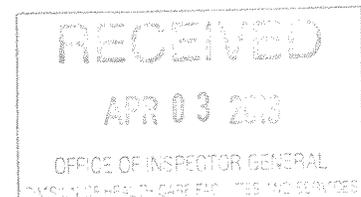
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| K 056 | Continued From page 14 supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system installed, in accordance with NFPA standards. The deficiency had the potential to affect twelve (12) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for two hundred fifty two (252) beds with a census of two hundred twenty eight (228) on the day of the survey. The facility failed to ensure the facility had complete sprinkler coverage. The findings include: Observation, on 02/28/13 between 9:00AM and 3:00 PM, with the Director of Facility Management revealed two hundred fifty two (252) resident closets did not have sprinkler protection. Further observation revealed the sprinkler heads located in the two (2) shower rooms on the 3rd Floor were of mixed temperature response ratings. Interview, on 02/28/13 between 9:00AM and 3:00 PM, with the Director of Facility Management revealed she was not aware the closets were required to be sprinkler protected. Further interview revealed she was not aware of the | K056 | Continued from page 14 The sprinkler heads in the shower rooms on the 3rd floor with the different temperature response times will be replaced with sprinkler heads of the same temperature response time as the other shower room sprinkler heads. This work was done by Landmark Sprinkler, an outside contractor on 3/25/13. After the contracted work is completed, all closets in the facility will be sprinkled. All other shower room sprinkler heads were inspected to meet K 056 expectations by maintenance staff on 3/5/13. Maintenance staff will inspect any new sprinkler heads installed to assure temperature response time is met. The Facility Management Director provided an inservice for all maintenance staff regarding the unacceptability of having different sprinkler head temperature response times in one compartment on 3/26/13. The Facility Management Director will submit monthly inspections on the progress of closet sprinkler installation to the Performance Improvement committee. Quarterly inspections of facility sprinkler heads will be done by an outside contractor, Landmark Sprinkler, and submitted to the Performance Improvement committee for two quarters. | May 3, 2013 |



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| K056 | Continued From page 15 mixed temperature response sprinkler heads in the 3rd Floor shower rooms. Interview, on 02/28/13 at 3:30 PM, with the Administrator revealed he was not aware the closets were required to be sprinkler protected. Further interview revealed he was not aware of the mixed temperature response sprinkler heads in the 3rd Floor shower rooms. Reference: NFPA 13(1999 Edition) 5-138.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. | K056 | | |



