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APR 14 2010
INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

PRINTED: 03/29/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED.
	185442	A. BUILDING _____ B. WING _____	03/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART VILLAGE	2120 PAYNE STREET LOUISVILLE, KY 40206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted 03/16/10 through 03/18/10 and Life Safety Code survey was conducted on 03/17/10. 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	F157 revised 4/13/2010 This plan of correction constitutes our facility's credible allegation of compliance for all cited deficiencies. Nothing in this plan of correction should be construed to constitute an admission by the facility of any violations of state and federal statutes, regulations or standards of care. This plan of correction is being completed solely for the purpose of complying with the state and federal requirements.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	**What corrective action will be accomplished for those residents found to have been affected?** For resident # 12, the attending physician was notified on 3/18/2010 and a chest x-ray was obtained. **How will the facility identify other residents having the potential to be affected?** *A review of* the medical record of or current residents *was completed on 4/8/2010* to identify *any* potential residents with a history of reactive	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Martha Workman | TITLE: Administrator | (X6) DATE: 4-13-2010

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

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F 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined the facility failed to consult with the attending physician regarding a positive reaction to, tuberculin skin test (PPD serum), for one (1) of twenty-two (22) sampled residents (#12). The findings include: Record review of the facility policy titled Change in a Resident's Condition or Status on 03/18/10 revealed the nursing services would notify the resident's attending physician when there was a need to alter the resident's treatment significantly. Review of the clinical record on 03/16/10 revealed Resident #12 was admitted on 02/20/10 with a history of a closed femur fracture, acute myocardial infarction, urinary retention, diabetes, hypertension, hyperlipidemia, and hypothyroidism. The facility assessed the resident as without any cognitive or memory impairments on the admission assessment dated 03/05/10. Record review of the Nurse's Notes dated 02/21/10 revealed Resident #12 told Licensed Practical Nurse (LPN) #5 that he/she was a positive reactor to tuberculin skin testing (PPD). The Nurse's Note written by LPN #5 continued to state, "this will be researched for accuracy." No documentation could be produced by the facility indicating a follow-up to the resident's report or that the attending physician had been notified.	F 157	TB test ***and the allergy and immunization record of residents found to have a history of a reactive TB test was updated to reflect this information.*** **What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur?** ***The policy, "Change in a Resident's Condition or Status", was reviewed on 4/9/2010 and the protocol for notifying the attending physician of a change in the resident's condition now includes "a reaction to medication, a positive TB test or history of a reactive TB test". The licensed nursing staff, i.e., RNs and LPNs will be in-serviced on the revised policy beginning 4-11-2010.*** **How does the facility plan to monitor its performance to ensure that solutions are sustained?** The Nursing Supervisors will review and monitor 100% of all new admissions with in 24 hours of admission to ensure an order for a chest x-ray is obtained for residents	

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F 157	Continued From page 2 Observation of Resident #12's right forearm on 03/17/10 revealed a 2-3mm induration where the resident had received a PPD test. Telephone interview with LPN #5 on 03/17/10 at 12:20pm revealed normally he did pass pertinent resident information onto the oncoming shift for follow-up, but apparently no one followed up on Resident #12's possible reaction to PPD serum. The LPN also stated he did not follow up on his next shift nor was he aware if the physician was notified. Interview with the Director of Nurses (DON) on 03/18/10 at 2:15pm revealed LPN #5 should have notified the physician on 02/21/10 when the resident voiced a concern over receiving the PPD test.	F 157	with a history of reactive TB test ***and appropriate action taken to correct identified concerns as needed. Each month the medical record of long term residents whose annual TB test is due will be reviewed, by Nursing Supervisor or designee, to ensure TB test, screening questionnaire or chest x-ray was given.*** A report of the findings of these reviews will be submitted to the QA committee for ***review, analysis, recommendations and follow up.*** The QA committee may amend or make alterations to this plan as needed to ensure compliance.	4-15-2010
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure the dining room chairs were sturdy and arms secure, the facility failed to repair caulking around the sinks in Room 505 and Room 517, the facility failed to ensure an accessible call system in the public restrooms by the main entrance utilized by residents. Observation during the environmental tour on 03/16/10 at 5:25pm revealed three (3) chairs, in	F 253	**What corrective action will be accomplished for those residents found to have been affected?** The chairs identified in the causal dining room by resident #25 were inspected by maintenance personnel on 3/18/2010 and 3/19/2010 and any chairs found to have loose joints or in need of other repairs were repaired or eliminated from use in the facility	

