

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

PRINTED: 08/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/09/2012
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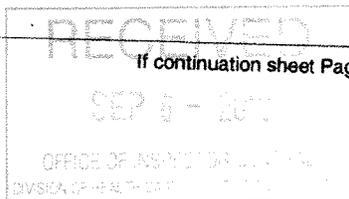
NAME OF PROVIDER OR SUPPLIER TREYTON OAK TOWERS	STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203
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F 000	INITIAL COMMENTS A standard health survey was initiated on 08/07/12 and concluded on 08/09/12. The Life Safety Code survey was conducted on 08/07/12. The highest scope and severity was an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to calibrate thermometers used to temp foods prior to serving foods in the Nursing Facility and the main dining. The facility failed to prevent the cross contamination from food item to food item, in addition, a staff member was observed buttering toast with bare hands. The findings Include: 1. Review of the facility's Dietetic Services Standards of Practice, dated 03/12, revealed the staff were to check the thermometer for proper	F 371		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: W. Service Moore TITLE: Administrator (X6) DATE: 8/31/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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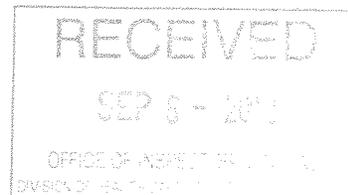
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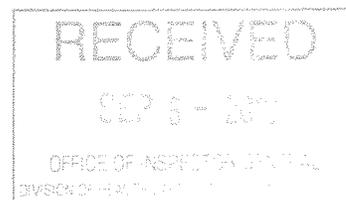
F 371	<p>Continued From page 1 calibration if it has been dropped or as least weekly.</p> <p>Observation of the food warmer holding the 2nd floor food items, in the main kitchen, on 08/08/12 at 10:54 AM, revealed the First AM Cook did not calibrate the thermometer before checking the foods for proper holding temperature greater than 150 degrees. Once the foods were tempted, the food was then transferred to the 2nd floor Tray line. Observation of the tray line on the 2nd floor, on 08/08/12 at 11:15 AM, revealed the Dietary Aid #1 did not calibrate her thermometer before use. Food Temperatures were documented to be above 150 degrees.</p> <p>Interview with Dietary Aid #1, on 08/08/12 at 11:42 PM, revealed no one had explained to her to calibrate the thermometer before taking the temperatures of the food. Dietary Aid #1 further stated she was not sure if the temperature of the tray line food was accurate if she did not calibrate her thermometer before use.</p> <p>Interview with the Certified Dietary Manager (CDM), on 08/08/12 at 11:35 PM, revealed she had been at the facility since January. The CDM stated she did not have a set time to calibrate thermometers and did not remember the last time the thermometers were calibrated. The CDM stated she had not taught the staff to calibrate the thermometers before tempting the foods on the tray line. The CDM further stated she could not provide evidence of any logs that the facility calibrated thermometers routinely.</p> <p>Interview with the Executive Chef, on 08/09/12 at 3:00 PM, revealed the staff was aware to</p>	F 371	<p>All food will be stored, prepared, distributed and served under sanitary conditions. In order to temp the foods prior to serving the foods in the nursing home, the thermometers will be calibrated before the first use and this will be recorded on the food temp log by the cook in the kitchen and the dipper on the nursing home floor. The Chef in the kitchen and the CDM will check weekly that this is being recorded and sign off on it. The Department Director will check this on a monthly basis and sign off on it. This will be reported to the QA Committee on a monthly basis for the next six months. A mandatory in-service for all food service employees hand-ling foods will be held to demonstrate the correct way to calibrate thermometers and the proper way of sanitizing them. This will be a documented in-service and will be conducted by the Registered Dietitian. (Copy of the Thermometer Calibration attached)</p>	8/30/12
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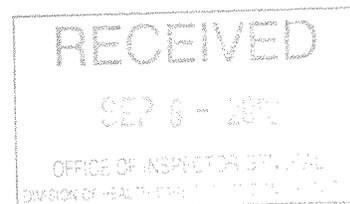
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F 371	<p>Continued From page 2</p> <p>calibrate thermometers daily and frequently as possible. The Executive Chef stated it was their practice to calibrate thermometers every other day.</p> <p>Interview with the Dietary Manager, on 08/09/12 at 3:10 PM, revealed she was not aware the staff was not calibrating their thermometers. The Dietary Manager stated she had seen her staff calibrate their thermometers in the Main Kitchen. She further stated she had in-services, but had not in-serviced on the calibration of thermometers. The Dietary Manager stated she knew the staff was aware the temperature danger zone and the staff were just assuming the temperature of the food was accurate since the thermometer was not calibrated.</p> <p>2. Review of the Food Safety During Preparation Practice Guideline, revealed employees should avoid touching ready-to-eat foods with their hands. Tongs (or other utensils) or gloves should be used instead. If gloves are worn, they should be clean, without tears, and changed between tasks. If employees must handle ready-to-eat foods with their bare hands, they should wash their hands according to procedure immediately.</p> <p>Observation of the tray line, on 08/08/12 at 11:45 AM, revealed Dietary Aid #1 touching roles and sandwiches and then touching plates and utensils. Observation of the Tray line on 08/08/12 at 12:02 PM revealed the Dietary Aid #1 garnished plates with strawberry halves while continuing to place roles and sandwiches on plates.</p> <p>Interview with Dietary Aid #1, on 08/08/12 at 1:35</p>	F 371	<p>2. In order to distribute and serve the food under sanitary conditions, employees should avoid touching ready-to-eat foods with their hands. Tongs or gloves should be used instead, and gloves should be changed between tasks. If employees must handle food with bare hands, they should use proper hand washing techniques. This will avoid cross contamination to other residents.</p>		



