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OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 10/27/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/13/2011
NAME OF PROVIDER OR SUPPLIER  PARK TERRACE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9700 STONESTREET ROAD LOUISVILLE, KY 40272	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 000	INITIAL COMMENTS	F 000	
F 252 SS=E	<p>483.15(h)(1) <b>SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</b></p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, it was determined the facility failed to 1. maintain safe and comfortable wheelchairs for nine (9) of twenty-eight (28) residents wheelchairs (Resident #2 and #7; Unsampled Resident A, B, C, D, E, F and G); 2. the facility failed to maintain the resident bathroom commodes for four (4) of thirty-four (34) resident bathrooms (resident rooms #309, #322, #333 and #346) had continuous water running in the commodes; 3. the facility failed to maintain the sink faucets in nine (9) of thirty-four (34) resident bathroom (resident room # 202, #211, #216, #236, #239, #304, #309, #313, and #348); 4. the facility failed to replace an inline water filter for one (1) of two (2) nourishment stations (South Hall nourishment station).</p> <p>The findings include:</p>	F 252	<p>The facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>Resident #2, #7 and Resident A, B, C, D, E, F and G had wheelchairs repaired by the Therapy Program Director.</p> <p>Director of Plant Operations repaired resident room commodes in Room #309, #322, #333 and #346. Director of Plant Operations replaced the sink faucets in the 9 rooms identified as #202, #211, #216, #236, #239, #304, #309, #313, and #348. Dining Services Director had the inline water filter replaced at the Nourishment Station on 3 Springs South.</p> <p>The DPO completed an audit on 10/28/11 of campus</p>

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

TITLE

(X6) DATE

*[Signature]* Executive Director 11/18/11

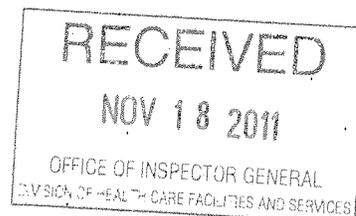
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 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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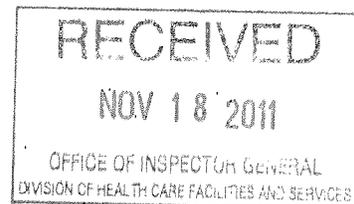
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F 252	Continued From page 2 reported he was not aware any resident had requested repair of a wheelchair. He reported the department had not kept a log of wheelchairs repaired, or a preventative maintenance on the wheelchairs. He reported he depended on the facility staff to report any wheelchair repair needs to him or the department.  2. Observation on tour, 10/11/11 at 8:20 AM, resident rooms #309, #322, #333 and #346) revealed water ran in the commodes and did not shut off.  3. Observation on tour, 10/11/11 at 8:20 AM and on 10/13/11 at 9:37 AM, revealed the sink faucets in resident room #202, #211, #216, #236, #239, #304, #309, #313, and #348 had a white thick, rough substance built up around the faucet outlet.  4. Observation of the South Hall nourishment station, on 10/12/11 at 11:20 AM, revealed an Inline water filter dated 04/05/07 located under the sink. The inline water filter was dated for 04/05/07; the Omipure K5528 manufacturer's label information stated service life one year/2000 gallons.  Interview with the Director of Maintenance (DOM), on 10/13/11 at 8:45 AM, revealed he had been employed by the company for four (4) years, but moved into this position two (2) months ago. He reported in this position he was not responsible for oversight of any employees. The DOM reported he did have a preventive maintenance program, however, he did depend on staff on the units to report on a work order needed repairs. He reported he would not know the commodes would need to be fixed unless he	F 252	The DPO will submit audits to the Q.A. Committee monthly to review and corrective action will be taken as needed. The Dietary Director will monitor inline filters and expiration dates during monthly checks on cleaning of equipment and notify provider when service is needed.	11/24/11