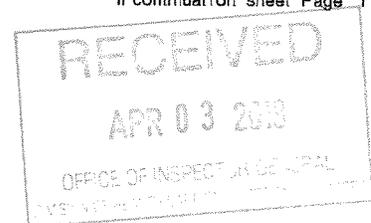
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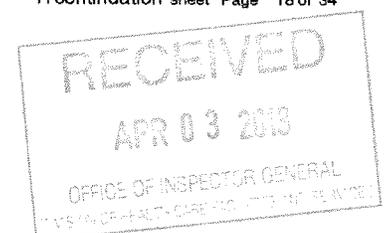
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| K056 | <p>Continued From page 16</p> <p>Reference: NFPA 13{1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="1"> <thead> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction [A] (B)</th> <th>Maximum Allowable Distance of Deflector Obstruction (in.)</th> </tr> </thead> <tbody> <tr><td>Less than 1 ft</td><td>0</td></tr> <tr><td>1 ft to less than 1 ft 6 in.</td><td>2 1/2</td></tr> <tr><td>1 ft 6 in. to less than 2 ft</td><td>3 1/2</td></tr> <tr><td>2 ft to less than 2 ft 6 in.</td><td>5 1/2</td></tr> <tr><td>2 ft 6 in. to less than 3 ft</td><td>7 1/2</td></tr> <tr><td>3 ft to less than 3 ft 6 in.</td><td>9 1/2</td></tr> <tr><td>3 ft 6 in. to less than 4 ft</td><td>12</td></tr> <tr><td>4 ft to less than 4 ft 6 in.</td><td>14</td></tr> <tr><td>4 ft 6 in. to less than 5 ft</td><td>16 1/2</td></tr> <tr><td>5 ft and greater</td><td>18</td></tr> </tbody> </table> <p>For SI units, 1 in.; 25.4 mm; 1 ft; 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p> | Distance from Sprinklers to above Bottom of Side of Obstruction [A] (B) | Maximum Allowable Distance of Deflector Obstruction (in.) | Less than 1 ft | 0 | 1 ft to less than 1 ft 6 in. | 2 1/2 | 1 ft 6 in. to less than 2 ft | 3 1/2 | 2 ft to less than 2 ft 6 in. | 5 1/2 | 2 ft 6 in. to less than 3 ft | 7 1/2 | 3 ft to less than 3 ft 6 in. | 9 1/2 | 3 ft 6 in. to less than 4 ft | 12 | 4 ft to less than 4 ft 6 in. | 14 | 4 ft 6 in. to less than 5 ft | 16 1/2 | 5 ft and greater | 18 | K056 | | |
| Distance from Sprinklers to above Bottom of Side of Obstruction [A] (B) | Maximum Allowable Distance of Deflector Obstruction (in.) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Less than 1 ft | 0 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 ft to less than 1 ft 6 in. | 2 1/2 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 ft 6 in. to less than 2 ft | 3 1/2 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 ft to less than 2 ft 6 in. | 5 1/2 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 ft 6 in. to less than 3 ft | 7 1/2 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 ft to less than 3 ft 6 in. | 9 1/2 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 ft 6 in. to less than 4 ft | 12 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 ft to less than 4 ft 6 in. | 14 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 ft 6 in. to less than 5 ft | 16 1/2 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5 ft and greater | 18 | | | | | | | | | | | | | | | | | | | | | | | | | |



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE &
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 -MAIN BUILDING 01 B.WING | (X3) DATE SURVEY COMPLETED 02/28/2013 |
|--|--|---|---|
| NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217 | |
| (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) |
| K 056 | <p>Continued From page 17 Reference: NFPA 13(1999 Edition)</p> <p>7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:</p> <ul style="list-style-type: none"> (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height <p>The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2.</p> | K056 | |

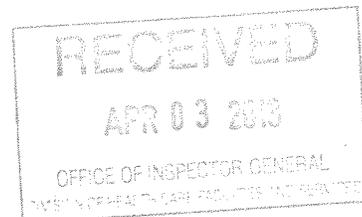


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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 RWING | (X3) DATE SURVEY COMPLETED 02/28/2013 |
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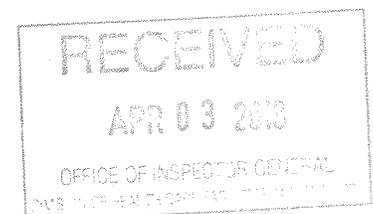
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| K056 | Continued From page 18 (See 8.2.1.) Exception: Any building of Type 1(443), Type 1(332), Type 11(222), or Type 11(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. | K056 | | |
| K064 SS O | NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire extinguishers were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for two hundred | K064 | K064 Placard signage stating hood suppression system must be used before class K fire extinguisher was placed above class K fire extinguishers in the Nutrition Service kitchen on 3/7/13. This is the only area affected by K 064 regulation. The Facility Management Director added inspection K class fire extinguisher placard presence to the monthly Preventive Maintenance log. Maintenance staff will inspect K class fire extinguishers and document presence of said placard. | |