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F 371	<p>Continued From page 3</p> <p>PM, revealed she was taught to wash her hands before and after glove change. Dietary Aid #1 stated she was nervous and focused on the time that she did not pay attention to what she was doing at the tray line station. Dietary Aid #1 stated she usually used tongs at the work station in which she used to retrieve the bread items. She also stated germs were passed to other food items when you touched other objects.</p> <p>Interview with the Dietary Manager, on 08/09/12 at 3:10 PM, revealed the staff should use tongs for bread and strawberry items. The Dietary Manager stated the Dietary Aid could contaminate someone else, for example the strawberry's; the Dietary Manager stated she was allergic to them and would have had an allergic reaction from the strawberries if she would have eaten the bread that was touched by the same hand that touched the strawberries.</p> <p>Observation, on 08/08/12 at 8:30 AM, revealed a Certified Medication Technician (CMT) buttered unsampled Resident A's breakfast toast using her bare hands.</p> <p>Interview, on 08/08/12 at 2:20 PM, with the CMT revealed she should have put on gloves before she touched Resident A's toast. The CMT stated she had worked for the facility for about five (5) months, and had received training on hand hygiene, but had not received instructions regarding hand hygiene and glove use related to food service.</p> <p>Interview, on 08/09/12, at 4:10 PM, with the Director of Nursing (DON) revealed staff should wash their hands and put on gloves before</p>	F 371	<p>The Food Service Director and the Registered Dietitian and the CDM will in-service the employees on proper hand washing procedures. The importance of avoiding cross contaminating other resident's food will be stressed.</p> <p>The RD and the FDS and the DON will hold an in-service about the sanitary way of handling resident's food and the proper hand sanitizing procedures when serving food to the residents. This will be a mandatory in-service, documented for all the nursing employees.</p>	9/6/12	



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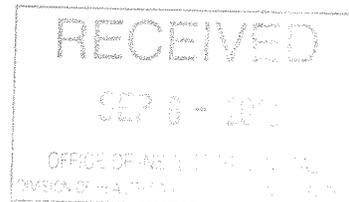
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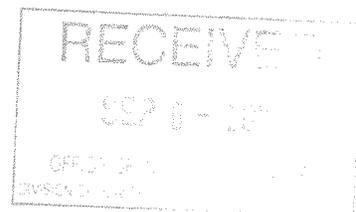
F 371	Continued From page 4 touching a resident's food. The potential problem with using bare hands to touch a resident's food would be the spread of infection to the resident.	F 371		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(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.</p> <p>(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 hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and</p>	F 441		