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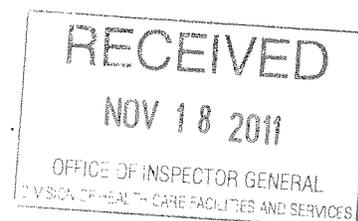
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F 252	Continued From page 3 got a work order. He reported the white build up on the faucets was a calcium build up. He reported they now have a water softener in use which prevents that from happening and the build up had been there for a long time. He reported it would be difficult for housekeeping services to completely clean the surface. He reported it was the standard of practice to date and initials items, such things as filters are replaced. He reported he was not aware the Inline filter was located on the South Hall nourishment station. He reported the inline filter is on the water line into the coffee pot located at this station. He reported the coffee pots are under contract and they may have replaced the filter, but was ultimately responsible to ensure filters are maintained and changed regularly.	F 252		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS  The facility must develop policies and procedures that ensure that-- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 334	The facility will develop policies and procedures that ensure that (ii) each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) the resident's medical record includes documentation that indicates, at a minimum, the	



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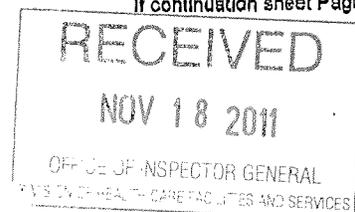
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F 334	<p>Continued From page 4</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal</p>	F 334	<p>following (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. Resident #11 legal representative and resident was provided education and documentation of the acceptance or refusal of the influenza vaccine. The ADH reviewed current residents medical records to ensure education and documentation of the acceptance or refusal of the influenza vaccine by the resident or their legal representative is present. House Supervisor and/or ADHS will complete an admission audit of new admission records within five days of admission to ensure during October 1 and March 31 the resident or the legal representative was</p>	



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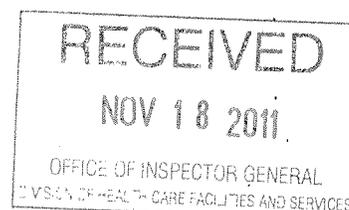
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F 334	Continued From page 5 Immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy titled Guidelines for Influenza and Pneumococcal Immunizations, it was determined the facility failed to provide education and documentation of the acceptance or refusal of the Influenza vaccine by the resident or their legal representative for one (1) of the eighteen (18) sampled residents (#11).  The findings include:  Review of the facility's policy titled Guidelines for Influenza and Pneumococcal Immunizations, which is not dated, revealed upon admission each resident/responsible party will be provided with information regarding the risk and benefits of influenza immunization. Upon admission each resident/responsible party would sign an informed consent form indicating the acceptance/refusal of immunization. Each resident would be provided annually with information regarding the risk and benefits of influenza vaccine and receive the immunization per their request unless medically contraindicated. It would be documented if the resident refused immunization or did not receive the immunization as a result of a medical contraindication, unavailability, or a precaution that delayed the administration and a later date for administration had been planned.	F 334	provided education and documentation of the acceptance or refusal of the influenza vaccination is present and will take immediate corrective action if deficit practice is identified. Director of Nursing will train nurses on 11/8/11 and 11/9/11 to review during completion of monthly summaries each month and report to DHS, or ADHS if consents are not present in the medical record to either accept or decline the influenza vaccine. Medical Records will complete audits of resident records between September 1, and October 1, to ensure influenza documentation is present and submit findings to the Q.A. Committee for immediate correction if indicated.	11/24/11	



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F 334	Continued From page 6  Interview with the Director of Health Services (DHS), on 10/13/11 at 3:20 PM, revealed the former ADHS was responsible for tracking the Flu vaccine. She revealed the resident should have had a consent signed upon admission and provided with education. The DHS revealed the elderly population are more susceptible to the Flu and have more complications.  Review of Resident #11's clinical record revealed the facility admitted the resident on 01/27/09. Review of the immunization record revealed no documented evidence the Influenza vaccine was administered. There was no documentation regarding consent, refusal, or education on the benefits and potential side effects of the immunization signed by the resident or the responsible party. There was no information from the physician stating the immunization was medically contraindicated.  Interview with the Director of Medical Records, on 10/13/11 at 1:30 PM, revealed she was not able to locate a consent form for the Influenza vaccine, administration records, or documentation of education or refusal of the vaccine.  Interview with Registered Nurse (RN) #1, on 10/13/11 at 2:45 PM, revealed the Assistant Director of Health Services (ADHS) provided a list of residents that were to receive an Influenza (Flu) vaccine. The RN revealed the nurses are responsible to administer the vaccine and follow for signs and symptoms of complication for three (3) consecutive days. The RN further revealed the elderly population was more compromised	F 334		



