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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185448	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES S TAYLOR MEMORIAL HOME	1015 W MAGAZINE STREET LOUISVILLE, KY 40203

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F 372	Continued From page 9 trash. Observation later that morning at 9:00am revealed facility staff loading the trash into a pick-up truck and removing it from the facility in two loads. Observation on 08/11/10 at 9:00am revealed trash bags on the ground by the dumpster being loaded by staff into a pick-up truck and piled as high as the top of the truck's cab. Interview with the Administrator in 08/12/10 at 4:50pm, revealed the trash was not picked up on 08/10/10 related to non-payment of the trash bill. She stated she was responsible to pay the bills; however, the facility was experiencing some financial set-backs. She stated the bill had since been paid through the month of August. She stated normally trash was picked up twice a week; however, the facility got rid of the trash privately on Monday and Tuesday and regular trash pick-up resumed on Tuesday.	F 372	The Maintenance Director will monitor the garbage dumpster daily for 2 weeks beginning 8/31/10 and then Monday-Friday until deemed necessary by the QA committee to ensure that trash bags are enclosed in the dumpster and the outside of the dumpster is free of trash bags. The results of this audit will be reported to the QA committee at the weekly QA meeting for 6 weeks, and then monthly. A system has been put in place to work to ensure the waste management bill is paid timely to avoid interruption of service. The Business Office Manager was in-serviced on working to pay the waste management bill by the due date by the Administrator on 9/1/10. This will be monitored by the Business Office Manager every month beginning September 2010 and reported to the QA committee at the monthly QA meeting for three months and then quarterly.	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by torn fall mats with the interior foam exposed in four (4) resident rooms.	F 465		

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F 465	Continued From page 10 The findings include: Observation on 08/10/10 at 7:18am during tour of the facility revealed resident rooms C4, C6, C9, and C10 had floor mats placed on the floor with separated seams and interior foam exposed. The floor mats, separated at the seams with the foam exposed, remained in the resident rooms and in use on 08/11/10 and remained in place on 08/12/10 at time of exit. Interview with the Maintenance Director on 08/12/10 at 3:45pm revealed other mats were available in the facility. He reported he did not track or look at the floor mats routinely when he was in the rooms. He did report the torn mats were a safety concern and an infection control concern. He reported he did not have a tracking tool for evaluation of the mats in the resident rooms.	F 465	The floor mats were replaced in resident rooms C4, C6, C9, and C10 on 8/13/10 by the Maintenance Director. All residents have the potential to be affected. The Maintenance Director made rounds in all rooms occupied by residents on 8/25/10 to evaluate the condition of floor mats in resident rooms. The Administrator ordered 5 floor mats on 8/17/10. The Administrative Assistant ordered an additional 12 floor mats on 8/30/10. The Interim Director of Nursing conducted an in-service for the staff on 8/23/10 on removing any equipment including floor mats that is not in good condition immediately, reporting it to the nurse and documenting it in the Maintenance Log. The Maintenance Director will make rounds in all rooms occupied by residents on a weekly basis to evaluate the condition of floor mats beginning August 30, 2010. The Maintenance Director was provided a tracking tool for evaluation of the floor mats on 8/30/10 by the Administrator. The results of these rounds will be reported to the QA committee at the weekly meeting for 5 weeks, monthly for 3 months, and then quarterly.	9-10-10

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 08/12/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a " F ".	K 000		
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 that the facility failed to ensure that fire extinguishers were mounted according to NFPA standards. The findings include: Observation on 08/12/2010 at 12:10 PM, revealed that a fire extinguisher in the business office was not properly mounted. The fire extinguisher was found to be sitting on the floor. The observation was confirmed with the Maintenance Director. Interview on 08/12/2010 at 12:10 PM, with the Maintenance Director, revealed that he was unaware of the fire extinguisher not being mounted properly. Reference: NFPA 10 (1998 edition) 1-6.7* Portable fire extinguishers other than wheeled types shall be securely installed on the	K 064	No specific Residents were cited. All residents have the potential to be affected. The Maintenance Director will ensure the fire extinguisher is mounted properly in the business office by September 7, 2010. The Maintenance Director and his assistant were in-serviced on August 27, 2010 by the Administrator on ensuring the fire extinguishers are properly mounted in the facility. The Maintenance Director made rounds throughout the facility on 8/27/10 to ensure fire extinguishers other than wheeled types in the facility were securely installed on the hanger or in the bracket supplied or placed in cabinets or wall recesses. In conducting these rounds the Maintenance Director did not find any other fire extinguishers that were not securely installed on the hanger or in the bracket supplied or placed in cabinets or wall recesses. The Maintenance Director or his full-time assistant will make rounds in the facility Monday-Friday to check for fire extinguishers other than wheeled types in the facility are securely installed on the hanger or in the bracket supplied or placed in cabinets or wall recesses beginning August 30, 2010 for 3 weeks, and then weekly thereafter. The results of this audit will be reported to the QA Committee in the weekly QA meeting.	9-17-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephanie L. Mathis
TITLE: Administrator
(X6) DATE: 9-1-10

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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 requisite to continued program participation.