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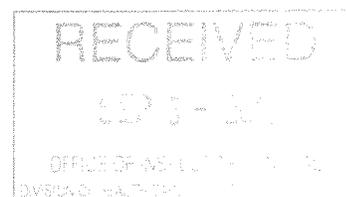
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F 441	<p>Continued From page 5 transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to wash their hands during skin assessments for two (2) of sixteen (16) sampled residents, Residents #2 and Resident #7.</p> <p>The findings include:</p> <p>Review, of the facility's hand washing policy, undated, revealed hands should be vigorously washed with soap and water, creating friction to all surfaces, rinsed thoroughly without touching fingertips to inside of sink, hands should be thoroughly dried, and then turn off faucets with a clean, dry paper towel.</p> <p>Observation, on 08/08/12 at 9:20 AM, revealed Licensed Practical Nurse (LPN) #2 washed her hands prior to Resident #2's skin assessment, turned off the sink's faucet handles with her elbow, and donned clean gloves. During the skin assessment LPN #2 removed her gloves and washed her hands three (3) additional times, and turned off the sink's faucet handles with her bare hands each time.</p> <p>Observation, on 08/08/12 at 9:45 AM, revealed LPN #2 washed her hands upon entering Resident #7's room, turned off the sink's faucet handles with her bare hands, donned clean gloves and began the skin assessment for</p>	F 441	<p>Resident #7 and Resident #2 have been assessed to assure that no negative outcomes have resulted from this deficient practice. No condition changes identified. To avoid recurrence of this deficient practice, licensed staff have been re-educated (in-serviced) in acceptable hand washing technique.</p> <p>Each Nursing Home Staff Member has been personally observed by the DON during resident skin assessments, resident meals and routine care for proper hand washing techniques to assure clinical competency. Certified Nursing Assistants and RN/LPN were in-serviced 8/15/12 and 8/16/12, with pre-testing and post testing and return demonstration 8/15/12 and 8/16/12. 100% compliance with facility policy and Standard Nursing Practice was observed.</p>	8/16/12	



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F 441	<p>Continued From page 6</p> <p>Resident #7. During the skin assessment LPN #2 removed her gloves, washed her hands six (6) additional times, and turned off the sink's faucet handles with her bare hands each time.</p> <p>Interview, on 08/08/12 at 2:15 PM, with LPN #2 revealed she should have turned off the faucet handles with her elbow or a paper towel after washing her hands. LPN #2 stated the Director of Nursing (DON) provided hand washing in-services at monthly staff meetings, and she knew the facility's hand washing policy was available for review at the nurses' station. LPN #2 stated the problem with using her bare hands to turn off the faucet handles would be cross contamination with the potential for spreading infection to Residents #2 and #7, other residents and staff.</p> <p>Interview, on 08/09/12 at 3:45 PM, with the DON revealed hands should be washed before and after giving care to the residents, and with each glove change throughout care procedures. Hands should be washed vigorously with soap and water and sink faucets should be turned off a paper towel to maintain the cleanliness of the hands. The DON stated the staff received hand washing reminders and instructions often related to tracking and trending of infections, as flu season approached, and any time issues with improper hand hygiene were identified. The DON stated the potential problem with not following the facility's policy for hand washing would be the spread of infection to other residents and staff members.</p>	F 441	<p>LPN #2 has been counseled by DON and acknowledges understanding that further non-compliance with facility policy and standard nursing practice will meet with disciplinary action. DON observation of LPN #2 hand washing technique on 8/16/12 revealed no breach of infection control standards and facility practice. LPN #2 will continue to be observed weekly for 4 weeks by DON. If 100% compliance maintained, random observations of hand washing technique will continue monthly x 3 months, then randomly thereafter by the DON.</p> <p>The orientation of new licensed employees has been revised to include personal observations of hand washing techniques by the DON/RN Supervisor to assure clinical competency.</p> <p>The DON will report monitoring results to monthly QA committee for further recommendations. (Attached is Hand washing guidelines, Post Test for employees on hand washing procedures, certificate for in-service)</p>	8/16/12



