

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

PRINTED: 02/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185335	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/07/2013
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 CRISTLAND ROAD LOUISVILLE, KY 40214
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F 000	INITIAL COMMENTS A recertification survey was initiated on 02/04/13 and concluded on 02/07/13 with a Life Safety Code survey initiated and concluded on 02/05/13 with the highest scope and severity of an "F". The facility had the opportunity to correct deficiencies before remedies would be recommended for imposition. This was a Nursing Home Initiative survey with entrance on 02/04/13 at 6:00 PM.	F 000	F 248 1. The facility's Quality of Life and Social Services Director assessed resident #8 and revised the activities and social services care plan to meet the resident's mental, physical and psychosocial needs. The care plan of resident #8 was signed by the	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to provide an on-going program of activities for the well-being of one (1) of seventeen (17) sampled residents (Resident #8) and two (2) unsampled residents. The facility failed to develop and implement a program of activities based on assessment of the resident's interests and preferences. The facility assessed the resident interests and preferences for religious activities, sports, music, books, and news. The findings include:	F 248	Quality of Life Director. Resident #8's, February activity log, was reviewed by the facility's Activity Director on February 6th and revised to meet the activity attendance of resident #8. The Quality of Life Director has provided resident #8 a calendar of scheduled basketball games, and has made arrangements for the TV to be turned on and the appropriate channel per the basketball games of resident #8's choice.	3/11/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 3/11/13
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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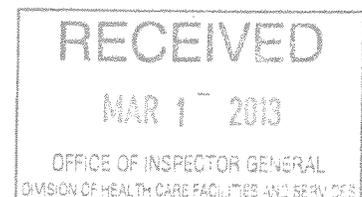
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F 248	<p>Continued From page 1</p> <p>Review of the facility's policy regarding Activities, dated August 2007, revealed the facility would develop a care plan for each resident to meet the resident's mental and psychosocial needs based on the comprehensive assessment.</p> <p>Observation of Resident #8, on 02/05/13 at 2:30 PM, revealed the resident sitting in the room in a wheelchair. The resident was noted as not engaged in any activity. There was a television in the room that was turned off. There was no evidence of books or magazines in large print or of a machine to play a book on. Observation, on 02/05/13 at 3:30 PM, revealed the resident continued to sit up in a wheelchair in the room without stimulation through any activities.</p> <p>Observation of the facility activity, on 02/05/13 at 2:30 PM, revealed a cooking class was in progress. Observation of the facility activity, at 3:30 PM, revealed a church/religious program in progress.</p> <p>Review of the clinical record for Resident #8, revealed the facility admitted the resident with diagnoses of End Stage Renal Disease and Hypertension. The facility completed an admission Minimum Data Set (MDS) assessment on the resident on 01/26/13 which revealed the resident was cognitively intact and had poor vision. The resident was assessed to enjoy books, music, religion, and news.</p> <p>Review of the Quality of Life Assessment for Resident #8 completed by the facility, on 01/25/13, unsigned, revealed the resident had interests in children, cooking, current events,</p>	F 248	<p>The Quality of life director contacted the public library in February inquiring about delivery for large print books and or audio books to be delivered to resident #8 for residents identified poor vision.</p> <p>2. Interviews will be completed by the Quality of Life director on 100% of the residents, by March 13th so all residents to ensure that the quality of life care plans are reviewed and up-to-date to express the resident's specific activities and interventions that the resident enjoys. All resident's will be assessed by the quality of life director and the social service according to their MDS schedule to ensure an ongoing program of activities designed to meet in accordance with the comprehensive assessment, and to identify interest of the residents, the physical,</p>	
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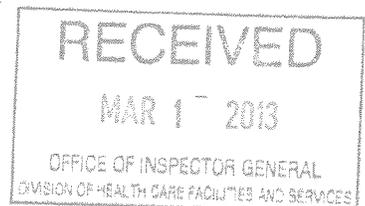


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F 248	<p>Continued From page 2</p> <p>exercise, religion, music, puzzles, social events, manicures, pedicures, sports, and television.</p> <p>Review of the comprehensive care plan for Resident #8, revealed the facility did not develop specific interventions to address the resident's interests and poor vision.</p> <p>Review of the activities participation log for Resident #8, revealed the resident did not attend activities and spent the days doing self-directed activities in his/her room during the month of January 2013. The log for February 2013 was blank.</p>	F 248	<p>3. The Administrator educated the Quality of Life Staff and Social Services department March 1, 2013 the necessity of having resident specific care plans and activities that meet the interest of the residents of the facility. The Quality of Life director will interview all new admissions</p>	
	<p>Interview with Resident #8, on 02/06/13 at 2:40 PM, revealed the resident enjoyed books and magazines; however, the facility had not made any arrangements for the resident to receive large print books or audio books. The resident stated it was not possible to read regular print due to very poor vision. The resident stated sports were of interest, especially college basketball; however, the resident did not know when the games were scheduled and the staff did not arrange for the television to be turned on for games. The resident expressed interest in attending activities.</p> <p>Interview with Certified Nurse Aide (CNA) #2, on 02/07/13 at 8:40 AM, revealed Resident #8 sat in the room unless out smoking or in therapy. She stated she never observed the resident engaged in room activities. She stated staff were trained to assist residents to activities; however, many times the staff were busy and not all residents were asked to attend. She stated this was probably not good for residents and isolated</p>		<p>to document and care plan resident specific activities. The Quality of life director will document and track when residents attend and refuse to attend all activities, specifically those activities directed toward their specific interest. On admission, the Quality of life director will assess all resident for appropriate visual materials for resident specific use. Specific needs for poor visual needs will be addressed for all resident needs with the assessment.</p>	