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F 253	Continued From page 3 the Casual Dining Room, with loose, wobbly arms, with displaced and/or loose bracing on the legs, leaving the chairs unsteady, and wobbly. Interview with Resident #23 on 03/16/10 at 5:25pm revealed concerns with the loose arms on the chair the resident was sitting in. The resident reported the chairs have been wobbly and loose for some time. The resident demonstrated the loose chair arms by shaking the arms of the chair during dinner. The resident reported the chairs are too wobbly for anybody to sit in. Interview with the Director of Maintenance on 03/18/10 at 11:20am revealed he was not aware the chairs in the Casual Dining Room were of concern. He reported the chairs were brought there about two (2) weeks prior. He reported the arms and legs on the chairs are loose and unsteady for use. Observation during the environmental tour on 03/17/10 at 9:43am revealed the following; in Resident Room 505 a five (5) inch strip of missing caulking on the splash board base, and in Resident Room 517 a four (4) inch strip of missing caulking on the splash board base. Interview with the Director of Maintenance on 03/18/10 at 11:22am revealed a recent caulking job was done throughout the facility in 11/09, and he was unsure why the caulking was missing and not sealed. He reported this was a source for infection control concerns. Observation during the environmental tour on 03/16/10 at 1:15pm revealed two (2) rest rooms, located near the main entrance and the conference room, had a call light system that was	F 253	The caulking in rooms 505 and 517 was repaired on 3/18/2010. The call light system in the two rest rooms located near the main entrance will be lowered to a level that is in reach for a person on the floor and unable to get up. **How will the facility identify other residents having the potential to be affected?** The chairs in resident rooms and dining rooms throughout the facility were inspected by the maintenance personnel on 3/18/2010 and 3/19/2010 and any chairs found to have loose joints or in need of other repairs were repaired or eliminated from use in the facility. The caulking in the bathrooms of resident rooms throughout the facility was reviewed and no other rooms were found to need repairs to the caulking.	

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F 253	Continued From page 4 out of reach for a person in the floor and unable to get up. Interview with the Director of Maintenance on 03/18/10 at 11:45am revealed he had not thought about someone in the floor not being able to reach the button on the wall to call for help. He reported a person in the floor would not be able to call for help in the rest rooms near the conference room and the main lobby. He reported the rest rooms are accessible to the residents for use when they are in that area of the facility.	F 253	The call light system in the two rest rooms located near the main entrance will be lowered to a level that is in reach for a person on the floor and unable to get up. See additional page	4-15-2010
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;	F 272		

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F253 Continued

How will the facility identify other residents having the potential to be affected?

The chairs in resident rooms and dining rooms throughout the facility were inspected by the maintenance personnel on 3/18/2010 and 3/19/2010 and any chairs found to have loose joints or in need of other repairs were repaired or eliminated from use in the facility.

The caulking in the bathrooms of resident rooms throughout the facility was reviewed and no other rooms were found to need repairs to the caulking.

The call light system in the two rest rooms located near the main entrance will be lowered to a level that is in reach for a person on the floor and unable to get up.

What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur?

The chairs in the resident rooms and dining rooms will be added to the preventive maintenance program. Chairs will be inspected 2 x per month and repairs made as necessary. Inspections, including action steps taken to repair will be documented by maintenance personnel conducting the review.

Review of the caulking will be included on the monthly room inspection audit and any identified areas of concern will be reported on a work order for repair by maintenance staff.

How does the facility plan to monitor its performance to ensure that solutions are sustained?

Findings of the inspections will be reported monthly to the QA committee by maintenance director or designee. The QA committee will review the findings and make any recommendations or revisions to the plan as may be needed to ensure solution is sustained.

The room inspection audits will be reviewed in the Safety committee for patterns and trends. A report of the findings will be submitted to the QA committee monthly and action plans will developed as necessary.