F 341 / N 283

Environmental Sanitation/Infection Control

Policy 9.60

Page 1 of 1

Subject: Calibration and Sanitizing Dial-Face Bi-Metal Food Thermometers

Policy: Food thermometers are routinely calibrated and sanitized.

Procedure:

Calibration

1. Thermometers are calibrated before their first use.
2. At regular intervals, at least once a week.
3. If dropped or when there is a question of accuracy, they are re-calibrated.
4. There are 2 methods for calibrating thermometers; by boiling point or using ice.

Boiling Point

Two inches of the thermometer stem is immersed in boiling water and adjusted to 212°F

Ice Method

Two inches of the thermometer stem is inserted into a cup of crushed ice. Sufficient cold water is added to remove air pockets between ice pieces. The thermometer is left in the ice/water slurry until temperature stabilizes and it is adjusted to 32°F.

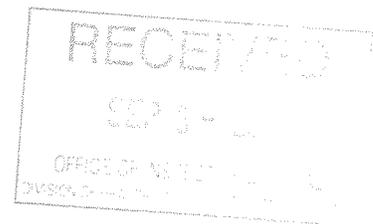
Calibration

Most dial-face thermometers have a nut directly behind the dial head. Pliers or a small wrench can be used to move the needle until it is at the appropriate temperature.

Sanitizing

Thermometers are sanitized to prevent cross-contamination. This is especially important when testing both raw and cooked foods.

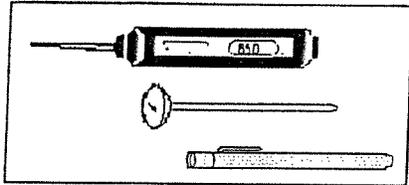
1. To sanitize the thermometer, remaining food particles are wiped off the stem.
2. The thermometer is placed in a sanitizing solution for at least 5 seconds and then air-dried.
3. If the thermometer is being used on only cooked or only raw foods, the stem of the unit can be sanitized by wiping it with an alcohol wipe and allowing it to air dry.



F 391 / N 283

Martha Gregory and Associates, Inc.
3010 Taylor Springs Drive
Louisville, Kentucky 40220
(502) 458-4588

FOOD THERMOMETER CLEANING PROCEDURES



Recommended Equipment:

Digital Pocket Thermometers
Pocket Thermometers

Recommended Products:

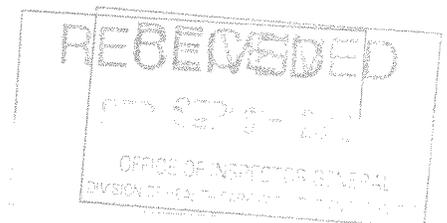
Pot & Pan Detergent
Chlorine Bleach or Quat Sanitizer
Chlorine test strips or Quat test strips

Cleaning Procedures:

1. Wash probe section of thermometer in detergent.
2. Rinse in clean water.
3. Sanitize in chlorine bleach (100 ppm) or quaternary sanitizer (200 ppm) for 30 seconds.
4. Air dry thermometer.
5. Clean & sanitize between temperature testing.

THERMOMETERS

Clean Between Uses



F 441 / N 150

Handwashing

Protective Barriers

Purpose

The purpose of this procedure is to provide guidelines to employees for proper and appropriate handwashing techniques that will aid in the prevention of the transmission of infections.

Objectives

To prevent the spread of infectious diseases.

Equipment and Supplies

1. Running water;
2. Soap (liquid or bar);
3. Paper towels;
4. Trash can;
5. Lotion; and
6. Waterless antiseptic solution (as indicated).

