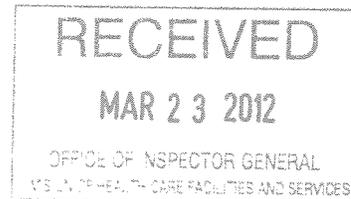


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 initiated on 02/28/12 and concluded on 03/01/12 and a Life Safety Code survey was conducted on 02/29/12 with the highest scope and severity of an F. The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	This plan of correction constitutes Mercy Sacred Heart's credible allegation of compliance for the cited deficiencies. Nothing in this plan of correction should be construed as admission by the facility of any violations of state or federal statutes, regulation, or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during an annual survey.	
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 and interview, the facility failed to serve food in a sanitary manner for five (5) of twenty-three (23) sampled and unsampled residents, Resident #3 and #5 and Unsampled Residents #21, #22 and #23. The facility served individual salads with the salad dressing packet placed on top of raw lettuce. The findings included: The facility provided no policy regarding service of food in a sanitary manner. Interview with the Dietary Director, on 03/01/12 at	F 371	Corrective action for those residents found to have been affected by the deficient practice: 1. Residents # 3, 5, 21, 22, and 23 are now being served salads with the salad dressing packet placed on the table/tray or if wrapped, salad is wrapped and dressing packet placed on top of plastic wrap.	03/30/12



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Kim T. Helmsman* TITLE: *Executive Director* (X6) DATE: *3/23/12*

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.

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

PRINTED: 03/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 183442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2012
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NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206
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(X4) ID PREFIX TAG F 371	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 371	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 371 Continued From page 1

3:45 PM, revealed the facility did not have a policy that was related to the prevention of contamination when serving fresh foods and prepackaged foods together on the same plate.

Observation of a lunch meal service, on 02/29/12 from 12:20 PM through 12:40 PM, revealed five (5) resident lunch trays which were removed from the tray cart with individual salads on the trays. The salads were served to the residents by the facility staff. The facility staff removed the plastic wrap from the salad, removed the salad dressing packet which was laid on the raw lettuce, opened the packet of salad dressing and poured the dressing over the lettuce. The salads were served to Sampled Resident #3 and #5 and to Unsampled Resident #21, #22 and #23.

Interview, on 03/01/12 at 3:10 PM, with Dietary Staff #1 revealed she worked the meal service tray line and it was common practice for the individual salad plates to have the salad dressing packet laid directly on the lettuce with plastic wrap which covered the salad and dressing packet.

Interview, on 03/01/12 at 3:25 PM, with the Dietary Manager revealed she was aware the staff on the tray line placed the salad dressing packets directly on the lettuce and then covered the salad and dressing packets with plastic wrap. She indicated the salad dressing packets came in a bulk box. She also reported she had not been concerned that the salad dressing packets could contaminate the residents' food by lying directly on the residents' food.

Interview, on 03/01/12 at 3:45 PM, with the Dietary Director revealed she knew it was

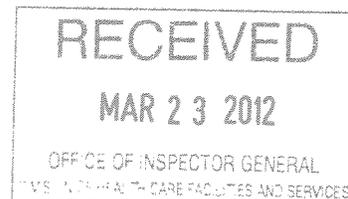
F 371 How the facility identified other residents having the potential to be affected by the same deficient practice:

1. All residents who are served salads with a salad dressing packet had the potential to be affected. Salads are now served with dressing packages placed on the table/tray or if wrapped, salad is wrapped and dressing packet placed on top of plastic wrap.

Measures put into place or systemic changes made to ensure the deficient practice will not recur:

1. All Dietary and Nursing staff have been in-serviced on cross contamination and serving fresh foods and prepackaged foods together on the same plate. Dietary has been instructed specifically on salad/dressing preparation and serving.

2. A protocol for preparation and serving of fresh foods and prepackaged foods was written to serve as a guideline for dietary staff.