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F 272	Continued From page 5 Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to utilize the Resident Assessment Instrument (RAI) process including the Pressure Resident Assessment Protocol (RAP) to assess a stage IV pressure area for one (1) of twenty-two(22) sampled residents (#22). The findings include: Review of the closed clinical record for Resident #22 revealed an admission date of 12/28/09 with diagnoses of; Malignant Neoplasm of the Prostate with secondary Neoplasm of the bone and Diabetes. The resident expired on 02/12/10. The admission MDS (Minimum Data Set) dated 01/05/10 indicated the resident had one (1) stage I and one (1) stage IV pressure area. Review of the Pressure RAP indicated the resident had a stage I pressure area on the coccyx. Review of the Admission History and Physical dated 12/31/09 revealed the resident had developed some Stage I and Stage II pressure ulcers on the coccyx and bottom. The hospital discharge summary dated 12/28/09 indicated the resident had three wounds; on the coccyx and two on the right lower leg. Review of the plan of care revealed the resident had the potential for skin breakdown.	F 272	F272 revised 4-13-2010 **What corrective action will be accomplished for those residents found to have been affected?** Resident #22 is no longer in the facility. **How will the facility identify other residents having the potential to be affected?** The MDS nurse will review the RAI including Pressure RAP of all residents that currently have pressure ulcers to ensure the Pressure RAP has been utilized appropriately and correctly. Any pressure RAP found to be incorrect will be corrected. **What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur?** The MDS nurses will be in-serviced on ***4-13-2010 on*** the Pressure RAP components of the RAI. ***This in-service will be provided by the Assistant Administrator/RN.*** For all residents identified pressure ulcers, whose MDS is under review, the MDS nurses will be responsible for reviewing the pressure RAP done by each other to ensure the RAP has been utilized appropriately. An audit tool will be developed to document this review.	4-15-2010

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F 272	Continued From page 6 Interview with Minimum Date Set (MDS) Registered Nurse #2 on 03/18/10 at 3:00pm revealed the Stage IV pressure area should have been addressed in the Pressure RAP and was not sure why it was not. RN #2 stated it may have been over looked. The nurse could not state what the potential for the resident was if a Stage IV pressure area was not further assessed utilizing the Pressure RAP. Interview with the MDS RN #1 on 03/18/10 at 3:00pm revealed the Stage IV pressure ulcer should have been addressed in the Pressure RAP to determine if all interventions had been analyzed. RN #1 confirmed the resident had been identified on admission as having a Stage IV pressure on the right outer foot; however, the facility failed to further assess and review the resident's care.	F 272		
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 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	F 279	F 279 revised 4-13-2010 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 22 is no longer at the facility. Resident #15's plan of care and CNA care card were updated to appropriately reflect proper lift to be used with the resident on 3/16/2010.	

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F 279	Continued From page 7 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to develop, review, and revise plans of care for two (2) of twenty-two (22) sampled residents (#15, #22). Resident #15's plan of care did not include a mechanical standing lift for the resident during transfers as assessed on admission. Resident #15 was transferred by staff using a stand-pivot transfer. Resident #22 was admitted to the facility with Stage IV and Stage I pressure areas that were not addressed in the plan of care for the resident. The findings include: Review of the facility's policy Care Plans - Comprehensive dated 08/01/05 indicated the comprehensive care plan included medical and nursing needs developed for each resident. In addition, it shall reflect treatment goals and objectives in measurable outcomes, incorporate identified problem areas and risk factors associated with the problem areas. Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information. In addition, any area of difficulty or concern that prevents the resident from reaching his/her fullest potential are identified and must be stated in behavioral and/or functional terms associated with the diagnoses or symptoms with the specific action(s) or interventions that the staff will take to assist the resident in meeting/achieving the short-term goal(s).	F 279	**How will the facility identify other residents having the potential to be affected?** Nursing personnel, as designated by the DON, will review current residents lift assessments for appropriateness and the care plans and or CNA care card of those residents identified as appropriate for a lift whose care plans and or CNA care card do not contain this information or has incorrect type listed will be updated to include the appropriate information. ***This review and any necessary corrections will be completed by 4-152010.*** ***The MDS nurses began a*** review ***of*** current residents identified with pressure ulcers ***on 4-12-2010*** to ensure their care plan addresses the pressure ulcer. ***This review will be completed and any corrections made by close of day on 4-15-201.*** **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** The ***policy entitled "Care Plans – Comprehensive"*** was reviewed and	