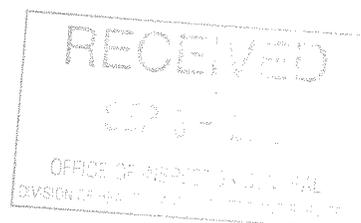
Miscellaneous

1. If bar soap is used for handwashing, it must be kept on a strainer that allows for drainage to insure that the soap does not remain in a puddle of water. If liquid soap is used, reservoirs must be discarded when empty. If refillable, they must be emptied and cleaned, rinsed and dried, and never topped off with additional soap.
2. The use of gloves does not replace handwashing.
3. A waterless antiseptic solution may be used as an adjunct to routine handwashing.

When to Wash Hands

Appropriate ten (10)- to fifteen (15)-second handwashing must be performed under the following conditions:

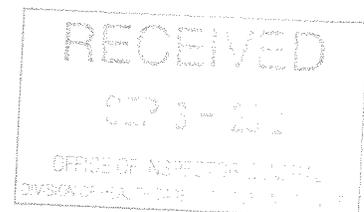
1. Upon reporting for work;
2. Whenever hands are obviously soiled;
3. Before performing invasive procedures;
4. Before preparing or handling medications and/or food products;
5. After having prolonged contact with a resident;
6. After handling used dressings, specimen containers, contaminated tissues, linen, etc.;
7. After contact with blood, body fluids, secretions excretions, mucous membranes, or broken skin;
8. After handling items potentially contaminated with a resident's blood, body fluids, excretions or secretions;
9. After removing gloves;
10. After using the toilet, blowing or wiping the nose, smoking, combing the hair, etc.;
11. Before and after eating;
12. Whenever in doubt; and
13. Upon completion of duty.



F/44 / W150

Procedure Guidelines

1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for ten (10) to fifteen (15) seconds under a moderate stream of running water, at a comfortable temperature. Hot water is unnecessarily rough on hands.
2. Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to inside of sink.
3. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel.
4. Discard towels into trash.
5. As an adjunct to routine handwashing, an antiseptic solution may be applied to the hands after proper handwashing.
6. In areas/rooms where sinks are not readily available, a waterless antiseptic hand preparation may be used between tasks that would normally require handwashing unless the hands are visibly soiled. (**Note:** Hands should be washed with soap and water at the first opportunity.)
7. Lotions should be used throughout the day to protect the integrity of the skin.



F 441/N150

POST-TEST

1. I should use my bare hands to turn the water off and on.

True

False

2. The following is the length of time it takes to properly wash my hands.

5 to 15 seconds

10 to 20 seconds

30 to 40 seconds

15 to 30 seconds

3. When rinsing my hands, I should allow the water to run off my finger tips?

True

False

4. Which is the preferred soap to use when performing hand hygiene?

Bar soap

Liquid antibacterial or antimicrobial soap

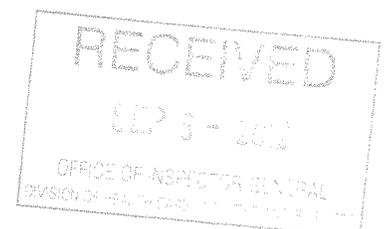
Dish soap

Body wash and shampoo

5. I can do my part to stop the spread of infection by proper hand washing?

True

False



HANDWASHING STEPS

- Use only a designated handwashing sink
- Use warm running water
- Wet hands & arms up to elbows
- Apply dispenser soap or detergent
- Rub hands and forearms vigorously for at least 10-15 seconds
- Scrub back of hands, between fingers and under nails
- Rinse thoroughly under running water
- Dry hands and arms using a single-service towel or hot air dryer
- Use the towel to turn off the faucet