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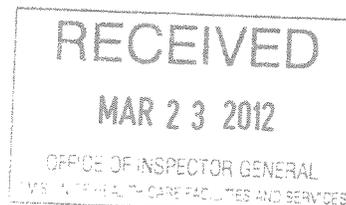
PRINTED: 03/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 371 Continued From page 2
common practice for the individual salad plates to have the salad dressing packet laid directly on the lettuce with plastic wrap which covered the salad and dressing packets. She reported this was the usual practice for 500 and 600 Hall residents. She stated she was not aware of how the salad dressing packets were handled or stored prior to arrival at the facility. She reported the salads served with salad dressing packets laid directly on lettuce posed a potential for cross contamination of bacteria which could result in foodborne illness.

F 371 How the facility plans to monitor its performance to ensure that solutions are sustained:

1. Dietary Director, Dietary Manager, or dietician will audit the preparation of salads weekly for four weeks, monthly for three, and then quarterly for the remainder of the year.
2. Dietary Director, Dietary Manager, or dietician will audit serving of fresh foods with prepackaged foods on the same plate weekly for four weeks, monthly for three, and then quarterly for the remainder of the year.
3. All findings will be reviewed and analyzed then reported to the CQI Committee.



F 371

PREPARATION AND SERVING

PROTOCOL

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MAR 23 2012
OFFICE OF INSPECTOR GENERAL
MISSION: HEALTH CARE FACILITIES AND SERVICES

Mercy Sacred Heart

Protocol for Preparation and Serving of Fresh Foods and Prepackaged Foods

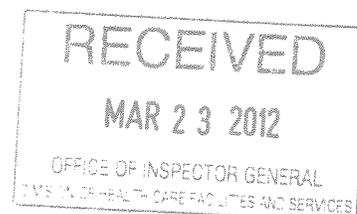
Purpose:

It is the protocol of the facility to prepare foods using methods to prevent contamination and the potential for food-borne illness as well as serve foods to our residents under sanitary conditions without the risk of contamination or the potential for food-borne illness.

Protocol:

- All fresh foods and premixed, packed foods (for example mixed salad, fruits) for resident use will be stored under controlled temperatures as needed.
- Fresh foods and premixed, packed foods will be measured according to the menu spread and placed on proper dinnerware.
- All prepacked condiments will be served separate from the fresh food on dinnerware. Condiments will be served by placing them on the table/tray or if wrapped, fresh food is wrapped and condiments placed on top of the plastic wrap.

March 23, 2012



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

PRINTED: 03/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/29/2012
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NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
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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: 1999, 2008</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Protected.</p> <p>SMOKE COMPARTMENTS: Ten (10) smoke compartments</p> <p>FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic (wet and dry) sprinkler system. Dry in the attic space and wet in the occupied space.</p> <p>GENERATOR: Two (2) Type II generators. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 02/29/12. Sacred Heart Village was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one-hundred and twenty-five (125) beds and the census was one-hundred and three (103) on the day of the</p>	K 000	<p>This plan of correction constitutes Mercy Sacred Heart's credible allegation of compliance for the cited deficiencies. Nothing in this plan of correction should be construed as admission by the facility of any violations of state or federal statutes, regulation, or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during an annual survey.</p>	
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NATIONAL HEALTH CARE FACILITIES AND SERVICES

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kim Thelen</i>	TITLE Executive Director	(X6) DATE 3/23/2012
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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 required to continued program participation.

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

PRINTED: 03/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING D1 B WING _____	(X3) DATE SURVEY COMPLETED 02/28/2012
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NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40208
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000 Continued From page 1 survey.

K 000

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)

Deficiencies were cited with the highest deficiency identified at "F" level.

K 018 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

K 018 K 018

03/30/12

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/2 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3

Corrective action for those residents found to have been affected by the deficient practice:

1. Resident room doors 411, 415, and 513 have been adjusted so the door stays open without the use of furniture or door stops or any other type of impediment to closing.

Roller latches are prohibited by CMS regulations in all health care facilities.

How the facility identified other residents having the potential to be affected by the same deficient practice:

1. All resident room doors were checked by maintenance to assure the doors stay open without the use of furniture, door stops, or any other type of impediment to closing. All doors found to not stay open without impediment to closure were adjusted.

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/29/2012
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NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 018 Continued From page 2
no impediments to the closing of corridor doors, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of ten (10) smoke compartments, approximately forty-five (45) residents, staff and visitors. The facility is licensed for one-hundred and twenty-five (125) beds and the census was one-hundred and three (103) on the day of the survey.