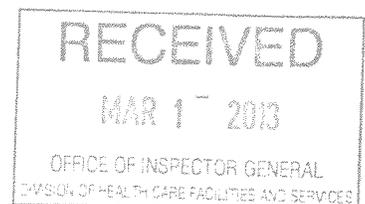
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F 248	Continued From page 3 them. Interview with the Quality of Life Director, on 02/07/13 at 9:50 AM, revealed Resident #8 preferred to stay in the room and she honored that wish. She stated the resident had not asked for any supplies to engage in room activities. She indicated one to one visits were not planned for any resident as the residents were all able to come out of their rooms. She stated the activity calendar was varied and the activity staff had no written directions or lists to ensure specific residents were invited to specific activities which met their interests. She stated activities were to enhance the residents' well-being. She revealed she assumed Resident #8 was happy since she did not ask for anything.	F 248	The Quality of Life director will interview all new admissions to document and care plan resident specific activities. The Quality of life director will document and track when residents attend and refuse to attend all	
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, interview and facility policy review, it was determined the facility failed to maintain a sanitary, orderly and comfortable	F 253	activities, specifically those activities directed toward their specific interest. An audit of 20% of resident care plans and resident interviews will be completed by the Quality of Life Director to ensure that the quality of life care plans are up-to-date to express the resident's specific activities and interventions that the resident enjoys. All resident's will be assessed by the quality of life director and	



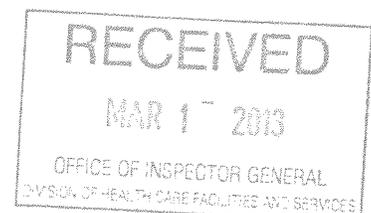
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F 253	<p>Continued From page 4</p> <p>environment in one (1) of two (2) shower rooms, one (1) of two (2) nurses stations, one (1) of two (2) common areas and three (3) of seven (7) wheelchairs were not maintained.</p> <p>The findings include:</p> <p>Upon request for the preventive maintenance policy for wheelchairs and common areas the Director of Maintenance reported the facility did not have a policy to address these areas.</p> <p>Observation, on 02/06/13 at 7:15 AM, revealed the East Common Area had one(1) of three (3) lights with loose particles in the base of the light fixture. The East Nurses Station had one (1) of two (2) light fixtures with loose particle in the base of the light fixture.</p> <p>Observation, on 02/06/13 during tour at 6:10 AM, revealed wheelchair arms were torn and rough in resident rooms 109, 110 and 115.</p> <p>Observation, on 02/06/13 at 7:00 AM, revealed six (6) cardboard boxes stored on the floor in the East Shower room. A green clothes basket with clothing was stacked on a clear plastic container on the floor.</p> <p>Interview, on 02/07/13 at 1:10 PM, with the Director of Maintenance, revealed the facility had a program where specific staff are assigned to certain rooms and locations of the building that each person tours on and makes recommendations of what needs to be fixed or corrected. He stated they do not have a preventive maintenance in place as such, but the staff looked at the environment and then reported</p>	F 253	<p>the social service director to ensure an ongoing program of activities designed to meet in accordance with the comprehensive assessment, and to identify interest of the residents, the physical, mental and psychosocial well-being of each resident. An attendance record audit will be completed weekly for a month by the Quality of Life Director and then monthly to ensure the attendance of residents is documented, and the visual needs of the residents are identified are met and signatures are present to their specific interest activity care plan to ensure residents are attending activities of interest and visual needs are met and care plans signed.</p>	



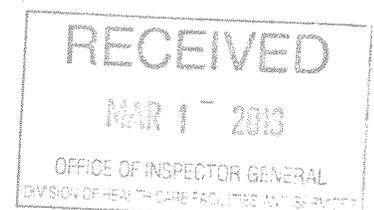
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F 253	Continued From page 5 the areas of concerns in the building. He stated he was responsible to ensure the wheelchairs were repaired. Interview, on 02/07/13 at 1:10 PM, with the Administrator, confirmed the facility had a program where staff are assigned to areas and locations within the building. The person is assigned tours and makes recommendations of what needs to be fixed or corrected and reports that to maintenance.	F 253	4. The attendance audit results of the weekly audit will be reported by the Quality of Life Director weekly in the morning meeting for review and follow up. The monthly audit results will be forwarded to the quarterly, quality assurance committee for review, follow up and recommendations of the medical director and team.	
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	F253 1. The plant operations director and the environmental services supervisor on February 7th cleaned and removed the loose particles in the base of the light fixtures in the East and West wing common areas. The arm rest on the wheel chairs in rooms 109, 110 and 115 were repaired by the plant operations director on February 12th.	3/14/13



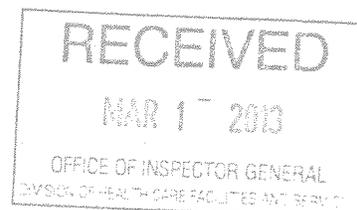
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F 431	<p>Continued From page 6</p> <p>controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure unauthorized persons/staff did not have unsupervised access to medical supplies and medications to assure the integrity and safe keeping of these medications in accordance with accepted professional principles and in agreement with the facility's policy for medication administration and storage in two (2) of two (2) medication rooms that were accessed by unauthorized staff.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Medication Administration and Medication Storage, dated as effective 12/2010, revealed the room was to be kept locked when unattended, only authorized persons were to have access to keys to the medication rooms and the medication rooms were not to be left unattended.</p> <p>Observation and interview, on 02/06/13 at 10:20 AM, revealed the Director of Maintenance removed his keys from his pocket and opened the East Medication room. He entered the room</p>	F 431	<p>The boxes and cloth basket in the East shower room was removed by the environmental services supervisor on 2/6/13.</p> <p>2. On March 11th the facility's plant operations director and environmental services director evaluated and audited 100% of common area light fixtures for dust and loose particles. A 100% audit of all wheelchairs was completed by the plant operations director on 2/12/13 to identify and repair wheelchairs that may have torn arm rest and not in compliance with wheel chair maintenance. The East and West shower rooms were inspected by the environmental services director on 2/12/13 for</p>	