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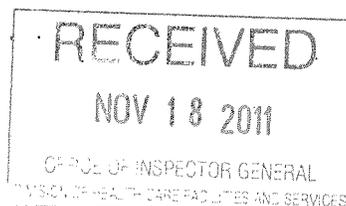
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F 334	Continued From page 7 and more likely to develop complication from the Flu. The RN stated she was not an employee during the previous flu season and did not know if the Flu vaccine was offered.  Concurrent interview with Licensed Practical Nurse #2, on 10/13/11 at 2:45 PM, revealed the nurse had worked on the day shift for one week and was aware of the facility's policy and procedure for Flu vaccines. The LPN revealed the elderly are more likely to get sick in a community type environment. The LPN revealed influenza in the elderly can cause complications such as bronchitis, and fluid filled lungs.  Interview with the ADHS, on 10/13/11 at 3:15 PM, revealed she had been in the position for two (2) months and was not aware if tracking the Flu vaccine was her responsibility.  Interview with the Director of Health Services (DHS), on 10/13/11 at 3:20 PM, revealed the former ADHS was responsible for tracking the Flu vaccine. She revealed the resident should have had a consent signed upon admission and provided with education. The DHS revealed the elderly population are more susceptible to the Flu and have more complications.	F 334		
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364	The facility will ensure each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper	

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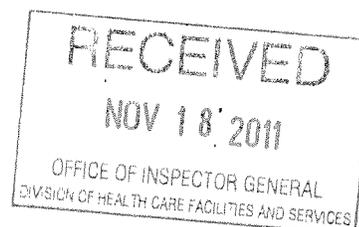
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F 364	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and the Food Temperature-Serving Line Policy, it was determined the facility failed to ensure food placed on the serving line of the three (3) north and south halls was tempted prior to meal service per facility policy.</p> <p>Review of the Food Temperature-Serving Line Policy, dated 2009, revealed temperatures of all foods on the serving line will be measured and recorded at every meal. Interview with the Assistant Director of Dietary Services, on 10/13/11 at 3:25 PM, revealed the policy stated the temperatures should be taken on the tray line. Continued review of the Food Temperature-Serving Line Policy revealed temperatures were taken prior to service to ensure hot foods and cold foods were maintained at the above temperatures. Temperatures must be recorded on the steam table temperature form and kept on file for one (1) year.</p> <p>Observation of the meal service in the 3 North dining room, on 10/11/11 at 12:20 PM, revealed resident plates being prepared and served by food service assistant #1 from the steam table without obtaining the food temperatures prior to service.</p> <p>Interview with food service assistant #1, 10/13/11 at 11:55 AM, revealed food temperatures were not usually obtained on the unit dining rooms.</p> <p>Observation of the meal service in the 3 North dining room, on 10/12/11 at 12:20 PM, revealed resident plates being prepared by a dietary</p>	F 364	<p>temperature.</p> <p>The Dietary staff serving will obtain food temperatures on the tray line for 3 Springs North and 3 Springs South prior to serving to the resident and record on a temperature log and retain for one year.</p> <p>The Dietary Director trained dietary staff on 11/10/11 on standard for taking and recording food on steam table on 3 Springs North and 3 Springs South prior to serving. The Dietary Manager will be responsible for checking the log weekly and taking immediate corrective action if indicated. The DFS will submit log to Q.A. Committee monthly for review and corrective action if needed.</p>	11/24/11