The findings include:

Observations, on 02/29/12 between 10:00 AM and 11:40 AM, with the Maintenance Director and Maintenance Assistant revealed trash cans were holding resident room doors 411 and 415 open; and a wood wedge holding resident room door 613 open.

Interviews, on 02/29/12 between 10:00 AM and 11:40 AM, with the Maintenance Director and the Maintenance Assistant revealed they were unaware the trash cans and a wood wedge were being used to hold open the resident room doors and acknowledged the methods used to hold the doors open were an impediment to closing the doors in the event of an emergency.

Reference: NFPA 101 (2000 Edition)

19.3.6.3.3*
Hold-open devices that release when the door is pushed or pulled shall be permitted.

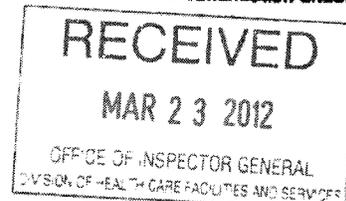
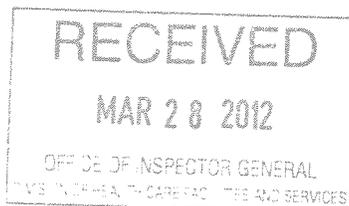
A.19.3.6.3.3
Doors should not be blocked open by furniture,

K 018 Measures put into place or systemic changes made to ensure the deficient practice will not recur:

1. Nursing, housekeeping, and maintenance staff have been in-serviced on NFPA standards that state "There is no impediment to the closing of the doors" and educated to report issues to maintenance so doors can be adjusted.
2. Checking of doors to assure they stay open without the use of furniture, doors stops, or any other type of impediment has been added to the Preventative Maintenance list to be done monthly.

How the facility plans to monitor its performance to ensure that solutions are sustained:

1. Maintenance staff will check resident room doors for any impediments to closing monthly for three months and then quarterly for the remainder of the year.
2. All findings will be reviewed and analyzed then reported to the CQI Committee.



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CENTERS FOR MEDICARE & MEDICAID SERVICES**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2012
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NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2128 PAYNE STREET LOUISVILLE, KY 40208
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 018 Continued From page 3
door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.

K 018

K 027 NFPA 101 LIFE SAFETY CODE STANDARD
SS-D
Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/2-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7

K 027 **K 027**

03/23/12

Corrective action for those residents found to have been affected by the deficient practice:

1. A new closure has been placed on the cross-corridor fire doors located on the 500 Hall so they will close completely resisting the passage of smoke.

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke, in accordance with NFPA standards. These doors must close all the way and be smoke tight to help prevent smoke from reaching other parts of the building in the event of an emergency. The deficiency had the potential to affect the two (2) of ten (10) smoke compartments, approximately thirty-five (35) residents, staff, and visitors. The facility is licensed for one-hundred and twenty-five (125) beds and the census was one-hundred and three (103) on the days of the survey.

How the facility identified other residents having the potential to be affected by the same deficient practice:

1. All fire doors were tested and found to close completely resisting the passage of smoke. No other residents were identified to be affected.