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| K 064 | <p>Continued From page 19</p> <p>fifty two (252) beds with a census of two hundred twenty eight (228) on the day of the survey. The facility failed to provide required signage for fire extinguishers.</p> <p>The findings include:</p> <p>Observation, on 02/28/13 at 2:41 PM, with the Director of Facility Management revealed there was no placard stating that the hood suppression system must be used before the class K fire extinguisher. This type of extinguisher is used as a secondary measure to the range hood extinguishing system.</p> <p>Interview, on 02/28/13 at 2:41 PM, with the Director of Facility Management revealed she was not aware of the signage requirement.</p> <p>Interview, on 02/28/13 at 3:30PM, with the Administrator revealed he was not aware of the signage requirement.</p> <p>Reference: NFPA 10 (1998 Edition). 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.</p> <p>Reference NFPA 10 (1998 Edition). 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire</p> | K064 | <p>Continued from page 19</p> <p>The Facility Management Director provided an inservice for all maintenance personnel to look for placard signage while inspecting the class K extinguishers. Nutrition Service Director provided an inservice to all nutrition service staff on the signage and instructions 3/22 - 3/26/13 and will annually thereafter. Facility Management Director will do quarterly inspection of class K fire extinguisher placard signage presence for two quarters and submit a written report to the Performance Improvement committee. Nutrition Service Director will submit a report of staff inservice to the Performance Improvement committee.</p> <p>March 30, 2013</p> |



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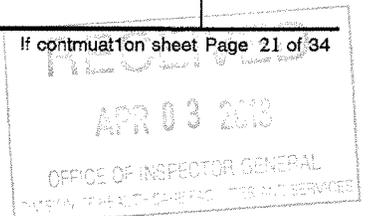
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/ SUPPLIER/ CLIA
IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY
COMPLETED

| | | | | |
|--|---|---------------------|---|----------------------------|
| NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER | | 185122 | STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217 | 02/28/2013 |
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| K 064 | Continued From page 20 extinguisher is not more than 5 ft (1.53 m) | K064 | | |
| K 066 SS=D | <p>above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> | K066 | <p>K066</p> <p>Fireproof containers, with self-closing cover device were placed in all smoking areas on 3/19/2013. The fireproof containers will allow ashtrays to be emptied into a fireproof container and will be maintained by maintenance staff. The Facility Management Director provided an inservice to all maintenance staff regarding the purpose of the fireproof containers and the need to be emptied daily on 3/26/13. The Facility Management Director provided an inservice to smoking aides in patient smoking area to empty ashtrays into the fireproof cigarette container after each smoking session on 3/26/13. Housekeeping staff were inserviced to empty the fireproof containers every day by the Facility Management Director on 3/26/13. The Facility Management Director will inspect smoking areas to assure fire proof containers are intact for the next two quarters and submit a report to Performance Improvement committee.</p> | March 30, 2013 |



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K066 Continued From page 21

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of fourteen (14) smoke compartments, smokers, staff and visitors. The facility is certified for two hundred fifty two (252) beds with a census of two hundred twenty eight (228) on the day of the survey. The facility failed to ensure the smoking areas had a metal container with a self-closing lid to dump ashtrays.

The findings include:

Observation, on 02/28/13 between 9:00AM and 3:00 PM, with the Director of Facility Management revealed the facility failed to provide a metal container with a self-closing lid to dump the ashtrays, located in the designated smoking areas.

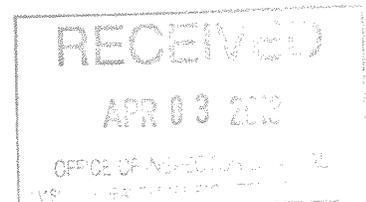
Interview, on 02/28/13 between 9:00AM and 3:00 PM, with the Director of Facility Management revealed she was not aware of the requirement for metal containers with a self-closing lid for dumping ashtrays.

Interview, on 02/28/13 at 3:30 PM, with the Administrator revealed he was not aware of the requirement for metal containers with a self-closing lid for dumping ashtrays.

Reference: NFPA Standard 101 (2000 Edition).