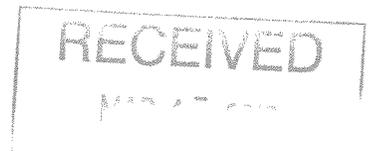
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F 431	<p>Continued From page 7</p> <p>with a cup of ice and returned to the east nurses station with the cup filled with water. He reported, he obtained the cup of water from the medication room and eye wash room.</p> <p>Observation, on 02/06/13 at 5:05 PM, on the West Wing revealed CNA #1 exited the medication room alone carrying a container of ice. The door to the medication room was observed to have a combination (push button) lock on the outside of the door. Observation of the medication room at 5:25 PM revealed an unlocked cabinet storing supplies for injections, antacids, dressing changes, and liquid nourishment. A plastic drawer unit contained IV antibiotics and numerous bags of IV fluids.</p> <p>Interview with CNA #1, on 02/06/13 at 5:06 PM, revealed she was in the medication room by herself. She stated the nurse had let her in the room to get ice. She stated she was alone in the room and the nurses regularly unlocked the door to let staff in to obtain ice from the ice machine.</p> <p>Observation, on 02/06/13 at 5:40 PM, of the East Wing medication room, revealed the interior door with locking mechanisms were not engaged and the door was easily opened. Emergency medications were stored in the unsecured interior closet.</p> <p>Interview with LPN #5, on 02/07/13 at 1:50 PM, revealed a CNA had requested to get some ice and she unlocked the medication room door to allow her entrance. She stated she did not know other staff were not to be in the locked medication room alone without a nurse present or she would</p>	F 431	<p>necessary services to maintain a sanitary orderly comfortable environment. No other deficient practice was identified.</p> <p>3. The regional plant operations director in serviced the facility's plant operations and housekeeping departments on 2/11/13 on the cleaning policy for common areas and light fixtures, the identification of worn arm rest and replacing arm rest when needed and the storage of items in the shower room. The plant operations director will audit all common area and light fixtures weekly for one month and then monthly for compliance.</p>	



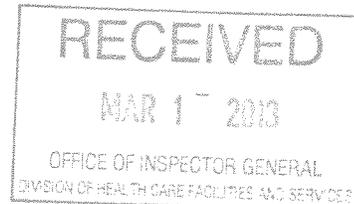
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F 431	Continued From page 8 have stayed with the CNA. Interview, on 02/06/13 at 5:50 PM, with the Administrator, Director of Nursing, and the Assistant Director of Nursing revealed they were not aware the medication rooms were accessed by non-medical staff. They were not aware the interior closet locking mechanism had failed to engage on the East Wing medication room, leaving emergency medications accessible to staff. They stated the nurse should have stayed in the medication room with the staff when they obtained the ice. They stated non-nursing persons were not allowed to access the medication rooms.	F 431	The plant operations director will audit the facility shower rooms daily for one month and then weekly for proper storage in the shower rooms, the resident wheelchairs will be audited weekly for one month and then monthly for three months to ensure compliance. Results of the audits will be forwarded to the morning meeting for immediate review and identified revisions by the administrator.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	4. The administrator will submit the weekly plant operations and environmental service audits and the monthly plant operations and	



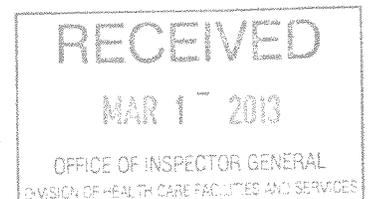
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F 441	Continued From page 9 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	environmental services audit results to the quarterly quality assurance meeting for review and follow up by the medical director and team. F431 1. The facility plant operations	3/14/13
	This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and review of the facility's policy, it was determined the facility failed to ensure staff used infection control practices to prevent the spread of germs between residents in contact precautions for one (1) of seventeen (17) sampled residents and two (2) unsampled residents. (Resident #9). The facility failed to ensure mini-nebulizer face masks were maintained in a clean manner for two (2) of seventeen (17) sampled residents and two (2) unsampled residents. (Residents #8 and #10). In addition, two (2) of forty-two (42) resident rooms, Rooms 204B and 206A had mini-nebulizer mouthpieces which were uncovered and lying on the bedside tables. The facility failed to ensure nurses followed infection control practices during direct care for one (1) of seventeen (17) sampled residents and two (2) unsampled residents.		director changed the locks on 2/6/13 to the medication room doors and educated C.N.A. #1. The Plant operations director and LPN #5 was educated by the director of nursing, regarding the policy of who is allowed to have keys to the medication rooms and that no one may enter the medication room without supervision.	



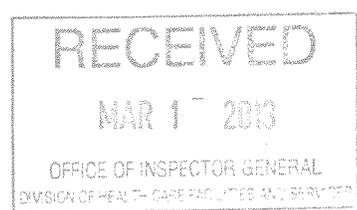
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185335	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/07/2013
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 CRISTLAND ROAD LOUISVILLE, KY 40214
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F 441	<p>Continued From page 10 (Resident #3). The nurse failed to wash her hands during the performance of a skin assessment and tracheostomy care. In addition, the nurse failed to maintain a sterile field during a sterile procedure. The facility failed to ensure nurses practiced hand hygiene prior to and after medication administration for two (2) of seventeen (17) sampled and two (2) unsampled residents (Resident's A and B).</p> <p>The findings include:</p>	F 441	<p>2. All medication rooms (two) were evaluated by the plant operations director and the director of nursing 2/6/13 for security of the locks and unauthorized entrance to the room. No other deficient practice was identified.</p> <p>3. 100% of the facility staff was educated by the Staff Development Coordinator on February 2/8/13 regarding</p>	
	<p>1. Review of the facility's policy on Handwashing/Hygiene, dated August 2009, revealed personnel would follow the Handwashing/Hygiene procedures to help prevent the spread of infection. All personnel received training on these procedures. All personnel would wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water when there was likely exposure to spores (i. e., C. Difficile). For effective mechanical removal of spores, wash hands for 30-60 seconds with soap and water.</p> <p>Observation of Certified Nurse Aide (CNA) #2, on 02/05/13 at 11:50 AM, revealed she entered Resident #9's room with signage on the door to see nurse before entering. A small cart containing gowns, red bags and gloves, was outside the door. The CNA entered the room after gloving and delivered the resident's lunch tray. She was observed to move the overbed table into reach and remove extra items from the table to make room for the meal tray. When the CNA left the room, she was observed to remove</p>		<p>who is authorized to have keys to the medication rooms and that the medication rooms are not to be left unattended. The clinical staff were informed that the drugs and biological used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions when applicable and</p>	