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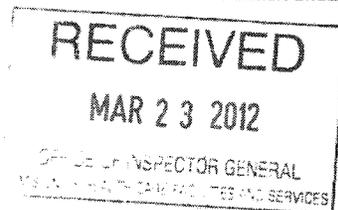
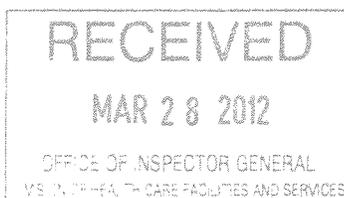
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/29/2012
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NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2120 RAYNE STREET LOUISVILLE, KY 40206
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 027	<p>Continued From page 4</p> <p>The findings include:</p> <p>Observation, on 02/29/12 at 10:42 AM, with the Maintenance Director and the Maintenance Assistant revealed the cross-corridor fire doors located in the 500 Hall would not close completely when tested.</p> <p>Interview, on 02/29/12 at 10:42 AM, with the Management Director and the Maintenance Assistant revealed they were unaware of the doors not completely closing and determined that one of the door closers needed to be adjusted for the doors to close completely and resist the passage of smoke in the event of an emergency.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p>	K 027	<p>Measures put into place or systemic changes made to ensure the deficient practice will not recur:</p> <ol style="list-style-type: none"> 1. The maintenance staff have been in-serviced on the NFPA standards regarding cross corridor doors located in a smoke barrier to resist the passage of smoke therefore, all fire doors must close completely. They have also been educated to report any issues with doors not closing completely when checked to the Director of Maintenance. 2. All fire doors will be tested bimonthly for two months to ensure complete closure. <p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <ol style="list-style-type: none"> 1. Maintenance staff will check all fire doors for complete closure bimonthly for two months, monthly for three months and then quarterly for the remainder of the year. 2. All findings will be reviewed and analyzed then reported to the CQI Committee. 	
K 029 SS=E		K 029		



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

PRINTED: 03/08/2012
FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188442	DC2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/29/2012
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2130 PRYME STREET LOUISVILLE, KY 40208		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 029	Continued From page 6 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 ensure hazardous areas were protected in accordance with National Fire Protection Association (NFPA) standards. The deficiencies had the potential to affect three (3) of ten (10) smoke compartments, residents, staff, and visitors. The facility is licensed for one-hundred and twenty-five (125) beds and the census was one-hundred and three (103) on the day of the survey. The findings include: Observations, on 02/29/12 between 9:15 AM and 10:17 AM, with the Maintenance Director and the Maintenance Assistant revealed two (2) mechanical closets located outside of the Dining Area, one (1) mechanical closet located next to room 418 and one (1) mechanical closet located in the Nursing Services Office had pipe penetrations in the ceilings that were not sealed smoketight. Interviews, on 02/29/12 between 9:15 AM and 10:17 AM, with the Maintenance Director and the Maintenance Assistant revealed they were unaware of the penetrations in the ceilings and acknowledged the penetrations should be sealed to resist the passage of smoke in the event of an	K 029	K 029 Corrective action for those residents found to have been affected by the deficient practice: 1. The pipe penetrations in the ceilings of the four mechanical closets listed have been sealed so that they are smoke tight. 2. A self-closing device has been placed on the dry storage room door in the kitchen. How the facility identified other residents having the potential to be affected by the same deficient practice: 1. All other mechanical closets were checked and noted to be without any penetrations in the smoke walls or ceilings. No other residents were affected by this practice. 2. All other doors to hazardous areas were noted to have self-closing devices in place. No other residents were affected by this practice.	03/23/12	

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

PRINTED: 03/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/29/2012
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NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40208
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 029 Continued From page 8 emergency.

Further observation, on 02/29/12 at 1:00 PM, with the Maintenance Director and the Maintenance Assistant, revealed the door to the dry storage room located within the Kitchen, did not have a self-closing device installed on the door.

Interview, on 02/29/12 at 1:00 PM, with the Maintenance Director and the Maintenance Assistant revealed they were unaware of the dry storage room being a hazardous area requiring the door to be self-closing.

Reference: NFPA 101 (2000 edition)

19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:

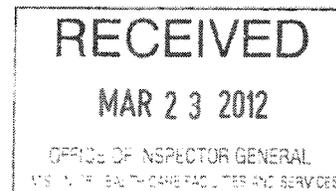
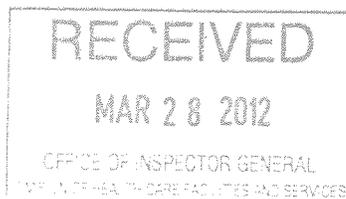
- (1) Boiler and fuel-fired heater rooms
- (2) Central/bulk laundries larger than 100 ft² (9.3 m²)

K 029 Measures put into place or systemic changes made to ensure the deficient practice will not recur:

1. The maintenance staff have been in-serviced on the NFPA 101 standards regarding the need for all smoke resisting partitions and doors to be sealed smoke tight and to be without penetrations. In addition, they were in-services that "the doors shall be self-closing or automatic-closing" to all hazardous areas.
2. Maintenance will follow-up on all vendor work in which smoke barriers may have been affected upon the vendors departure from the work area.