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K 064	Continued From page 1 hanger or in the bracket supplied or placed in cabinets or wall recesses. The hanger or bracket shall be securely and properly anchored to the mounting surface in accordance with the manufacturer ' s instructions. Wheeled-type fire extinguishers shall be located in a designated location.	K 064		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (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. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain	K 066	The facility ordered the proper metal containers with self closing devices into which ashtrays can be emptied on. This proper metal container will be placed in the gated outside smoking area where staff can empty ashtrays into by September 7, 2010. The Maintenance Director and his full-time assistant were in-serviced by the Administrator on 8/27/10 on the proper metal containers with self closing devices into which ashtrays can be emptied The Maintenance Director will audit the facility smoking area 5 days a week for 2 weeks beginning August 30, 2010, then 3 days a week for 2 weeks, and thereafter once a week to ensure that the approved metal containers with self-closing devices are being used which ashtrays can be emptied. The results of this audit will be reported to the QA Committee at the weekly QA meeting.	9-17-10

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K 066	Continued From page 2 smoking areas according to NFPA standards. The findings include: Observation on 08/12/2010 at 12:48 PM, revealed that the facility did not have a metal container with a self closing device. The area was found to have a metal can with no self closing device in which staff would empty ash trays into. The observation was confirmed with the Maintenance Director. Interview on 08/12/2010 at 12:48 PM, with the Maintenance Director, revealed that he felt the metal trash can that was located in the smoking area met the requirements for smoking areas.	K 066		
K 072 SS=F	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 that the facility failed to ensure that corridors were maintained free from obstructions to full instant use in the case of fire or other emergency. The findings include: Observation on 08/12/2010 at 12:28 PM, revealed that in the B Hallway next to room 4 a clean linen	K 072	The Maintenance Director and his assistant were in-serviced on August 27, 2010 by the Administrator on ensuring the corridors were maintained free from obstruction to full instant use in the case of fire or other emergency. An in-service was conducted for Nursing and Housekeeping Staff on 8/30/10 by the Maintenance Director on ensuring the corridors were maintained free from obstruction to full instant use in the case of fire or other emergency. The Maintenance Director removed the clean linen carts from the hall way on 8/27/10. The Maintenance Director will make rounds throughout the facility to ensure that corridors are maintained free from obstruction to full instant use in the case of fire or other emergency. This audit will be done daily Monday-Friday for 2 weeks beginning 8/30/10, then 3 days a week for 2 weeks, and thereafter once a week. The results of this audit will be reported to the QA Committee at the weekly QA meeting.	9-17-10

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K 072	Continued From page 3 cart was left unattended. Further observation on 08/12/2010 at 2:18 PM, revealed the clean linen cart was still next to room 4. Clean Linen carts were also observed during the Life Safety Code Survey in Hallways A, C, and D. Corridors are intended for means of egress, internal traffic and emergency use, not storage spaces. The Life Safety Code has specific requirements for storage spaces. These items would also limit the use of the hand rails by occupants of the building when needed. Interview on 08/12/2010 at 2:18 PM, with the Maintenance Director, revealed that the linen carts are routinely left in the hallways.	K 072		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that electrical wiring was according to NFPA standards. The findings include: Observation on 08/12/2010 at 12:46 PM, revealed that in room 8 of E wing there was an electrical outlet next to a sink that was not ground fault rated (GFCI). The observation was confirmed with the Maintenance Director. Further observation revealed that electrical outlets that were not ground fault rated were found in the	K 147	All residents have the potential to be affected. No specific residents were cited. The Maintenance Director contacted a local electric company on 8/27/10 to look at the electrical outlets next to the sinks in the resident rooms due to the facility having to have ground fault plugs installed. A representative from the local electric company came to the facility on 8/30/10 and suggested that we remove power from these electrical outlets next to the sink in the resident rooms and replace with blank cover plates. The power from these electrical outlets next to the sink in the resident rooms will be removed and replaced with blank cover plates by the local electric company. This will be completed by September 15, 2010.	9-17-10

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K 147	Continued From page 4 following rooms: E Wing rooms (12 and 14), D Wing rooms (4 and 11), C Wing (1, 8, and 11), and E Hall rooms (1, 3, 7, and 12) Interview on 8/12/2010 at 12:46 PM, with the Maintenance Director, revealed that he believed the electrical outlets had been disconnected after the new electrical outlets had been installed. Reference: NFPA 70 (1999 edition) 517-20. Wet Locations a. All receptacles and fixed equipment within the area of the wet location shall have ground-fault circuit-interrupter protection for personnel if interruption of power under fault conditions can be tolerated, or be served by an isolated power system if such interruption cannot be tolerated. Exception: Branch circuits supplying only listed, fixed, therapeutic and diagnostic equipment shall be permitted to be supplied from a normal grounded service, single- or 3-phase system, provided that a. Wiring for grounded and isolated circuits does not occupy the same raceway, and b. All conductive surfaces of the equipment are grounded. b. Where an isolated power system is utilized, the equipment shall be listed for the purpose and installed so that it meets the provisions of and is in accordance with Section 517-160. FPN: For requirements for installation of therapeutic pools and tubs, see Part F of Article 680.	K 147		
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the	K 155		

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K 155	Continued From page 5 building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to maintain a fire watch according to NFPA standards. The findings include: Observations on 08/11/2010 at approximately 2:30 PM, by the Health Survey Team, revealed that the smoke detectors in Rooms C5 and C7 were covered with a plastic bag. Interview on 08/12/2010 at 2:45 PM, with the Maintenance Director, revealed that the facility has been doing construction in rooms C5 and C7 for approximately the last two weeks. Further interview with the Maintenance Director revealed that the facility had placed plastic bags over the smoke detectors to prevent dry wall dust from setting the smoke detectors off. Record review on 08/12/2010 at 2:45 PM, revealed that the facility could not produce documentation that a fire watch had been conducted for the area affected by the construction.	K 155	All residents have the potential to be affected. No specific residents were cited. The facility has implemented a fire watch policy and procedure that addresses the fire alarm watch when the system is down for more than 4 hours. The Maintenance Director and his assistant were in-serviced again on this policy and procedure on August 27, 2010 by the Administrator. The Maintenance Director will report to the QA Committee when the fire alarm system is down for more than 4 hours and the QA Committee will monitor to see that the fire watch was done when required as stated in facility policy.	9-17-10

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