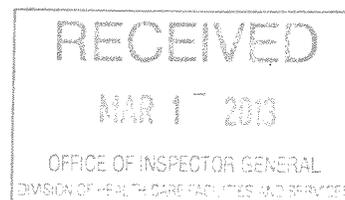
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F 441	<p>Continued From page 11</p> <p>her gloves and sanitize her hands with gel.</p> <p>Observation of CNA #3, on 02/05/13 at 12:20 PM, revealed she entered Resident #9's room with gloved hands. She was observed to empty a trash can into a red bag and remove it from the room. She disposed of the red bag in the utility room, removed her gloves then sanitized her hands with gel.</p> <p>Review of the clinical record for Resident #9, revealed the facility admitted the resident from the hospital with a diagnosis of Clostridium Difficile (C. Diff) Colitis. The facility implemented contact precautions, placed a sign on the door to see the nurse before entering the room and placed an isolation cart outside the room.</p> <p>Interview with CNA #2, on 02/05/13 at 12:15 PM, revealed Resident #9 was in isolation for an unknown reason. She stated this required her to use gloves and gel when she left the room. She stated she did not know the resident had been in isolation secondary to C. Diff or what that meant. She stated she had not used soap and water to clean her hands and had used gel. She stated the nurse did not tell her that C. Diff required her to wash her hands with soap and water. She stated she was trained to either use gel or soap and water and thought she should have used soap and water to prevent the spread of the organism.</p> <p>Interview with CNA #3, on 02/05/13 at 12:20 PM, revealed she was very new in her job and had been trained to use gel after removing gloves. She stated she was not informed by nursing to use soap and water when removing gloves and</p>	F 441	<p>must store all drugs and biological in locked compartments under proper temperature control and permit only authorized personnel clinical staff to have access to the keys. The facility's plant operations director will keep a log of who has Possession of the East and West medication room keys. The Director of Nursing and or the Administrator will audit clinical staff daily for 5 days to ensure all clinical licensed staff with approved possession of the medication room keys allow only authorized personnel into the medication room with supervision by the nurse. Results of medication room for authorized personnel entry without supervision</p>	



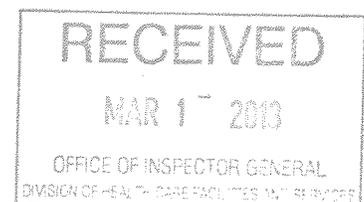
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F 441	<p>Continued From page 12</p> <p>leaving isolation for residents with C. Diff. She stated she did not know the reason the resident was in isolation and she should have washed her hands to prevent spread of the organism.</p> <p>Interview with Registered Nurse (RN) #3, on 02/05/13 at 2:50 PM, revealed the CNAs were trained on washing hands with soap and water. She stated Resident #9 continued on contact isolation for C. Diff to ensure the organism was not passed to others. She stated the CNAs should have been told during report how to manage the isolation as the information was not documented anywhere for the CNAs to read. She stated handwashing was the acceptable method for preventing the spread of spores like C. Diff.</p> <p>2. The facility did not provide a facility policy for care of oxygen equipment.</p> <p>Interview with LPN #4, on 02/07/13 at 1:30 PM, revealed oxygen equipment was to be stored in a clean plastic bag when not in use.</p> <p>Observation of the facility, on 02/04/13 at 6:30 PM, and 02/05/13 at 10:00 AM, and 02/06/13 at 2:15 PM, revealed Resident #8's mini-nebulizer face mask was uncovered and on top of the dresser with the tubing draped down and in contact with the floor.</p> <p>Observation of the facility, on 02/04/13 at 7:00 PM, and 02/05/13 at 10:15 AM, revealed Resident #10's mini-nebulizer face mask was uncovered in a chair next to the resident's bed.</p> <p>Observation of Room 204B on 02/04/13 at 6:40</p>	F 441	<p>audit will be discussed by the administrator and or director of nursing in the daily team meeting. Identified revisions to the plan will be discussed at the daily team meeting and the education department will educate the parties involved with appropriate discipline as necessary. On day six the medication room for non-authorized personnel without supervision audit will go to weekly and will remain weekly until 100% compliance is met for four consecutive weeks. The administrator and or director of nursing will monitor monthly x three months and then quarterly times three months to ensure compliance.</p>	



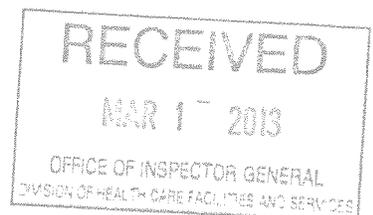
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F 441	<p>Continued From page 13</p> <p>PM revealed a nebulizer mouthpiece connected to the nebulizer lying on the bedside table without a covering.</p> <p>Observation of Room 206A on 02/04/13 at 6:50 PM also revealed a nebulizer mouthpiece connected to the nebulizer tubing lying on the bedside table without a covering.</p> <p>Interview with LPN #8, on 02/07/13 at 8:50 AM, revealed the oxygen equipment needed to be stored in a clean plastic bag after use to prevent contamination and the spread of infection. She stated she was responsible to store the equipment after administering breathing treatments to residents. She stated the RN supervised the unit.</p> <p>Interview with RN #3, on 02/07/13 at 9:20 AM, revealed the nurses administering breathing treatments were responsible to store oxygen equipment when not in use. She stated the nurses were trained and knew how to store the equipment to prevent the spread of infection. She stated she normally made rounds and reminded nurses to store the items.</p> <p>3. Review of the facility policy regarding Medication Administration-Administering Medications, effective 12/2010, revealed the rule for handwashing was to be performed before beginning medication pass and after any direct contact with the resident.</p>	F 441	<p>4. Results of medication room for authorized personnel entry without supervision audit will be taken to the quarterly quality assurance meeting for review and follow up by the medical director and the quality assurance team.</p> <p>F 441</p>	3/14/13
			<p>1. Resident #9 was assessed by the licensed nursing staff on 2/5/13. The Staff Development Coordinator on 2/5/13 educated CNAs #2 and #3 regarding the C-diff policy, hand-washing & isolation precautions with accurate return demonstrations. Resident #8 and #10' was assessed 2/5/13 by the licensed nurse and the mini-nebulizer masks were replaced for resident #8 and</p>	