How the facility plans to monitor its performance to ensure that solutions are sustained:

1. Maintenance staff will check for smoke tight seals in the ceilings of all mechanical closets monthly for three months and then quarterly for the remainder of the year.
2. Maintenance staff will check that all smoke barrier walls are sealed after any vendor work is done for one year.
3. All findings will be reviewed and analyzed then reported to the CQI Committee.



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2012
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NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40208
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 029 Continued From page 7
 (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 038 NFPA 101 LIFE SAFETY CODE STANDARD
 SS=F
 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1

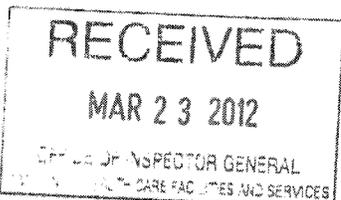
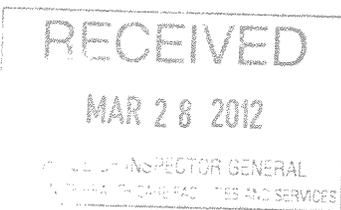
K 038 K 038

03/30/12

Corrective action for those residents found to have been affected by the deficient practice:

1. The code that allows immediate release of the delayed egress doors has been posted above the key pad on the seven exit doors listed.

This STANDARD is not met as evidenced by:
 Based on observation and interview, it was determined the facility failed to ensure delayed



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NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(K4) 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)	(K5) COMPLETION DATE	
K 038	<p>Continued From page 8</p> <p>egress doors and exits were maintained in accordance with NFPA standards. The deficiencies had the potential to affect eight (8) of ten (10) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and twenty-five (125) beds and the census was one-hundred and three (103) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 02/28/12 between 9:40 AM and 11:55 AM, with the Maintenance Director and the Maintenance Assistant revealed seven (7) exterior, exit doors were equipped with delayed egress hardware, but did not have the required signage displayed, stating the doors were equipped with a thirty (30) second delay before opening. The exit door locations were as follows:</p> <ol style="list-style-type: none"> 1. Between resident rooms 406 and 407. 2. Between resident rooms 416 and 417. 3. Between resident rooms 419 and 421. 4. At the Ambulance entrance. 5. At the Rehab entrance. 6. At the Activities room. 7. At the end of the 500 Hall. <p>Interviews, on 02/29/12 between 9:40 AM and 11:55 AM, with the Maintenance Director and the Maintenance Assistant revealed they were not aware that exit doors being equipped with delayed egress hardware were required to have the proper signage displayed.</p> <p>Reference:</p>	K 038	<p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <ol style="list-style-type: none"> 1. All other doors with delayed egress hardware have been checked and the code allowing immediate release of the doors has been posted above the key pad. <p>Measures put into place or systemic changes made to ensure the deficient practice will not recur:</p> <ol style="list-style-type: none"> 1. All staff have been in-serviced on the NFPA 101 standards requiring proper signage be posted on all delayed egress doors in the facility and where the code has been posted on the doors. 2. Checking of the code being posted on all delayed egress doors has been added to the Preventative Maintenance checks to be done monthly. 3. Maintenance will educate all new employees during orientation on the purpose of the delayed egress doors in the facility and use of the posted code at these doors. 		

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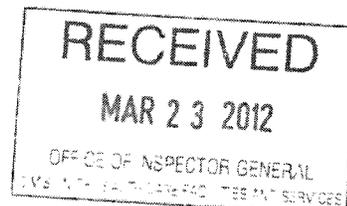
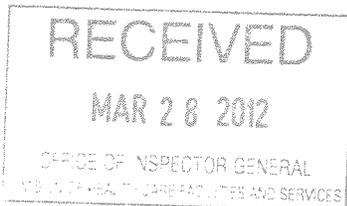
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**DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES**