19.7.4 Smoking (4)
Metal containers with self-closing cover devices

K066



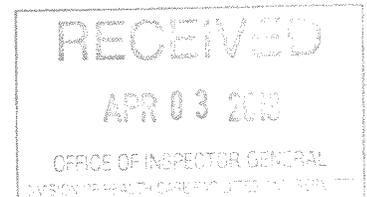
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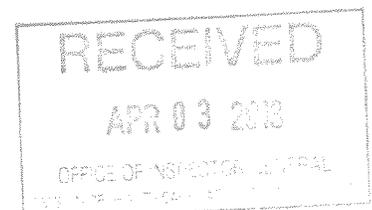
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| K 066 | Continued From page 22 into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. | K066 | | |
| K 069 SS=D | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA96</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cooking facilities were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of fourteen (14) smoke compartments, residents, staff, and visitors. The facility is certified for two hundred fifty two (252) beds with a census of two hundred twenty eight (228) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/28/13 at 2:49 PM, with the Director of Facility Management revealed the manual pull for the hood suppression system for the grill area was not located in the path of egress. The hood suppression pull was located behind a door that would first have to be closed to be reached.</p> <p>Interview on 02/28/13 at 2:49PM, with the Director of Facility Management revealed she was not aware the hood suppression pull was to be located in the path of egress, and not blocked by a door.</p> <p>Interview on 02/28/13 at 3:30PM, with the Administrator revealed he was not aware the</p> | K069 | <p>K069</p> <p>A manual pull for the hood suppression system in the grill area of coffee shop was installed in the pathway of egress on 3/18/2013.</p> <p>This is the only area affected by this K069 tag.</p> <p>The hood suppression system was installed and will be inspected every six months by FESCO Fire Alarm Company.</p> <p>Nutrition Services Director provided an inservice to all Nutrition Service staff on where the manual pull station is located and how to use it on 3/26/13, and will yearly thereafter.</p> <p>The FESCO Inspection Report will be reviewed by the Facility Management Director and a copy will be given to the Performance Improvement committee after the next two inspections. A copy of the Nutrition Service training will be given to the Performance Improvement committee.</p> | March 30, 2013 |



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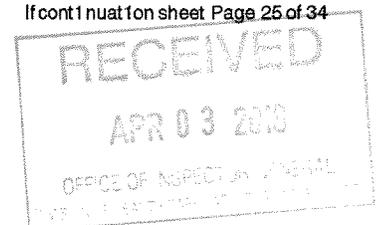
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| K 069 | Continued From page 23 hood suppression pull was to be located in the path of egress. | K069 | | |
| K 073 SS=F | Reference: NFPA 96 (1998 edition) 7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other. Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link. Exception No. 2: An automatic sprinkler system. NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that combustible decorations were used in accordance with NFPA standards. The deficiency had the potential to affect fourteen (14) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for two | K073 | K073 Resident and staff combustible decorations were treated with a fire retardant (Flamex) spray and documented on 3-4 to 3-8-2013. Activities staff will apply fire retardant chemical to new combustible items brought into the facility by resident, family or staff at least monthly. Combustible items of residents that need laundering will be retreated after laundering by the laundry staff. Facility decorations will | |



