

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

PRINTED: 12/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/21/2015
NAME OF PROVIDER OR SUPPLIER GEORGETOWN MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 900 GAGEL AVENUE LOUISVILLE, KY 40216		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 12/11/15 as alleged.	{F 000}		

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

TITLE

(X6) DATE

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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185096	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 12/21/2015
Name of Facility GEORGETOWN MANOR		Street Address, City, State, Zip Code 900 GAGEL AVENUE LOUISVILLE, KY 40216

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0246</u> Reg. # <u>483.15(e)(1)</u> LSC _____	Correction Completed 12/11/2015	ID Prefix <u>F0502</u> Reg. # <u>483.75(l)(1)</u> LSC _____	Correction Completed 12/11/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>my</u> State Agency	Reviewed By <u>14</u>	Date: <u>12/22/15</u>	Signature of Surveyor: <u>Stellie Zimola</u>	Date: <u>12/22/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on:
12/3/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

RECEIVED

PRINTED: 12/16/2015
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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2015
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NAME OF PROVIDER OR SUPPLIER GEORGETOWN MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 900 GAGEL AVENUE LOUISVILLE, KY 40216
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F 000	INITIAL COMMENTS	F 000		
F 246 SS=E	<p>A Recertification Survey was initiated on 12/01/15 and concluded on 12/03/15 and found the facility not meeting the minimum requirements for recertification with deficiencies cited at the highest scope and severity of an "F".</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</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 ensure resident call lights were accessible while the residents were in their rooms for two (2) of twenty (20) sampled residents and six (6) of eight (8) unsampled residents, Residents #2 (Room 156 A) and #7 (Room 106 A) and Unsampled Residents A (Room 143 A), B (Room 123 A), C (Room 123 B), D (Room 125 A), E (Room 128 A) and F (Room 128 B). The residents' rooms were on four (4) of five (5) nursing units.</p> <p>The findings include: Review of the facility's policy regarding Call Lights, not dated, revealed the purpose of the</p>	F 246	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. The plan of correction constitutes our credible allegation of compliance.</p> <p>F-246 Reasonable accommodation of needs/preferences S/S=E</p> <p>I. Call lights are accessible for Resident #2, #7, and un-sampled Residents A, B, C, D, E and F.</p> <p>II. Residents have been checked and call lights are accessible.</p> <p>III. On 12/04/15, the nursing staff was in-serviced by the Staff Development Coordinator on call lights being accessible to residents.</p> <p>IV. The Director of Nursing and/or Staff Development Coordinator will complete random audits for call light accessibility weekly for 4 weeks, then monthly for 2 quarters. The results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.</p> <p>V. Completion Date:</p>	12/11/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ronald Bell</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12/21/15</i>
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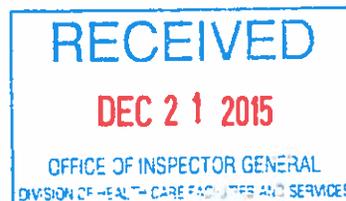
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SW

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F 246	<p>Continued From page 1</p> <p>policy was to provide the resident with a means to request assistance.</p> <p>Observation of Room 123 A, on 12/01/15 at 9:00 AM, revealed Unsampld Resident B's call light was draped over the wall outlet on the opposite side from Unsampld Resident B seated in a wheelchair at the windows.</p> <p>Interview with Unsampld Resident B, on 12/01/15 at 9:02 AM, revealed the resident could not reach the call light to summon staff help if it was needed.</p> <p>Review of a Minimum Data Set (MDS), dated 10/30/15, revealed the facility assessed Unsampld Resident B with a Brief Interview for Mental Status (BIMS) with a score of nine (9) meaning moderately impaired cognition and the resident would be interviewable.</p> <p>Interview with CNA #12, on 12/01/15 at 9:07 AM, revealed the call light was not accessible to the resident in Room 123 A and it should have been. She stated she had been taught to never leave a resident's room without ensuring the call light was accessible and she thought the aide who took the resident back to his/her room after breakfast had failed to do so.</p> <p>Observation of Room 128 A, on 12/01/15 at 9:10 AM, revealed Unsampld Resident E was seated in a wheelchair with his/her call light on the floor on the opposite side of his/her bed.</p> <p>Interview with Unsampld Resident E, on 12/01/15 at 9:12 AM, revealed the resident did not know where the call light was and could not reach the call light if he/she needed help.</p>	F 246		