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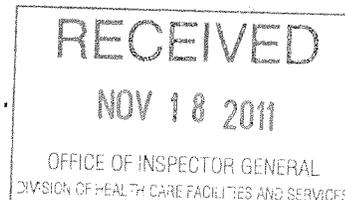
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F 364	<p>Continued From page 9</p> <p>assistant from the steam table without obtaining the food temperatures prior to service.</p> <p>Interview with the Dietary Assistant, on 10/12/11 at 12:20 PM, revealed food temperatures were not completed in the dining room prior to service.</p> <p>Interview with the Assistant Director of Dietary Services, on 10/13/11 at 3:25 PM, revealed staff had not been taking temperatures on the tray line unless the steam table was down.</p> <p>Interview with Service Assistant #1, on 10/13/11 at 11:55 AM, further revealed there was no log of the food temperatures for food held in the kitchen hot box.</p> <p>Interview with the Dietary Manager, on 10/13/11 at 3:50 PM, revealed he had no temp log for three (3) south and three (3) north halls.</p> <p>Further interview with the food service assistant, revealed he was not aware of the facility's policy for obtaining food temperatures on unit dining rooms and recording in a log.</p> <p>Interview with the Dietary Manager, on 10/13/11 at 3:50 PM, revealed he was not aware staff was not tempting food on the three (3) north and three (3) south halls.</p> <p>Interview with the Administrator, on 10/13/11 at 4:33 PM, revealed she was not aware that dietary staff was not tempting foods on three (3) north and three (3) south halls prior to service.</p> <p>Interview with the Administrator, on 10/13/11 at 4:33 PM, revealed she was responsible to</p>	F 364		



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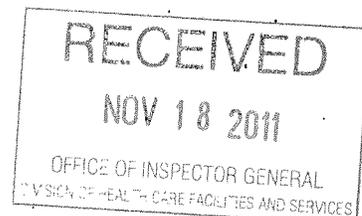
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F 364	<p>Continued From page 10</p> <p>monitor to make sure the Dietary Manager was completing his duties. She further stated we ask for food to be tempted for safety and food borne illness.</p> <p>Observation the meal service hot box delivered to the Three (3) South dining room, on 10/11/11 at 12:16 PM, and the lunch meal food transferred to the steam table by Food Service Staff (FSS) #2 revealed the FSS #2 prepared and served food from the steam table without food temperatures obtained prior to serving to the residents.</p> <p>Interview with FSS #2, on 10/11/11 at 12:40 PM and 10/12/11 at 12:24 PM, revealed the hot food temperatures should be one hundred seventy (170) to one hundred eighty (180) degrees Fahrenheit (F) and the cold food items should be below forty (40) degrees (F). She reported the food temperatures were taken in the kitchen and are not taken on the unit once the food has been delivered to the dining room. She reported the only temperature logs kept are in the main kitchen where the food was prepared and not in the Three (3) South dining room where the food was served.</p> <p>Observation of the Dietary Manager (DM) revealed he obtained the service line food temperatures, on 10/12/11 at 12:28 PM, of the peas and pearl onions at 129 degrees on the steam table. The DM instructed FSS #2 the peas and pearl onions needed to be reheated to a temperature above 135 degrees F.</p> <p>Interview with the Dietary Manager (DM), on 10/12/11 at 12:29 PM, revealed the FSS would</p>	F 364		



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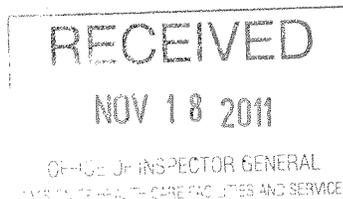
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/13/2011
NAME OF PROVIDER OR SUPPLIER  PARK TERRACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 9700 STONESTREET ROAD LOUISVILLE, KY 40272	
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F 364	Continued From page 11 not know the temperature of the food at the time of service unless the temperature of the food had been taken after arrival to the unit and prior to food service. He reported the food temperature was taken in the kitchen and the log is kept in the kitchen. He reported the food temperature was not taken in the dining room and there are no temperature logs kept in the dining rooms on the units.	F 364		
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to date and label food items in the refrigerator and freezer's of the kitchen area, three (3) north hall and three (3) south hall. The facility failed to provide beard covers for one (1) of four male staff members. In addition, the facility failed to practice good hand hygiene and distribute meal trays in a sanitary manner. The findings include: 1. Review of the Date Marking Policy, dated 2009, revealed all prepared foods that are stored would be properly dated to ensure food safety.	F 371	The facility will procure food from sources approved or considered satisfactory by Federal, State or local authorities; and Store, prepare, distribute and serve food under sanitary conditions. Food identified as not dated and labeled in the facility refrigerators and freezers was discarded. Dietary Director trained dietary staff on 11/10/11 on dating and labeling items that been opened at the time if being placed into a freezer or refrigerator and ensuring food is sealed. The Dietary Cooks will monitor the refrigerators and freezers daily to ensure items are sealed, dated and	