PRINTED: 03/08/2012
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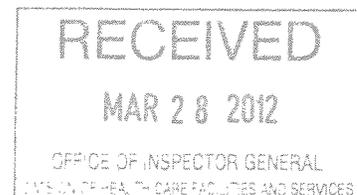
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/29/2012
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 038	Continued From page 9 NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.8. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not	K 038	How the facility plans to monitor its performance to ensure that solutions are sustained: 1. Maintenance staff will check that the code is posted on all delayed egress doors monthly for three months and then quarterly for the remainder of the year. 2. All findings will be reviewed and analyzed then reported to the CQI Committee.		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/29/2012
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 038	Continued From page 10 less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 038	Measures put into place or systemic changes made to ensure the deficient practice will not recur:	
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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect five (5) of the ten (10) smoke compartments, approximately fifty (50) residents, staff and visitors. The facility is licensed for one hundred and twenty-five (125) beds and the census was one-hundred and three (103) on the day of the survey. The findings include: Observations, on 02/29/12 between 9:40 AM and 11:00 AM, with the Maintenance Director and the Maintenance Assistant revealed corrosion on the sprinkler heads protecting the exterior roof overhangs in the following locations: 1. Outside of resident rooms 406 and 407 2. Outside of resident rooms 416 and 417. 3. Outside of resident rooms 419 and 421.	K 062	1. The maintenance staff have been in-serviced on the NFPA 25 standards regarding sprinkler heads being free of corrosion, foreign materials, paint, and physical damage and have been educated to request replacement of such sprinkler heads during quarterly checks by the sprinkler company. 2. Continue quarterly inspections by the sprinkler company with maintenance staff present to observe for sprinkler heads in need of replacement. How the facility plans to monitor its performance to ensure that solutions are sustained: 1. Maintenance staff will inspect sprinkler heads for corrosion, foreign materials, paint, or physical damage during quarterly inspections with sprinkler company. 2. All findings will be reviewed and analyzed then reported to the CQI Committee.	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2012
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NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40208
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 038 Continued From page 10
less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows:
**PUSH UNTIL ALARM SOUNDS
DOOR CAN BE OPENED IN 15 SECONDS**
K 062 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.8, 4.6.12, NFPA 13, NFPA 25, 9.7.5

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect five (5) of the ten (10) smoke compartments, approximately fifty (50) residents, staff and visitors. The facility is licensed for one hundred and twenty-five (125) beds and the census was one-hundred and three (103) on the day of the survey.

The findings include:

Observations, on 02/28/12 between 8:40 AM and 11:00 AM, with the Maintenance Director and the Maintenance Assistant revealed corrosion on the sprinkler heads protecting the exterior roof overhangs in the following locations:

1. Outside of resident rooms 406 and 407
2. Outside of resident rooms 416 and 417.
3. Outside of resident rooms 419 and 421.

K 038

K 062 **K 062**

04/06/12

Corrective action for those residents found to have been affected by the deficient practice:

1. The five sprinkler heads noted are being replaced by sprinkler company.

How the facility identified other residents having the potential to be affected by the same deficient practice:

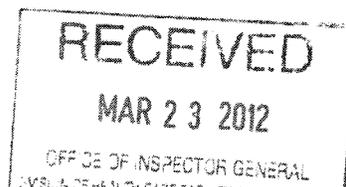
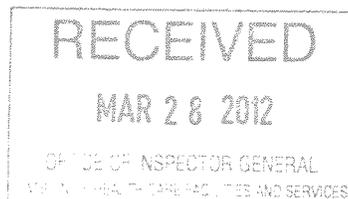
1. All remaining sprinkler heads have been inspected. All sprinkler heads that are not free of corrosion, foreign materials, paint, or physical damage are being replaced by the sprinkler company.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2012
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 3120 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
K 062	Continued From page 11 4. Outside of the ambulance entrance. 5. Outside of the rehab entrance. Interviews, on 02/28/12 between 9:40 AM and 11:00 AM, with the Maintenance Director and the Maintenance Assistant revealed they were not aware of the corrosion on the sprinkler heads. Reference: NFPA 25 (1998 Edition). 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of egress were maintained free and clear of obstructions in accordance with NFPA standards. The deficiency had the potential to affect three (3)	K 062		
K 072 SS=D			K 072 Corrective action for those residents found to have been affected by the deficient practice: 1. The linen carts on 400 Hall and 500 Hall and the lift stored on 600 Hall have been stored in a location out of the hallways. How the facility identified other residents having the potential to be affected by the same deficient practice: 1. All hallways have been checked for storage of items such as linen carts, lifts, other equipment, other carts and the items stored in a new location if needed.	03/30/12