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F 279	Continued From page 8 Additionally, the Interdisciplinary team is responsible for maintaining care plans on a current status. The comprehensive care plan is revised as changes in the resident's condition dictates. The policy also states the comprehensive care plan has been designed to present services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well being. Review of the clinical record for Resident #15 revealed an admission date of 01/05/10 with diagnoses of; Senile Dementia, Paralysis, Agitation, and Aphasia. The Minimum Data Set (MDS) Admission Assessment dated 01/11/10 revealed cognition of moderate impairment, decisions poor, and supervision required. Resident #15 was assessed as non-ambulatory, bed mobility and transfer of total dependence, with two-person physical assistance. The Resident Assessment Protocol (RAP) completed on 01/11/10 for Activities of Daily Living (ADL) -Functional Potential revealed Resident #15 required the use of a mechanical standing lift, and was non-ambulatory. A review of the Comprehensive Care Plan initiated on 01/11/10 revealed interventions on how to transfer or shower Resident #15 was not listed on the care plan. A review of the Nurse Aide Care Card for the month of March 2010 revealed Resident #15 transferred with a one person assist. Interview on 03/18/10 at 11:15am with Certified Nurse Aide (CNA) #3 revealed she had given Resident #15 a shower in the resident's room. When she was done with the shower, Resident #15 was transferred back into the wheelchair then taken to the side of the bed. When attempting to transfer Resident #15 by stand-pivot, CNA #3	F 279	revised ***to include "care plans and CNA care cards are revised as information about the resident and the resident's condition change". The DON or designee will in-service*** licensed nurses on this revision ***by close of day on 4-15-2010.*** Nursing supervisors and or MDS nurses will review all new admissions and residents with a significant change or annual assessment to ensure both the use of a lift and or pressure ulcers are addressed on the residents care plan and CNA care cared. ***The Nursing supervisor and or MDS nurses reviewing the new admissions and or residents with significant change or annual assessment will be responsible for making any necessary revisions to the care plan and or care card.*** **How will the facility plan to monitor its performance to ensure that solutions are sustained?** A report of findings from these reviews will be provided to the QA committee monthly, by the DON or designee, for review for compliance, trends, patterns, and opportunities	

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SACRED HEART VILLAGE	2120 PAYNE STREET LOUISVILLE, KY 40206

(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 279	Continued From page 9 stated she tripped, lost her grip on the resident, fell back, and the resident went down on his/her right side. After the incident CNA #3 stated someone told her the resident was suppose to be a mechanical standing lift transfer. She said she had never been told that before, and it was not on the Nurse Aide Care Card. She further stated she did not think Resident #15 could use the mechanical standing lift due to contractures of the hands. A review of Resident #15's MDS admission assessment revealed the resident had a limitation of range of motion on both sides. The RAP summary for Falls dated 01/11/10 revealed Resident #15 has bilateral contractures to both hands. Telephone interviews on 03/18/10 at 2:05pm with Licensed Practical Nurse (LPN) #1, and Certified Medication Technician (CMT) #1 on 03/18/10 at 2:30pm, and interviews with CNA #2 on 03/18/10 at 2:45pm and CNA #1 on 03/18/10 at 2:00pm revealed they all thought Resident #15 was a one person transfer. LPN #1 stated the resident had always been a one person transfer, and they never used the lift on the resident before. An interview with MDS RN #1 on 03/18/10 at 3:00pm revealed she utilized the lift assessment for Resident #15 to complete her admission MDS and RAPS and it was her error not adding the lift to the care plan for Resident #15. She further stated it should have been on the care plan. She stated the lift is used for safety purposes when transferring residents. An interview with LPN #3 on 03/18/10 at 3:25pm regarding care plan updates for residents revealed she would update the Care Plan and CNA Care Cards when she received a new order	F 279	for improvement, make recommendations for action and or follow up. The QA committee may amend the plan as necessary to ensure sustainability of solution.	4-15-2010

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OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 10 or knew about a change. LPN #3 did not know why the new intervention for a mechanical standing lift added on 03/16/10 for Resident #15 was not added to the CNA Care Card, but stated she always thought Resident #15 was a mechanical standing lift transfer. An interview with the Director of Nursing (DON) on 03/18/10 at 3:30pm revealed she had added the intervention for a mechanical standing lift to the Care Plan on 03/16/10 for Resident #15, but failed to add it to the CNA Care Cards. The DON stated the night shift nurse updates the changes to the CNA Care Card. In addition, there was no documentation of a re-assessment for the resident's use of the standing lift after Resident #15 fell. The DON stated "we have a system problem with communication". Review of the facility investigation dated 03/19/10 revealed when staff determined Resident #15 could not use the lift and was able to transfer by stand-pivot; this information was not communicated to the MDS RN to change the care plan and the CNA Care Card. Review of the closed clinical record for Resident #22 revealed the resident was admitted to the facility with a Stage IV pressure ulcer on 12/28/09 and was noted on the Admission MDS dated 01/05/10. The Pressure RAP indicated the resident had a Stage I on the coccyx and would proceed to care plan. Review of the plan of care revealed the resident had a potential for skin breakdown, not actual skin breakdown, and the plan of care did not address the care of the stage IV or stage I pressure areas. Interview on 03/18/09 at 3:00pm with the MDS	F 279		