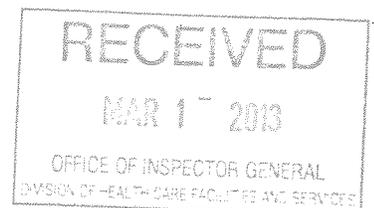
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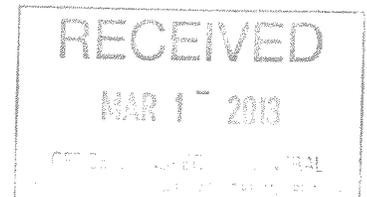
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F 441	<p>Continued From page 14</p> <p>Interview with the Director of Nursing on 02/07/13 at 1:50 PM, revealed staff were to wash and/or disinfect their hands before and after every resident contact.</p> <p>Observation during the medication pass on 02/06/13 at 9:50 AM, revealed LPN #4 failed to wash or disinfect her hands prior to the medication preparation and administration or after each resident contact for two (2) unsampled residents. (Resident's A & B) Nurse #4 prepared and administered medications for Resident A without washing/disinfecting her hands prior to or after administering the oral medications. She administered an inhalant for another resident; (Resident B) without washing or disinfecting her hands prior to or after administering the medication.</p> <p>Interview with LPN #4, on 02/06/12 at 10:00 AM, revealed she was supposed to wash or disinfect her hands between each resident contact. She stated they were to wash their hands with soap and water after every third (3rd) resident contact. She stated she was nervous and should have disinfected her hands.</p> <p>4. Observation, on 02/05/13 at 11:20 AM, of Licensed Practical Nurse (LPN) #9 while performing skin assessment and tracheotomy care on Resident #9 revealed the nurse entered the room and applied clean gloves with out proper hand hygiene. Further observation of LPN #9 during the skin assessment of the resident revealed a Granulex treatment was preformed to the resident's left heel and the LPN changed gloves without performing hand hygiene.</p>	F 441	<p>resident #10 on 2/5/13 to ensure that the mini-nebulizer face mask were maintained in a clean manner. Oxygen equipment in rooms 204 and 206 were replaced by nursing staff on 2/4/13 with new clean (not sterile) equipment. The Staff Development Coordinator on 2/5/13 completed Re-Education was completed with LPN #4 on medication administration and proper hand washing, with return demonstration. Residents A and B were assessed BY nursing staff on 2/6/13. The assessment revealed residents A & B to be at baseline status. LPN #9 was educated by the</p>	



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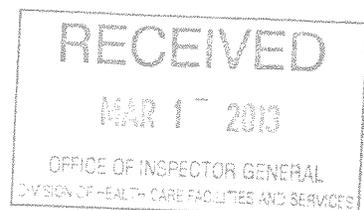
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 CRISTLAND ROAD LOUISVILLE, KY 40214	
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F 441	Continued From page 15 Continued observation of the resident's overbed table revealed a urinal with urine and a tracheotomy care kit. Further observation of LPN #9 revealed she applied clean gloves, opened the tracheotomy care kit and then removed the resident's tracheotomy tubing for cleaning. She then removed the clean gloves and applied sterile gloves without hand hygiene. Continuous observation of LPN #9 revealed tracheotomy care was preformed with the urinal on the table and urine visible. Phone interview, on 02/07/13 at 2:00 PM, with LPN #9 revealed she was trained on handwashing and that hand hygiene should be preformed during each glove change. She further stated that no dirty items should be visible while a clean or sterile procedure is being preformed. LPN #9 stated not washing/sanitizing hands properly and not maintaining a clean surface when preforming care could lead to infection or cross-contamination.	F 441	Staff Development Coordinator on 2/6/13 on infection control program to prevent the spread of infections to include washing hands after each direct resident contact for which hand washing is indicated by accepted professional practice. 2. The facility's nurse management team completed a 100% audit on 2/4/13 on all residents who was receiving oxygen therapy to ensure that all oxygen equipment was stored appropriately, there were no other deficient practices identified on this date. The facility's Director of Nursing, Unit Managers and Staff Development Coordinator completed rounds on 2/6/13 and educated the nursing	



staff on infection control program to prevent the spread of infections to include washing hands after each direct resident contact for which hand washing is indicated by accepted professional practice specifically isolation, c-diff, medication administration and tracheotomy care.

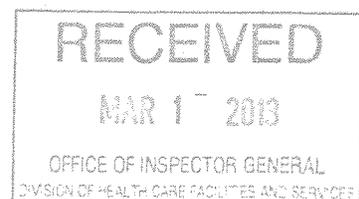
3. The Staff Develop Coordinator educated and completed clinical infection control competencies on 100% of the nursing staff by 2/17/13 for infection control, proper hand washing, isolation policy and procedures and infection control while giving tracheotomy care.



The unit managers will audit all oxygen therapy equipment four times per week for four weeks for proper storage. When the four times per week audit is 100% compliant the unit managers will audit weekly for 3 months. The Staff Development Coordinator will ensure proper tracheotomy care competencies are completed for 100% of the clinical nurses by 2/17/13. The staff development coordinator will evaluate tracheotomy care on 50% of the resident population weekly for four weeks to ensure compliance. New licensed staff will receive a tracheotomy competency check prior to being released to the unit for care.