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| NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1155EASTERN PARKWAY LOUISVILLE, KY 40217 | |
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| <p>K073 continued From page 24 hundred fifty two (252) beds with a census of two hundred twenty eight (228) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/27/13 at 2:32PM, with the Director of Facility Management revealed the facility did not have documentation that newly introduced personal decorations for residents or staff had been treated with a flame retardant material.</p> <p>Interview, on 02/27/13 at 2:32 PM, with the Director of Facility Management revealed she was not aware decorations were required to be treated with a fire retardant and documentation was to be kept on the items that had been treated.</p> <p>Interview, on 02/28/13 at 3:30PM, with the Administrator revealed he was not aware decorations were required to be treated with a fire retardant and documentation was to be kept on the items that had been treated.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>119.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant</p> <p>K075 NFPA 101 LIFE SAFETY CODE STANDARD SS=D Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 Usq m). A</p> | <p>K073</p> <p>K 075</p> | <p>Continued from page 24</p> <p>be sprayed with flame retardant by the Activities Department.</p> <p>The Facility Management Director and Activities Director developed a new policy and procedure and a new form for documentation on 3/4/13.</p> <p>Documentation requirements include description of item, date, and initials of person applying flame retardant</p> <p>The Facility Management Director provided an inservice to all laundry staff on how to re-treat and document laundry items requiring flame retardant chemical treatment on 3/27/13.</p> <p>Activities staff were inserviced on how to treat and document facility decorations and residents personal items with the flame retardant spray (Flamex) by the Activities Director on 3/27/13. Administration sent a letter to all residents and families that flame retardant chemical has been applied to all residents' combustible items, and the need to treat any combustible items brought to the facility in the future on 3/25/13. Facility Management Director will review documentation, check treated items for two quarters, and submit a written report to the Performance Improvement committee.</p> <p>The Director of Facility Management will submit the new policy and procedure, new forms and the letter sent to residents and families to the Performance Improvement committee.</p> | <p>March 30, 2013</p> |



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE

MEDICAID SERVICES

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(XI) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A BUILDING 01-MAIN BUILDING 01

(X3) DATE SURVEY
COMPLETED

185122

B.WING

02/28/2013

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PARKWAY MEDICAL CENTER

1155 EASTERN PARKWAY
LOUISVILLE, KY 40217

(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

K075

Continued From page 25
capacity of 32 gal (121 L) is not exceeded within
any 64 sq ft (5.9-sq m) area. Mobile soiled linen
or trash collection receptacles with capacities
greater than 32 gal (121 L) are located in a room
protected as a hazardous area when not
attended. 19.7.5.5

This STANDARD is not met as evidenced by:
Based on observation and interview, it was
determined the facility failed to ensure trash
collection receptacles with capacities greater than
32 gallon were stored in accordance with NFPA
standards. The deficiency had the potential to
affect one (1) of fourteen (14) smoke
compartments, residents, staff and visitors. The
facility is certified for two hundred fifty two (252)
beds with a census of two hundred twenty eight
(228) on the day of the survey.

The findings include:

Observation, on 02/27/13 at 3:20PM, with the
Director of Facility Management revealed four (4)
soiled linen carts and one (1) trash cart with
capacities over thirty two (32) gallons that were
left unattended in the back hall on the 1st Floor by
the Rear Exit

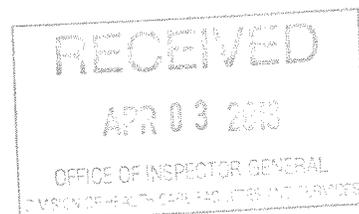
Interview, on 02/27/13 at 3:20PM, with the
Director of Facility Management revealed she
was unaware of the requirement for soiled linen
or trash receptacles with capacities greater than
thirty two (32) gallons.

K075

K075

Soiled linen carts and trash carts were
removed from back hall on 1st floor
rear exit on 2/28/2013. The carts have
been placed in a protected hazardous
area room in the basement linen room
and trash room.
All other facility means of egress were
inspected and found to comply with
K 075 on 2/28/13.
The Facility Management Director has
set the expectation that nothing is
permitted to stay in the corridor area.
The 1st floor rear exit area will be
monitored daily by maintenance;
housekeeping and central supply staff to
assure the 1st floor corridor area is
kept clear of items. A daily log of
inspections will be kept for three
months.
Facility Management Director
provided an inservice to all
housekeeping, maintenance, and central
supply staff on 3/26/13.
The Facility Management Director will
monitor the daily log for one quarter,
and a written report will be given to the
Performance Improvement committee.
The Facility Management Director will
then evaluate response and decide on
needed frequency of documented
monitoring with the goal to monitor
monthly.