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F 279	Continued From page 11 RN #2 revealed she was the person responsible for the development of the resident's plan of care. She stated she was not sure why the actual skin breakdown was not addressed in the plan of care and could not state what the potential for the resident would be if it were not addressed in the plan of care. Interview with the MDS RN #1 on 03/18/10 at 3:00pm revealed the person completing the RAP is responsible for developing the plan of care. Further interview revealed the Stage IV pressure area not being addressed in the plan of care was a concern. RN #1 stated it placed the resident at risk for further breakdown, risk of infection, and staff would not know or follow the treatment plan.	F 279		

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 03/17/10 for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility not in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at a Scope/Severity of "F".	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the building's fire alarm system as required by the National Fire Protection Association (NFPA) Standard 72 for all residents of the facility. The findings include: Observations during the Life Safety Code	K 052	***This plan of correction constitutes our facility's credible allegation of compliance for all cited deficiencies. Nothing in this plan of correction should be construed to constitute an admission by the facility of any violations of state or federal statutes, regulations or standards of care. This plan of correction is being completed solely for the purpose of complying with state and federal requirements*** **The auto-dialer was replaced on 3/18/2010 and the auto-dialer was tested. The system verified transmission to the supervising station for both the primary and secondary line within the 4 minute time requirement.** **The dialer will be tested monthly by Maintenance personnel. Documentation of test and length of time to connect will be obtained from the monitoring company and maintained in the Fire Drill documentation book and a report of monthly test to be submitted to the QA committee monthly by the Maintenance Director or designee. QA committee will review findings for compliance and potential opportunities to improve the process.** **Completion Date: 4/15/2010**	4-15-2010 mfw

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Martha Workman — TITLE: Administrator — (X6) DATE: 4-8-2010

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.

RB

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K 052	Continued From page 1 Inspection, conducted on 03/17/10 at 9:44am, revealed when the primary phone line was placed in line failure for over five (5) minutes and forty (40) seconds by unplugging the primary phone line, the Digital Alarm Communicator Transmitter: auto-dialer (DACT), system failed to verify transmission to the supervising station within four (4) minutes of detection of the fault. Interview with the Director of Maintenance on 03/17/10 at 9:44am revealed, he was not aware that the primary phone line was not working to NFPA standards. NFPA: 72 7-2.1* 1999 b. Digital Alarm Communicator Transmitter (DACT) Connection of the DACT to two separate means of transmission shall be ensured. Exception: DACTs that are connected to a telephone line (number) that is also supervised for adverse conditions by a derived local channel. DACT shall be tested for line seizure capability by initiating a signal while using the primary line for a telephone call. Receipt of the correct signal at the supervising station shall be verified.	K 052		

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K 052	Continued From page 2 Completion of the transmission attempt within 90 seconds from going off-hook to on-hook shall be verified. The primary line from the DACT shall be disconnected. Indication of the DACT trouble signal at the premises shall be verified as well as transmission to the supervising station within 4 minutes of detection of the fault. The secondary means of transmission from the DACT shall be disconnected. Indication of the DACT trouble signal at the premises shall be verified as well as transmission to the supervising station within 4 minutes of detection of the fault. The DACT shall be caused to transmit a signal to the DACR while a fault in the primary telephone number is simulated. Utilization of the secondary telephone number by the DACT to complete the transmission to the DACR shall be verified.	K 052		
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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.	K 076		