A weekly medication pass observation 100% of licensed staff will be completed by the staff development coordinator for one month and then monthly for 3 months to ensure proper infection control practices on infection control program to prevent the spread of infections to include washing hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

4. The Infection control audits results will be forwarded WEEKLY to the morning meeting by the director of nursing and or staff development coordinator for immediate review and revision of interventions as identified. The results will be forward to the Quarterly quality assurance meeting for review and follow up by the medical director and team.



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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 CRISTLAND ROAD LOUISVILLE, KY 40214
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1974, 1992 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type V (111) SMOKE COMPARTMENTS: Six (6) smoke compartments. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system. GENERATOR: Type II generator, installed new in 2009. Fuel source is diesel. A standard Life Safety Code survey was conducted on 02/05/13. Signature Healthcare of South Louisville was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The facility is certified for one hundred (100) beds with a census of eighty six (86) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from	K 000	K 029 1. The facility immediately installed a self-closing device on the doors of the Medical Records Office and the dry storage areas in the kitchen to be in compliance with accordance 8.4.1 and 19.3.5.4 protects hazardous areas. 2. The facility was evaluated by the regional plant operations on 2/25/13 and a 100% audit was completed on all storage room and office doors to identify any other deficient practice for self-closing devices on doors that protects against hazardous areas. There were no other deficient practices identified.	3/14/13
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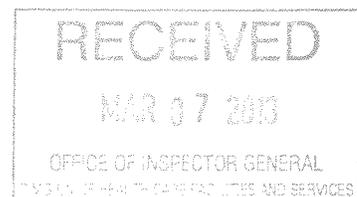
LATENCY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 3/17/13
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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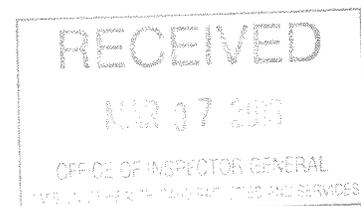
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185335	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2013
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K 000	Continued From page 1 Fire).	K 000		
K 029 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "E" level.</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 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for one hundred (100) beds with a census of eighty six (86) on the day of the survey. The facility failed to provide self-closing devices for doors protecting hazardous areas.</p> <p>The findings include:</p>	K 029	<p>3. On 2/25/13 the regional plant operations director educated 100% of the facility plant operations team on the requirement of 8.4.1 and 19.3.5.4 protects hazardous areas and the need for self-closing devices on office and storage doors that contain hazardous areas. The facility administrator and regional plant operations director will ensure any addition of hazardous areas to the facility will be reviewed for compliance for an automatic door closures for doors protecting against hazardous areas.</p>	



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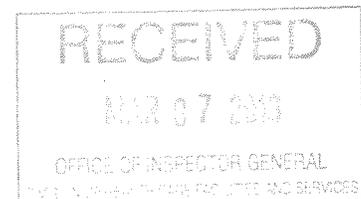
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 CRISTLAND ROAD LOUISVILLE, KY 40214	
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K 029	Continued From page 2 Observation, on 02/05/13 between 10:00 AM and 3:30 PM, with the Maintenance Director and the Regional Plant Operations Supervisor revealed rooms that required self-closing devices or rooms that contained a hazardous amount of combustibles did not have self-closing devices to keep the door closed. The rooms identified as hazardous requiring a self-closing device are the Medical Records Office and the Dry Storage in the Kitchen. Interview, on 02/05/13 between 10:00 AM and 3:30 PM, with the Maintenance Director and the Regional Plant Operations Supervisor revealed he was not aware the doors to these rooms were required to be self-closing. Interview, on 02/05/13 at 4:00 PM, with the Administrator revealed he was aware of the requirements for doors protecting hazardous areas. 8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.	K 029	4. The regional plant operations director will forward any new additions of hazardous areas and or renovations to current hazardous areas to the quarterly quality assurance committee for review and compliance of life safety code 8.4.1 and 19.3.5.4. K047 1. The facility plant operations director immediately installed exit signs located in the kitchen, dining, and T.V. room making a clear path of egress recognizable.	3/14/13



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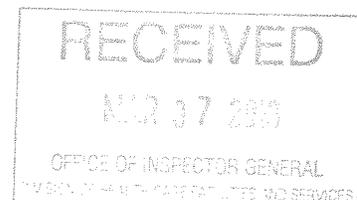
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K 029	Continued From page 3 Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029	2. On 2/25/2013 the plant operations director performed a 100% inspection of all paths of egress to ensure that all paths of egress were clearly marked and recognizable with exit signs. No other deficient practice was identified. 3. On 2/25/2013 the plant operations director educated 100% of the plant operations team regarding exit and directional signs displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting		



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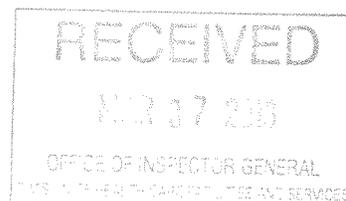
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K 047 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for one hundred (100) beds with a census of eighty six (86) on the day of the survey. The facility failed to ensure exits were clearly recognizable with proper exit signage.</p> <p>The findings include:</p> <p>Observation, on 02/05/13 between 10:00 AM and 3:30 PM, with the Maintenance Director and the Regional Plant Operations Supervisor revealed the exit doors located in the Kitchen, Dining Room, and T.V Room did not have an exit sign above the door making the path of egress clearly recognizable.</p> <p>Interview, on 02/05/13 between 10:00 AM and 3:30 PM, with the Maintenance Director and the Regional Plant Operations Supervisor revealed he was not aware the exits did not have proper signage.</p>	K 047	<p>system 19.2.10.1 NFPA 101 life safety to include that obviously and clearly are identifiable as exits shall be marked by an approved sign readily visible from any direction of exit access. The facility plant operations director will audit facility exit signs weekly x four weeks then monthly to ensure that the exit signs are appropriately lit, light bulbs are not burnt out and operating correctly.</p> <p>4. The facility plant operations director will report any weekly and or monthly non-compliance audits immediately to the administrator for immediate follow up and correction.</p>	