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F 441/N 150

THIS CERTIFIES THAT

HAS PARTICIPATED IN THE
PERSONAL HYGIENE & HANDWASHING

INSERVICE TRAINING PROGRAM

PRESENTED THIS 15th DAY OF August, 2012

AT Treyton Oak Towers

SIGNED Katrinlea Whitney

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DIVISION OF HEALTH SERVICES

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185175	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/07/2012
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NAME OF PROVIDER OR SUPPLIER TREYTON OAK TOWERS	STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203
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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: 1983</p> <p>Survey under: 2000 existing</p> <p>Facility type: S/NF DP on the second floor of a Health Care facility.</p> <p>Type of structure: Twelve (12) stories, Type II protected construction.</p> <p>Smoke Compartment: Four (4) smoke compartments.</p> <p>Fire Alarm: Complete fire alarm system with heat and smoke detectors.</p> <p>Sprinkler System: Complete automatic (wet) sprinkler system, hydraulically designed.</p> <p>Generator: Type II, 275 KW generator, fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 08/07/12. The skilled nursing facility located on the second floor of Treyton Oak Tower was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE W. Derrick Moore TITLE Administrator (X6) DATE 8/31/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

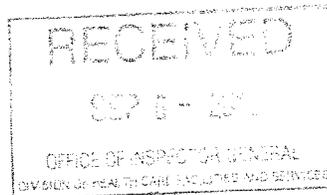
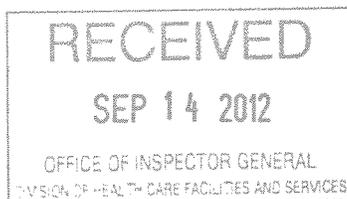
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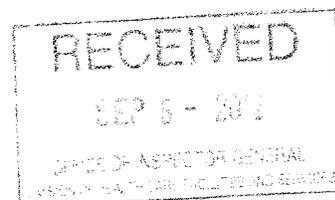
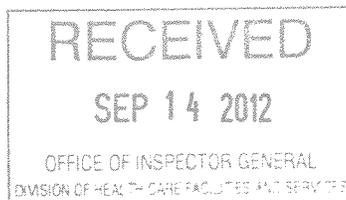
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K 000	Continued From page 1 Fire).	K 000		
K 029 SS=E	Deficiencies were cited with the highest deficiency identified at F level. NFFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, twenty-two (22) residents, staff and visitors. The facility has sixty (60) certified beds and the census was fifty-seven (57) on the day of the survey. The findings include: Observation, on 08/07/12 at 9:30 AM, with the Director of Facility Operations revealed the door	K 029	All maintenance personal were in-serviced by the Director of Maintenance on the NFFPA requirements that all areas greater than 50 sq. ft. are separated from other areas with doors having self-closing devices. Southern Ohio Door Co. has installed a door closure on the door in question. Proper protection of Hazards, ie. doors with self closing devices has been added to the monthly inspection report of the Maintenance Department. These reports are reviewed by the Safety Committee and the QA Committee. The Director of Maintenance and the Administrator will review this report once a month to see compliance.	8/30/12



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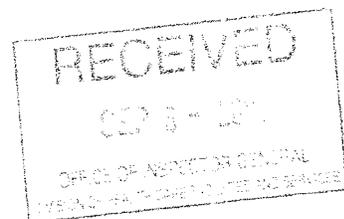
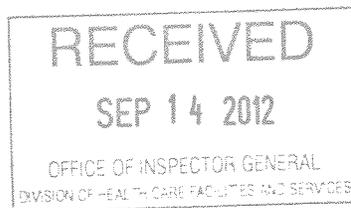
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K 029	<p>Continued From page 2</p> <p>to the storage room located within Service Room 257 did not have a self-closing device installed on the door.</p> <p>Interview, on 08/07/12 at 9:30 AM, with the Director of Facility Operations revealed the door had never been equipped with a self-closing device. He acknowledged that the room was slightly greater than fifty (50) square feet in area and required to have a self-closing device installed.</p> <p>Observation, on 08/07/12 at 10:40 AM, with the Director of Facility Operations revealed the storage room located across the corridor from the Therapy Department had a hole in the ceiling where an exposed drain line passed through. The hole was slightly greater than the pipe diameter and would not resist the passage of smoke in the event of a fire.</p> <p>Interview, on 08/07/12 at 10:40 AM, with the Director of Facility Operations revealed he was unaware of the penetration in the ceiling not being sealed smoke tight and acknowledged the room would not resist the passage of smoke in the event of a fire.</p> <p>Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided</p>	K 029	<p>The penetration through the ceiling in the storage room located 8/7/12 across from the Therapy Dept. was sealed on 8/7/12. The Maintenance staff were in-serviced to check for any penetrations which would allow passage of smoke in the event of a fire. These are to be noted on the monthly inspection forms which are checked by Director of Maintenance.</p>	8/15/12	