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K 076	Continued From page 3 (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 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that oxygen cylinders were stored according to NFPA standards. The findings include: 1. Observation during the Life Safety Code inspection, on 03/17/10 at 2:45pm, with the Director of Maintenance, revealed there were four (4) transferring oxygen tanks in the oxygen storage room located at the nurse's station. The four trans-filling oxygen tanks in this storage room left very little space to refill the oxygen tanks. In addition, there was a quarter inch gap six inches up from the bottom of the door. An interview with Nurse #1, on 03/17/10 at 3:00pm, revealed on occasion she refilled the oxygen tanks with the door open because there was not enough space to stand inside the room with the door closed and refill the tanks. Nurse #1 stated she knew to shut the door when refilling the oxygen tanks. An interview with the Unit Nurse on 03/17/10 at 3:00pm revealed the Unit Nurse was aware of oxygen storage NFPA requirements. She stated leaving the door open while filling oxygen cylinders could cause harm to the residents and	K 076	Two (2) trans-filling oxygen tanks were removed from this oxygen storage room on ~~3/1/2010.~~ The door jam was adjusted by maintenance personnel on 3/18/2010 eliminating the gap. Only two (2) trans-filling oxygen tanks will be stored in this oxygen storage room to allow room for personnel to fill tanks with door closed. A sign has been posted on the door of this oxygen storage room stating oxygen is stored within and to keep the door closed at all times, including when trans-filling oxygen tanks. Nursing personnel will be in-serviced by the DON or designee on the need to keep door closed while trans-filling oxygen tanks. The DON or designee will observe at least 10 trans-filling procedures per month to ensure compliance by nursing personnel. A report of these observations will be reported to the QA committee monthly for review, analysis, recommendation and follow up. The QA committee will review or revise this plan as needed to ensure compliance. Completion Date: 4/15/2010	03/17/10 per MFW 4-15-2010 MFW

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K 076	Continued From page 4 staff while the door is open. 2. Observation on 03/18/10 at 2:05pm revealed the health survey team member observed two staff members trans-filling oxygen with the door open. Interview with Nurse #1 revealed she was not aware the door needed to be closed while filling the oxygen tanks. Interview with Nurse #2 revealed she was not aware the door needed to be closed while filling the oxygen tanks. Review of the facility records on 03/18/10 at 2:05pm revealed no tracking records of employees learning to trans-fill oxygen cylinders. An interview with the Unit Nurse on 03/18/10 at 2:05pm revealed the Unit Nurse was aware of oxygen storage NFPA requirements and stated leaving the door open while filling oxygen cylinders could cause harm to the residents and staff. NFPA: 99, 1999 8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring;	K 076		

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K 076	Continued From page 5 and c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted. Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures. The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities. NFPA: 99, 1999 8-3.1.11 Storage Requirements. 8-3.1.11.1 Storage for nonflammable gases greater than 3000 ft3 (85 m3) shall comply with 4-3.1.1.2 and 4-3.5.2.2. 8-3.1.11.2 Storage for nonflammable gases less than 3000 ft3 (85 m3). a. Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. b. Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. c. Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or incompatible materials by either: 1. A minimum distance of 20 ft (6.1 m), or	K 076		

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K 076	Continued From page 6 2. A minimum distance of 5 ft (1.5 m) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, or 3. An enclosed cabinet of noncombustible construction having a minimum fire protection rating of one-half hour for cylinder storage. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. d. Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. e. Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. f. Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. g. Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. h. Cylinder or container restraint shall meet 4-3.5.2.1(b)27. i. Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. j. Cylinder valve protection caps shall meet 4-3.5.2.1(b)14. 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 076		

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K 076	Continued From page 7 8-2.1.2.3 A particular hazard exists when oxygen equipment becomes contaminated with oil, grease, or other combustible materials. Such contaminants will ignite readily and burn more rapidly in the presence of high oxygen concentrations and make it easier to ignite less combustible materials with which they come in contact. An oxygen-enriched atmosphere normally exists in an oxygen tent, croup tent, incubator, and similar devices when supplemental oxygen is being employed in them. These devices are designed to maintain a concentration of oxygen higher than that found in the atmosphere. Oxygen-enriched atmospheres can exist in the immediate vicinity of all oxygen administration equipment. (See definition of Site of Intentional Expulsion in Section 2-2.) The transfer of liquid oxygen from one container to another container can create an oxygen-enriched atmosphere within the vicinity of the containers. If oxygen is supplied by a container that stores the oxygen as a liquid, there will be a small amount of oxygen vented into the vicinity of the container after a period of nonuse of the equipment. Larger amounts of oxygen will be vented if the container is accidentally tipped over or placed on its side. This venting may create an oxygen-enriched atmosphere if the container is stored in a confined space [see 4-3.1.1.2(a)9]. 8-2.1.2.4 Sources of ignition include not only the usual ones in ordinary atmospheres, but others that become significant hazards in oxygen-enriched atmospheres (see 8-2.1.2.1) such as the following: a. Open flames, burning tobacco, and electric	K 076		