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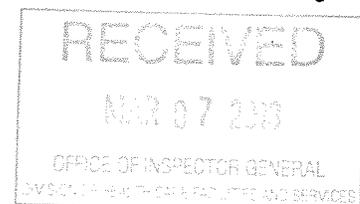
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K 047	Continued From page 5 Interview, on 02/05/13 at 4:00 PM, with the Administrator revealed he was not aware the exits did not have proper signage. Reference: NFPA 101 (2000 edition) 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047	The administrator will report in the quarterly quality assurance committee, compliance and non-compliance audits to the committee and the medical director for further review and follow up.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the	K 056	K 056 1. The facility plant operations director immediately moved the exit sign located at the West Hall Center exit that was located in front	3/14/13



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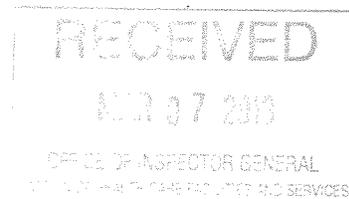
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K 056	<p>Continued From page 6</p> <p>building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for one hundred (100) beds with a census of eighty six (86) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/05/13 at 3:29 PM, with the Maintenance Director and the Regional Plant Operations Supervisor revealed a sprinkler head was blocked by the exit sign located at the West Hall Center Exit.</p> <p>Interview, on 02/05/13 at 3:29 PM, with the Maintenance Director and the Regional Plant Operations Supervisor revealed he was not aware of the blocked sprinkler head.</p> <p>Interview, on 02/05/13 at 4:00 PM, with the Administrator revealed he was not aware of the blocked sprinkler head.</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1</p> <p>Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved,</p>	K 056	<p>of the sprinkler head, 18 inches to the left leaving the exit sign in a visible place while not impeding on the sprinkler head.</p> <p>2. A 100% audit was completed by the regional plant operations director and facility plant operations director on 2/26/13 to identify any facility exit signs blocking sprinkler heads that would affect additional residents. There were no other deficient practices identified.</p> <p>3. On 2/25/13 the regional plant operations director educated the facility's plant operations staff on NFPA 13 that sprinkler heads cannot be blocked and kept in accordance with NFPA standards.</p>	



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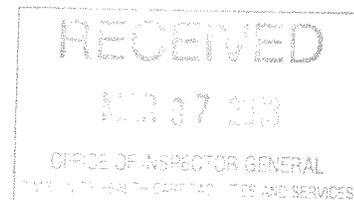
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K 056	<p>Continued From page 7</p> <p>supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <p>(1) Sprinklers installed throughout the premises</p> <p>(2) Sprinklers located so as not to exceed maximum protection area per sprinkler</p> <p>(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">Maximum Allowable Distance</td> <td></td> </tr> <tr> <td style="text-align: center;">Distance from Sprinklers to above Bottom of Side of Obstruction (A)</td> <td style="text-align: center;">of Deflector Obstruction (in.)</td> </tr> <tr> <td style="text-align: center;">(B) Less than 1 ft</td> <td style="text-align: center;">0</td> </tr> </table>	Maximum Allowable Distance		Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (in.)	(B) Less than 1 ft	0	K 056	<p>The facility plant operations director will audit facility exit signs weekly x four weeks then monthly to ensure that they are not blocking any sprinkler heads and the installation of any new sprinkler heads or exit signs must be approved by the facility administrator and or regional plant operations director.</p> <p>4. The facility's plant operations director will report any weekly and or monthly non-compliance audits immediately to the administrator for immediate follow up and correction. The administrator will report</p>	
Maximum Allowable Distance										
Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (in.)									
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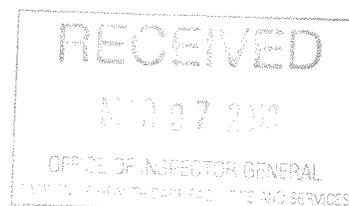
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K 056	Continued From page 8 1 ft to less than 1 ft 6 in. 21/2 1 ft 6 in. to less than 2 ft 31/2 2 ft to less than 2 ft 6 in. 51/2 2 ft 6 in. to less than 3 ft 71/2 3 ft to less than 3 ft 6 in. 91/2 3 ft 6 in. to less than 4 ft 12 4 ft to less than 4 ft 6 in. 14 4 ft 6 in. to less than 5 ft 161/2 5 ft and greater 18 For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.	K 056		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the installation of portable fire extinguishers per NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff, and visitors. The facility is certified for one hundred (100) beds with a census of eighty six (86) on the day of the survey. The findings include:	K 064	in the quarterly quality assurance committee, compliance and non-compliance audits to the committee and the medical director for further review and follow up. Any new additions of exit signage or sprinkler heads will be forwarded to the quarterly quality assurance committee for review. K 064 1. The fire extinguisher located in the center hall was immediately lowered to the five (5) feet from the floor requirement.	3/14/13



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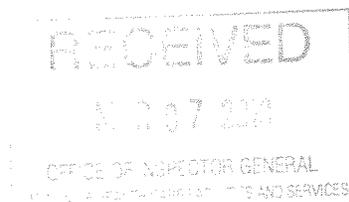
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K 064	Continued From page 9 Observation, on 02/05/13 at 10:06 AM, with the Maintenance Director and the Regional Plant Operations Supervisor revealed the wall mounted, portable fire extinguisher located in the Center Hall was mounted above five (5) feet from the floor. The extinguisher was mounted at five foot, eight inches above the floor. Interview, on 02/05/13 at 10:06 AM, with the Maintenance Director and the Regional Plant Operations Supervisor revealed they were not aware of the installation requirements for wall mounted portable fire extinguishers. Interview, on 02/05/13 at 4:00 PM, with the Administrator revealed he was not aware of the installation requirements for wall mounted portable fire extinguishers. Reference NFPA 10 (1998 Edition). 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064	2. The facility's plant operations director audited 100% of the portable fire extinguishers to ensure that all portable fire extinguishers were located five (5) feet from the floor. There were no other deficient practices identified. 3. On 2/25/13 the regional plant operations director educated the facility's plant operations staff on NFPA 10 1-6.10 the portable fire extinguishers may not be more than 5 feet above the floor. All new installation of portable		
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no	K 066			