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F 246	<p>Continued From page 2</p> <p>Review of a Minimum Data Set (MDS), dated 09/30/15, revealed the facility assessed Unsampled Resident E with a Brief Interview for Mental Status (BIMS) with a score of eight (8) meaning moderately impaired cognition and the resident would be interviewable.</p> <p>Observation of Room 106 A, on 12/01/15 at 9:40 AM, revealed Resident #7's call light was tied to the bed's siderail opposite the resident seated in a wheelchair.</p> <p>Interview with Resident #7, on 12/01/15 at 9:41 AM, revealed he/she could not reach the call light to contact the staff if he/she needed assistance. Resident #7 stated the staff had left the room without ensuring he/she could reach the call light.</p> <p>Review of a Minimum Data Set (MDS), dated 10/10/15, revealed the facility assessed Resident #7 with a Brief Interview for Mental Status (BIMS) with a score of fifteen (15) meaning cognitively intact and the resident would be interviewable.</p> <p>Observation of Room 143 A, on 12/03/15 at 10:25 AM, revealed Unsampled Resident A was seated in a wheelchair by his/her bed with no access to the call light. The resident's call light was observed hanging from the upper siderail on the bed opposite the resident.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, on 12/03/15 at 10:30 AM, revealed the call light was not accessible to the resident in Room 143 A and it should have been. She stated she had been told in orientation the resident always had to have the call light in reach. CNA #2 stated she thought the call light was not in reach</p>	F 246			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER GEORGETOWN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 900 GAGEL AVENUE LOUISVILLE, KY 40216		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 248	Continued From page 3 because she had been in a hurry to do her work. Observation of Room 156 A, on 12/03/15 at 10:40 AM, revealed Resident #2 was lying supine in bed with eyes closed. Resident #2's call light was lying on the floor under the chair by the head of the bed and was not accessible to the resident. Interview with LPN #1, on 12/03/15 at 10:43 AM, revealed the resident's call light should always be accessible and the staff had just been in too big a hurry to ensure the call light was in reach of the resident in Room 143 A. LPN #1 stated she was a nursing supervisor and she tried to make rounds on her unit every two (2) hours when she was working; however, her rounds did not always get done. LPN #1 also stated she had not noticed if the call lights were in reach of the residents when making her rounds and she did not document the accessibility of resident call lights. LPN #1 further stated she knew it was part of her responsibility to ensure call lights were accessible to residents, but she did not monitor that issue every time she rounded and she depended on the aides to ensure the accessibility of call lights. Interview with the Director of Nursing, on 12/03/15 at 2:00 PM, revealed she monitored the nursing units and her staffs' work once every month which was documented but call light accessibility was not on that monitoring document. She stated she had given the responsibility of monitoring the accessibility of call lights to the CNA's and the unit nurse managers who were trained in orientation to ensure the accessibility of call lights.	F 246			
F 502	483.75(j)(1) ADMINISTRATION	F 502			



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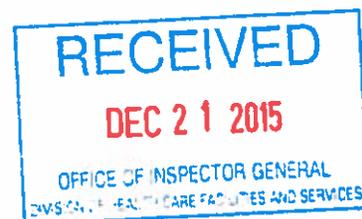
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
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F 502 SS=F	<p>Continued From page 4</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to have an effective system in place to monitor for expired Vacutainers in two (2) of two (2) medication rooms.</p> <p>The findings include:</p> <p>The facility had no procedure for monitoring and documenting that audits were completed to check for expired Vacutainers.</p> <p>Observations, on 12/02/15 at 1:15 PM, on the North Nursing Unit revealed in the medication room thirty-seven (37) orange top Vacutainers, forty-one (41) blue top Vacutainers, five (5) red Vacutainers, and four (4) pink Vacutainers for a total of 87 Vacutainers had expired between January 2015 and September 2015.</p> <p>Observations, on 12/02/15 at 1:25 PM, on the South Nursing Unit revealed sixty (60) blue Vacutainers, nine (9) orange Vacutainers, forty (40) pink Vacutainers, and nine (9) red Vacutainers had expired between October 2014 and April 2015 for a total of 118 Vacutainers.</p> <p>Interview with the Director of Nursing (DON), on 12/02/15 at 1:30PM, revealed the night shift nurse was supposed to check for expired</p>	F 502	<p>F-502 Administration S/S=F</p> <p>I. The Director of Nursing immediately removed the expired lab supplies on 12/03/15.</p> <p>II. The Director of Nursing and Unit Managers inspected both nursing medication rooms and supply area for expired lab supplies.</p> <p>III. On 12/03/15, the Director of Nursing and Staff Development Coordinator were in-serviced by the Administrator on monitoring for expired lab supplies. The Unit Managers and licensed nurses were in-serviced on 12/03/15 by the Director of Nursing and Staff Development Coordinator on monitoring for expired lab supplies. The lab company was contacted and delivered new lab supplies. A lab audit sheet was implemented to monitor for expiration dates.</p> <p>IV. The Director of Nursing, Unit Managers and/or Staff Development Coordinator will complete random audits of lab supplies in both medication/supply areas weekly for 4 weeks, then monthly for 2 quarters. The results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.</p> <p>V. Completion Date:</p>	12/11/2015	



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NAME OF PROVIDER OR SUPPLIER GEORGETOWN MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 900 GAGEL AVENUE LOUISVILLE, KY 40216		
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F 502	<p>Continued From page 5</p> <p>vacutainers, but there was no follow-up to ensure this was done. Neither the North nor the South Nursing Unit Managers were assigned to monitor the vacutainers.</p> <p>Interview with the North Unit Nurse Manager, on 12/03/15 at 9:00 AM, revealed the night shift nurse was to check for expired Vacutainers, but there was no specific time or date this was to be done and no documentation tool to validate the monitoring had been done.</p> <p>Interview with the South Unit Nurse Manager, on 12/03/15 at 2:55 PM, revealed she had no monitoring system in place and there was no date or time requirements for the night nurse to validate the Vacutainer checks.</p>	F 502		



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NAME OF PROVIDER OR SUPPLIER GEORGETOWN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 900 GAGEL AVENUE LOUISVILLE, KY 40216	
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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: 1968</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story, with a partial Basement, Type V (111).</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete, automatic dry sprinkler system.</p> <p>GENERATOR: Type II, 60 KW generator. Fuel source is natural gas.</p> <p>A Recertification Life Safety Code Survey was conducted on 12/01/15. The facility was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000		

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

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