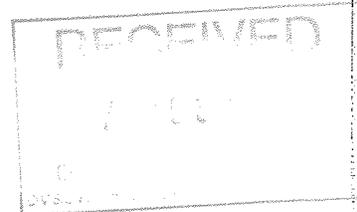
March
30,
2013



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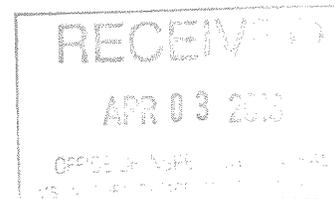
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01-MAIN BUILDING 01 B. WING | (X3) DATE SURVEY COMPLETED 02/28/2013 |
|--|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217 | |
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| K 075 | Continued From page 26 InteiView, on 02/28/13 at 3:30PM, wrth the Administrator revealed he was unaware of the requirements for soiled linen or trash receptacles with capacities greater than thirty two (32) gallons. 19.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft2 (20.4 Um2). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft2 (5.9-m2) area. Mobile soiled linen or trash collection receptacles with capacties greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. Exception: Container size and density shall not be limited in hazardous areas. | K075 | | |
| K 144 | NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. | K 144 | K 144 A generator load test was conducted on 3/20/13 and found the transfer time to be 2.4 seconds. Acceptable transfer time is under 10 seconds. Findings were documented. There is only one generator in the facility. Facility Management Director revised the generator inspection log to include documentation of transfer time under load on 3/20/13. The generator is inspected by maintenance staff weekly | |



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| K 144 | <p>Continued From page 27</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect fourteen (14) of fourteen (14) smoke compartments, residents, staff, and visitors. The facility is certified for two hundred fifty two (252) beds with a census of two hundred twenty eight (228) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/27/13 at 2:30 PM, with the Director of Facility Management revealed the facility did not document the transfer time of the facilities generator monthly as required. In the event of normal power interruption the facility generator must transfer within ten (10) seconds.</p> <p>Interview, on 02/27/13 at 2:30PM, with the Director of Facility Management revealed she was aware the generator must transfer within ten (10) seconds; however, she was not aware the transfer times were to be documented monthly.</p> <p>Interview, on 02/28/13 at 3:30 PM, with the Administrator revealed he was aware the generator must transfer within ten (10) seconds; however, he was not aware the transfer times were to be documented monthly.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be</p> | K 144 | <p>Continued from page 27</p> <p>and exercised under load for 30 minutes a month and documented. The Facility Management Director provided an inservice to all maintenance staff on how to test the generator under load and the new inspection form with the transfer time documentation on 3/26/13. Facility Management Director will physically monitor testing, document monthly for two quarters, and submit a copy of inspection to the Performance Improvement committee.</p> | <p>March 30, 2013</p> |



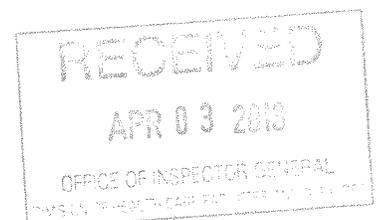
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| K 144 | <p>Continued From page 28</p> <p>sized to minimize voltage drop in accordance with the manufacturers' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.</p> <p>Reference: NFPA 99 (1999 Edition)</p> <p>Actual NFPA Standard: NFPA 99, 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1.</p> <p>(b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1 (b).</p> <p>Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p> <p>Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all</p> | K 144 | | |
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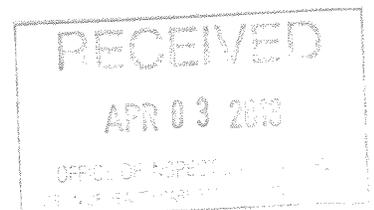
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| K 144 | <p>Continued From page 29</p> <p>appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>(b) Inspection and Testing.</p> <p>Reference: NFPA99 (1999 Edition).</p> <p>3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel -when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start)</p> | K 144 | | |