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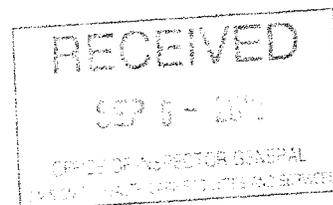
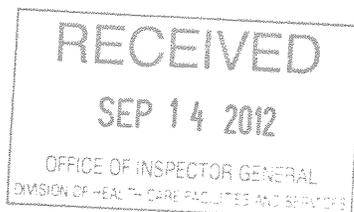
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K 029	Continued From page 3 with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062			



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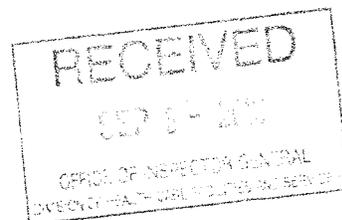
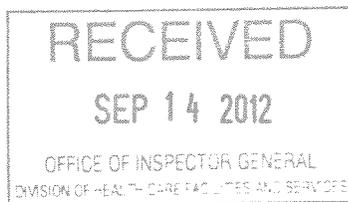
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K 062	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure the sprinkler system was being maintained and tested in accordance with NFPA standards. The deficiency had the potential to affect each of the four (4) smoke compartments, all residents, staff and visitors. The facility has sixty (60) certified beds and the census was fifty-seven (57) on the day of the survey.</p> <p>The findings include:</p> <p>Record review, on 08/07/12 at 11:50 AM, with the Director of Facility Operations revealed the last interior pipe inspection for the automatic sprinkler system was unknown. This inspection must be done once every five years.</p> <p>Interview, on 08/07//12 at 11:50 AM, with the Director of Facility Operations revealed he was not aware the interior pipe inspection of the automatic sprinkler system had not been performed within the past five (5) years.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection,</p>	K 062		



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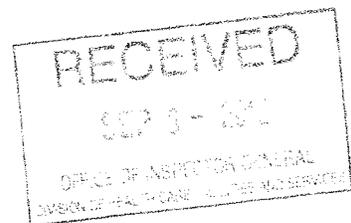
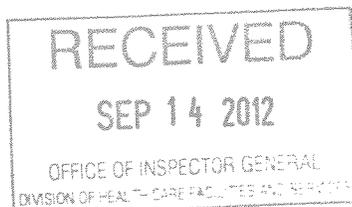
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K 062	Continued From page 5 testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years	K 062		



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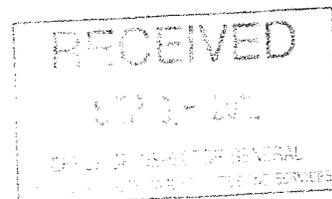
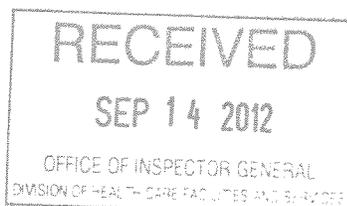
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K 062	Continued From page 6 thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections. 10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. NFPA 101 LIFE SAFETY CODE STANDARD	K 062	The interior pipe inspection for the automatic sprinkler system must be performed once every five years to ensure the safety of the residents, employees, and visitors. Midwest Sprinkler Corp. was contacted to perform the Interior pipe inspection during their September inspection of the sprinkler system. The five (5) year interval has been added on the sprinkler inspection report folder on 8/10/12 so that future 5 year inspections will be performed. This will be monitored by the Director of Maintenance and reported to the QA committee.	8/10/12
K 076 SS=D	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076		