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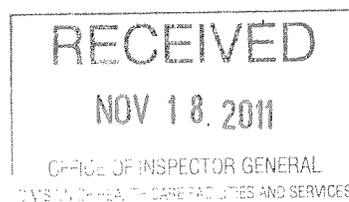
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  188462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/13/2011
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F 371	<p>Continued From page 12</p> <p>Interview with the Dietary Manager, on 10/11/11 at 8:45 AM, revealed he was aware that food should be kept sealed and dated when opened. Food items should be date marked when the food requires refrigeration; commercially prepared food items are opened; when leftovers are stored and when purchased ready-to-eat foods are removed from their original container and not served during the next meal. Continued review of the Policy revealed refrigerated items that are open must be discarded used or discarded within 7 days. Interview with the Dietary Manager, on 10/11/11 at 8:45 AM, revealed he had a seven (7) day rule when it came to disposing food.</p> <p>Observation of the kitchen during the initial tour, on 10/11/11 at 8:45 AM, revealed a bag of cheese dated 10/01/11 and pasta salad dated 09/30/11 which were on plates to be served to the residents. Further observations of the kitchen refrigerator, revealed multiple open and non-dated food items such as, five (5) pound container of cottage cheese, three (3) trays of uncovered apple pie, uncovered and undated cottage cheese, plates of tuna, chicken salad and pasta salad uncovered and undated.</p> <p>Observations of the Freezer in the Kitchen, on 10/11/11 at 8:45 AM, revealed a bag of ravioli, a ten (10) pound bag of burgers, a ten (10) pound bag of chicken breast, five (5) pound bag of waffle fries, two (2) ten (10) pound bags of raw breaded cod filets and a five (5) pound bag of fries opened and not dated.</p> <p>Interview with the Dietary Manager, on 10/11/11 at 8:45 AM, revealed the pasta salad dated 9/30/11 was past seven (7) days and "got to be</p>	F 371	<p>labeled correctly and will discard items immediately if not correctly stored. The DFS trained dietary staff on 11/10/11 on the dress code policy and requirement to cover beards and mustaches. The DFS has provided affected employees with appropriate hair nets to cover facial hair. The DFS and ADFS will monitor compliance with the dress code daily.</p> <p>The DFS trained dietary staff on 11/10/11 and DHS trained nursing staff on 11/8/11 and 11/9/11 on hand washing, infection control and cross contamination with food preparation and delivery of trays to the residents. The DFS will complete weekly sanitation audit and observe tray line and tray pass weekly to ensure compliance. The DFS will take immediate corrective action if deficient practice is identified. The DFS will submit audits to the Q.A. Committee monthly for review and intervention if deficit practice is identified.</p>	11/24/11