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K 076	Continued From page 8 radiant heaters are sources of ignition. b. The discharge of a cardiac defibrillator can serve as a source of ignition. c. Arcing and excessive temperatures in electrical equipment are sources of ignition. Electrically powered oxygen apparatus and electrical equipment intended for use in an oxygen-enriched atmosphere are sources of ignition if electrical defects are present. d. Electrical equipment not conforming to the requirements of 7-6.2.4.1, which can include, but is not limited to, electric razors, electric bed controls, hair dryers, remote television controls, and telephone handsets, can create a source of ignition if introduced into an oxygen-enriched atmosphere (see 7-6.2.4.1). e. A static discharge having an energy content that can be generated under normal conditions in respiratory therapy will not constitute an ignition source as long as easily ignited substances (such as alcohols, acetone, oils, greases, or lotions) are not present. f. Rapid opening of cylinder valves can cause sudden increase in downstream gas pressure and temperature caused by the adiabatic heat of recompression with consequent ignition of combustible materials in contact with the hot gas downstream, including the valve seat. CHAPTER 32 CRYOGENIC FLUIDS 3204.1 General. Storage of containers shall comply with this section.	K 076		

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K 076	Continued From page 9 In addition to the requirements of this section, health care, residential care, and assisted living facilities shall be required to comply with CGA P-2.7, 2000 edition, Guide for the Safe Storage, Handling, and Use of Portable Liquid Oxygen Systems in Health Care Facilities. 3205.1 Applicability. Use and handling of containers and systems shall comply with sections 3205.1.1 through 3205.5.2. In addition to the requirements of this section, health care, residential care, and assisted living facilities, shall be required to comply with CGA P-2.7, 2000 edition, Guide for the Safe Storage, Handling, and Use of Portable Liquid Oxygen Systems in Health Care Facilities. 3205.4 Filling and dispensing. Filling and dispensing of cryogenic fluids shall comply with Sections 3205.4.1 through 3205.4.3 4. 3205.4.4 Trans-filling of liquid oxygen. In addition to the requirements of this section, when trans-filling of liquefied oxygen is performed inside buildings for respiration purposes, the maximum aggregate quantity of all containers shall be limited to 72 pounds (32.7 kg). Trans-filling shall be on bare concrete floors with no combustible seams. The room shall be separated from the means of egress by one-hour fire barriers. The room shall have ventilation to handle off gassing of the containers. Refer to pamphlet CGA P-2.6, 1995 edition, Trans-filling of Liquid Oxygen to be Used for Respiration, for the requirements within health care, residential care, and assisted living facilities.	K 076		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185442	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/17/2010

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K 076	Continued From page 10 Minnesota Department of Health. Information Bulletin 04-15 NH-106 BCH-25 HOSP-44 Use Of Liquid Oxygen How many cubic feet are in a liter of liquid oxygen? Base containers for liquid oxygen are available in several capacities. Base containers are commonly 31 or 41 liters in capacity. A liter of liquid oxygen at 70 degrees Fahrenheit and 14.7 pounds per square inch (psia) is equal to 30.4 cubic feet of gaseous oxygen. Using this conversion factor, multiply the number of liters in the base container of liquid oxygen by 30.4. The resulting product is the number of equivalent cubic feet of oxygen. For example, 41 liters of liquid oxygen times 30.4 equals 1246.4 cubic feet of oxygen. A 41-liter base container is equivalent to 1246.4 cubic feet of oxygen at standard pressure and temperature. Storage: The storage of nonflammable gases is addressed in NFPA 99, Sec. 8-3.1.11. Storage requirements are divided into two categories - requirements for quantities less than 3000 cubic feet and requirements for quantities more than 3000 cubic feet. Using the conversion factors outlined earlier, it follows that three (3) 41-liter containers of liquid oxygen in storage exceeds the threshold 3000 cubic feet. Here are some important points to remember about the storage of liquid oxygen: The guidelines of CGA Pamphlet P-2.6, Transfilling of Low-Pressure	K 076		

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K 076	Continued From page 11 Liquid Oxygen to be Used for Respiration, and CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities, are met.	K 076		