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B WING _____		(X3) DATE SURVEY COMPLETED 02/29/2012
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 072	Continued From page 12 of ten (10) smoke compartments, approximately fifty (50) residents, staff and visitors. The facility has the capacity for one-hundred and twenty-five (125) beds and the census was one-hundred and three (103) on the day of the survey. The findings include: Observations, on 02/29/12 between 9:45 AM and 11:05 AM, with the Maintenance Director and the Maintenance Assistant revealed a linen cart stored in the 400 Hall, a linen cart stored in the 500 Hall, and a lift stored in the 500 Hall to be stationary for a period of more than thirty (30) minutes. Interviews, on 02/29/12 between 9:45 AM and 11:05 AM, with the Maintenance Director and the Maintenance Assistant revealed the linen carts and lift were routinely located in the corridors. Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	Measures put into place or systemic changes made to ensure the deficient practice will not recur: 1. Nursing, housekeeping, and maintenance staff have been in-serviced on NFPA 101 standards that state "Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency." 2. A new storage location has been identified for linen carts and lifts as needed on all nursing halls. How the facility plans to monitor its performance to ensure that solutions are sustained: 1. Maintenance staff, Director of Nursing, or Nurse Manager will monitor halls for presence of linen carts or lifts that are stationary in the hall for a period of more than 30 minutes weekly for four weeks, monthly for three and quarterly for the remainder of the year. 2. All findings will be reviewed and analyzed then reported to the CQI Committee.		
K 147 88-D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/29/2012
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NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 147 Continued From page 13

This STANDARD is not met as evidenced by:
 Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of the ten (10) smoke compartments, approximately forty-five (45) residents, staff, and visitors. The facility is licensed for one-hundred and twenty-five (125) beds and the census was one-hundred and three (103) on the day of the survey.

The findings include:

Observation, on 02/29/12 at 8:30 AM, with the Maintenance Director and Maintenance Assistant revealed Resident Room 303 had medical equipment plugged into an extension cord that was plugged into a power strip that was plugged into a wall receptacle.

Interviews, on 02/29/12 at 8:30 AM, with the Maintenance Director and Maintenance Assistant revealed they was unaware of the misuse of a power strip within the Resident's room. They indicated that the Resident's families occasionally install extension cords and power strips in their rooms, not knowing they are prohibited.

Reference: NFPA 99 (1999 edition)

3-3.2.1.2 D

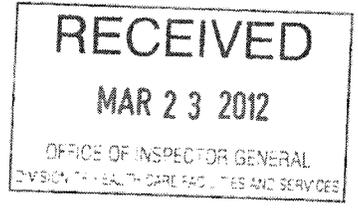
K 147 K 147

Corrective action for those residents found to have been affected by the deficient practice: 03/30/12

1. The extension cord in room 303 has been removed and contact made with the family to inform them of the regulation regarding use of extension cords.

How the facility identified other residents having the potential to be affected by the same deficient practice:

1. All resident rooms have been checked for the use/presence of extension cords. All extension cords found have been removed and the residents and/or families have been contacted and informed of the regulation regarding use of extension cords.



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2012
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 147	Continued From page 14 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 adaptars.	K 147	Measures put into place or systemic changes made to ensure the deficient practice will not recur: 1. Nursing, housekeeping, and maintenance staff have been in-serviced on NFPA 99 standards regarding use of extension cords in resident rooms or in the nursing facility. They were educated to remove the extension cords and/or contact maintenance to address the use. 2. Weekly checks of resident rooms will be conducted for one month and contact made with families with noted issues. Room checks will reduce to monthly after one month. How the facility plans to monitor its performance to ensure that solutions are sustained: 1. Maintenance staff will check resident rooms for use of extension cords weekly for four weeks, monthly for three months and then quarterly for the remainder of the year. 2. All findings will be reviewed and analyzed then reported to the CQI Committee.	

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