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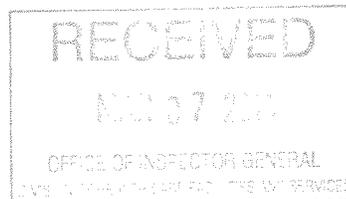
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K 066	<p>Continued From page 10 less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff and visitors. The facility is certified for one hundred (100) beds with a census of eighty six (86) on the day of the survey. The facility failed to ensure the smoking areas had a metal container with a self-closing lid to dump ashtrays.</p>	K 066	<p>fire extinguishers must be approved by the facility administrator and regional plant operations director, to ensure proper installation and no higher than 5 feet from the floor.</p> <p>4. The regional plant operations director will forward any new construction and or renovations to the quarterly quality assurance committee for review and compliance of life safety code NFPA 10.</p>	



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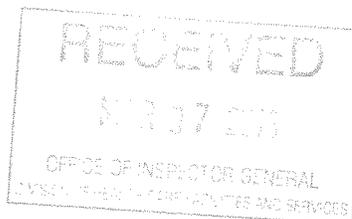
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K 066	Continued From page 11 The findings include: Observation, on 02/05/13 at 2:13 PM, with the Maintenance Director and the Regional Plant Operations Supervisor revealed the facility failed to provide a metal container with a self-closing lid to dump the ashtrays, located in the designated smoking areas. Interview, on 02/05/13 at 2:13 PM, with the Maintenance Director and the Regional Plant Operations Supervisor revealed he was not aware of the requirement for metal containers with a self-closing lid for dumping ashtrays. Interview, on 02/05/13 at 4:00 PM, with the Administrator revealed he was not aware of the requirement for metal containers with a self-closing lid for dumping ashtrays. Reference: NFPA Standard 101 (2000 Edition). 19.7.4 Smoking (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066	K 066 1. The facility obtained a quote from direct supply on 2/25/13 and an order was place on 2/25/13 to purchase a metal container with a self-closing lid to dump ashtrays in located in the designated smoking areas. The self-closing containers were put in place on 3/8/13. 2. The facility was evaluated by the regional plant operations director to identify any other deficient practices, for not having a self-closing lid container to dump ashtrays in. No other deficient practices were identified.	3/14/13
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 147		



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185335	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2013
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K 147	<p>Continued From page 12</p> <p>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 six (6) smoke compartments, residents, staff, and visitors. The facility is certified for one hundred (100) beds with a census of eighty six (86) on the day of the survey. The facility failed to ensure the proper use of power strips, and failed to maintain proper space around electrical panels.</p> <p>The findings include:</p> <p>Observations, on 02/05/13 between 10:00 AM and 3:30 PM, with the Maintenance Director and the Regional Plant Operations Supervisor revealed:</p> <ol style="list-style-type: none"> 1) A power strip was plugged into another power strip located in the Admissions Office. 2) A desk was blocking an electrical panel located in the Dry Storage Room. 3) A power strip was plugged into another power strip located in the Beauty Shop. <p>Interview, on 02/05/13 between 10:00 AM and 3:30 PM, with the Maintenance Director and the Regional Plant Operations Supervisor revealed he was aware of the proper use of power strips; however, he was not aware the power strips had been misused. Further interview revealed they were not aware the desk had been placed in front of the electrical panel.</p> <p>Interview, on 02/05/13 at 4:00 PM, with the Administrator revealed he was aware of the proper use of power strips; however, he was not aware the power strips had been misused.</p>	K 147	<ol style="list-style-type: none"> 3. On 2/25/13 the regional plant operations director educated 100% of the plant operations staff on NFPA Standard 101 19.7.4 that metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. A weekly audit x 4 weeks and then monthly for 4 months of the designated smoking areas will be completed to ensure the presence of a metal self-closing container where ashtrays can be emptied. 4. The facility plant operations director will report any weekly and or monthly non-compliance audits 	



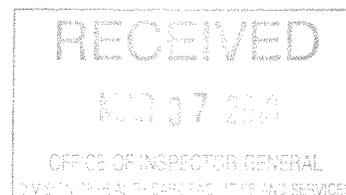
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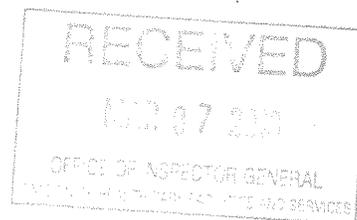
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K 147	<p>Continued From page 13</p> <p>Further interview revealed he was not aware the desk had been placed in front of the electrical panel</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <p>(1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet</p>	K 147	<p>immediately to the administrator for immediate follow up and correction. The administrator will report in the quarterly quality assurance committee, compliance and non-compliance audits to the committee and the medical director for further review and follow up.</p> <p>K 147</p> <p>1. The facility plant operations director immediately unplugged the power strip in the admissions office and in the beauty shop. The desk located in the dry storage room was moved to provide access to the electrical panel.</p>	3/19/13



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K 147	Continued From page 14 adapters. 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147	<p>2. The plant operations director evaluated all medical equipment and power strips to ensure that no medical equipment was plugged into power strips and that no power strips were plugged into other power strips. Also an audit of all electrical panels was complete to ensure access. No other deficient practice was found.</p> <p>3. By March 5th 2013 an all staff in-service will be held by the maintenance director on the proper use of power strips and that no medical and or</p>		



appliance can be plugged into a power strip and power strips cannot be plugged into other power strips and access to electrical panels. The plant operations department will make weekly rounds for one month and then monthly to ensure the proper usage of power strips and to ensure there is nothing blocking electrical panels.

4. The findings of the weekly/monthly audits will be forwarded to the quarterly Quality Assurance meeting for compliance, follow up and recommendations.