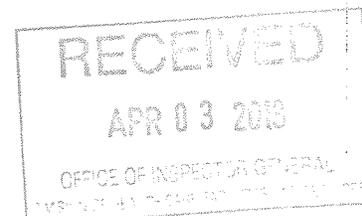


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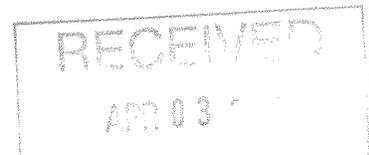
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| K 144 | Continued From page 30 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110:3-5.5.2] Reference: NFPA 110 (1999 Edition). 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch. | K 144 | | |
| K 147 | NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to | K 147 | K 147 The misuse of electrical plugs and electrical strips in areas 507, 713, 703, 710, 506, 3rd floor lounge, 306 doorway to hall, 2nd floor lounge, and Chief Financial Officer Office have all been corrected. Electrical strips have been removed and all devices are plugged into an electrical outlet in accordance with NFPA standards on 3/5-3/8/2013. | |



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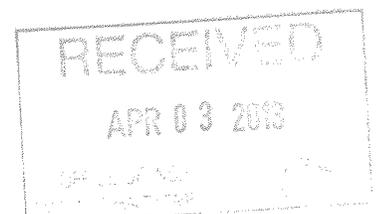
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| K 147 | <p>Continued From page 31</p> <p>affect seven (7) of fourteen (14) smoke compartments, residents, staff, and visitors. The facility is certified for two hundred fifty two (252) beds with a census of two hundred twenty eight (228) on the day of the survey. The facility failed to maintain the proper use of power strips and extension cords.</p> <p>The findings include:</p> <p>Observations, on 02/28/13 between 9:00 AM and 3:00 PM, with the Director of Facility Management revealed:</p> <ol style="list-style-type: none"> 1) A multi-plug adaptor was plugged into a power strip that was plugged into another power strip located in room #507. 2) A power strip was plugged into another power strip located in room #713. 3) A refrigerator was plugged into a power strip located in room #703, 710, and 506. 4) Lift battery charger was plugged into a power strip located in the 3rd Floor Employee Lounge. 5) An oxygen concentrator cord was run through the doorway to the hall located in room #306. 6) A power strip was plugged into another power strip located in the 2nd Floor Lounge. 7) A power strip was plugged into an extension cord that was plugged into a power strip located in the Chief Financial Officers Office. <p>Interview, on 02/28/13 between 9:00AM and 3:00 PM, with the Director of Facility Management and the Maintenance Supervisor revealed they were not aware the power strips and extension cords had been misused.</p> <p>Interview, on 02/28/13 at 3:30 PM, with the</p> | K 147 | <p>Continued from page 31</p> <p>Maintenance staff will formally inspect all facility areas for misuse of electrical cords, or items improperly plugged into an approved electrical outlet and will correct and document findings on the Preventive Maintenance log monthly. Maintenance staff will correct any misuse unless medical equipment is involved. If medical equipment is involved, maintenance staff will assist nursing in finding an acceptable outlet. Facility Management Director provided an inservice to all maintenance staff on misuse of electrical strips and electrical cords on 3/26/13. On 3/20/13, the RN/LPN Nursing Resource team inserviced facility staff on misuse of electrical plugs and electrical cords to maintain compliance with K 147 and empower staff to intervene when a misuse is observed. This inservice/training is also mandatory during orientation for all new employees, then semi-annually with the fire inservices for all facility staff. Social Service advises new residents and families about misuse of electrical cords and plugs at admission. The Facility Management Director will perform random inspections of 10 rooms per floor for the next four quarters. A copy of inspections and findings will be given to the Performance Improvement committee to review.</p> |
| | | | (X5) COMPLETION DATE March 30, 2013 |



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| K 147 | <p>Continued From page 32</p> <p>Administrator revealed he was not aware of the misuse of power strips and extension cords.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric.</p> <p>Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where runthrough holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p> | K 147 | |



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| K 147 | Continued From page 33 (3) Where runthrough doorways, windows, or similar openings (4) Where attached to building surfaces | K 147 | | |