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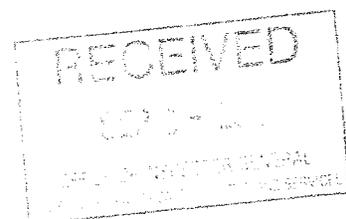
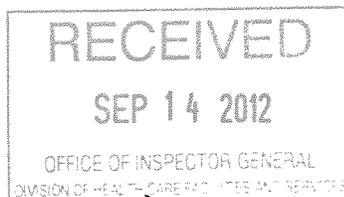
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K 076	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored in accordance with NFPA standards. The deficiency had the potential to affect each of the four (4) smoke compartments, all residents, staff and visitors. The facility has sixty (60) certified beds and the census was fifty-seven (57) on the day of the survey. The findings include: Observation, on 08/07/12 at 10:15 AM, with the Director of Facility Operations revealed four (4) empty and three (3) partially full oxygen cylinders located within the oxygen storage room, were not placed in a rack to prevent falling or being knocked over and not clearly separated as empty or full cylinders. Interview, on 08/07/12 at 10:15 AM, with the Director of Facility Operations revealed he was unaware of oxygen cylinders being improperly stored and acknowledged the potential hazard involved. Further interview, on 08/07/12 at 10:25 AM, with the Unit Secretary of the area where the oxygen storage room was located, revealed the room was typically kept per Code requirements. It was	K 076	Oxygen cylinders must be properly stored to prevent harm to the residents, employees, and visitors. The Unit Secretary is responsible for the storage area containing the oxygen cylinders and will understand the importance of the proper storage of the cylinders. A checklist has been posted in the oxygen storage room on 8/28/12 which the Unit Secretary will check off daily Monday through Friday. Separate racks for storage of empty and full containers have been placed in opposite corners of the area and marked for the empty and full containers. This area has been added to the Maintenance checklist as a monthly follow-up and will be checked by the Director of Maintenance. (Checklists are attached)	8/28/12



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K 076	Continued From page 8 indicated the room was used by both the Staff at the central Nurse's Station and the Staff at the newly expanded Therapy Department. Reference: NFPA 99 (1999 Edition). 4-3.1.1.2 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use. 4-3.5.2.2 2. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. 4-5.1.1.1 Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over.	K 076		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical	K 147		



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NAME OF PROVIDER OR SUPPLIER TREYTON OAK TOWERS			STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 147	<p>Continued From page 9</p> <p>wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, twenty-one (21) residents, staff, and visitors. The facility has sixty (60) certified beds and the census was fifty-seven (57) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 08/07/12 at 11:30 AM, with the Director of Facility Operations revealed two (2) power strips were being used in resident room 252. The power strip plugged into the duplex outlet on the West wall was used to power a computer, a monitor, a router and a printer. The power strip plugged into a duplex outlet on the South wall was used to power a lamp, a fan, a telephone, a paper shredder and a pencil sharpener.</p> <p>Interview, on 08/07/12 at 11:30 AM, with the Director of Facility Operations revealed he was not aware of the misuse of power strips in resident room 252.</p> <p>Reference: NFPA 99 (1999 edition) 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>	K 147	<p>An in-service was given by the Director of Maintenance to the Maintenance department and the nursing department on the use of electrical wiring and equipment in accordance with NFPA 70.</p> <p>The misuse of power strips has been added to the Resident Admission Packet by the administrator. An additional category was added to the Maintenance checklist for the Nursing Home rooms and will be checked monthly by the Director of Maintenance to make sure compliance with the NFPA 70. The results will be reported and monitored by the Safety Committee and the results will be presented to the QA Committee on a monthly basis for 6 months. If compliance is achieved 100% for six months, then the Director of Maintenance will monitor and present the findings to the QA committee on a yearly basis.</p> <p>Ready Electric has installed permanent outlet strips on an additional circuit for the power strip in question in Resident Room 252.</p>		8/28/12