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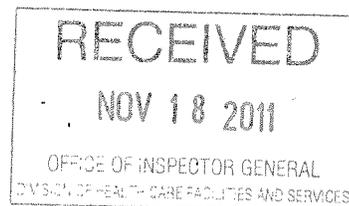
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F 371	Continued From page 13 tossed".  Interview with the Food Service worker #1, on 10/13/11 at 1:30 PM, revealed staff must label and date open food items and discard food within three (3) days. He stated it was everyone's responsibility to make sure the refrigerators are neat and clean.  Interview with the Food Service worker #2, on 10/13/11 at 3:20 PM, revealed staff are suppose to recap open food items and label, date food items.  Interview with the Assistant Director of Food Services, on 10/13/11 at 3:25 PM, revealed he was not aware of all the food items that were opened and not dated. We are suppose to label and date open food items so that we can make sure food is safe to use.  Interview with the Dietary Manager, on 10/13/11 at 3:50 PM, revealed open food items should be dated and sealed. The staff have had a lot put on them and staff were not thinking about the acceptability of the elderly residents. I have been working with three (3) staff members instead of seven (7).  Observation of the 3 North warming kitchen, on 10/12/11 at 11:45 AM, revealed a jar with a commercial label for Jet Puffed Marshmallow cream containing a brown mush substance in the refrigerator. No other label or a date noted to the container.  Observation of the South Hall nourishment station, on 10/11/11 at 10:53 AM, on 10/12/11 at	F 371		



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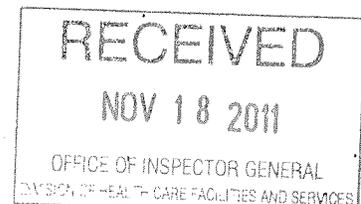
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F 371	<p>Continued From page 14</p> <p>2:20 PM and on 10/13/11 at 8:45 AM, revealed a one gallon container of multi-flavored ice cream opened and undated in the freezer compartment of the refrigerator. In addition, a one pint container of ice cream was opened and undated in the same location.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 10/12/11 at 12:10 PM, revealed Dietary was responsible for cleaning and monitoring the warming kitchen refrigerator.</p> <p>Interview with Food Service Assistant #1, on 10/13/11 at 11:55 AM, revealed unit refrigerators were assigned to a staff member to be monitored for cleanliness and expiration dates. The food service assistant stated the unit refrigerators are checked whenever the assigned person has time.</p> <p>Interview with the Dietary Manager (DM), on 10/12/11 at 1:10 PM, revealed he did not know what substance was in the jar or how long it had been in the refrigerator. The DM stated the dietary assistants were responsible to check the refrigerators daily and sign off on an assignment log. The DM stated he monitored the unit refrigerators twice a week.</p> <p>The Assignment log was not provided as requested.</p> <p>2. Review of the Dress Code and Personal Hygiene Policy, dated 2009, revealed the organization had strict requirements regarding hair: employees will wear hair nets that completely cover the hair while in the kitchen or serving food, Beard and mustaches must be</p>	F 371		



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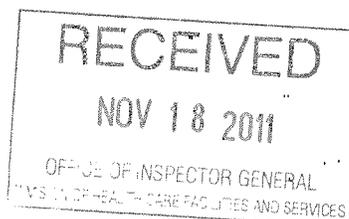
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F 371	<p>Continued From page 15. covered with effective hair restraint.</p> <p>Observation of the meal service in the 3 North dining room, on 10/11/11 at 12:20 PM, revealed a male food service assistant with facial hair preparing the resident meals without a beard cover.</p> <p>Interview with the Food Service #1, on 10/13/11 at 11:55 AM, revealed he thought it was o.k. to have a beard as long as it is well groomed and was told by Dietary Manager to keep his beard well groomed.</p> <p>Interview with the Assistant Director of Dietary Services, on 10/13/11 at 3:25 PM, revealed he was aware that staff should keep their beards neat and trimmed and was aware of the Dress Code and Personal Hygiene Policy. He was not aware of the part of the policy which stated, beard and mustaches must be covered with an effective hair restraint. He stated he had not seen staff utilize any beard restraints in the facility and that if hair falls into the food the food can become contaminated.</p> <p>Interview with the Dietary Manager, on 10/13/11 at 3:50 PM, revealed he just paid no attention and was not aware of Food Service #1 even had a beard. The Dietary Manager further stated, if hair falls into food, bacteria and food born illness can occur.</p> <p>3. Review of the Dress Code and Personal Hygiene Policy, dated 2009, revealed all employees are required to wash their hands on occasions such as: before and after serving food to residents and patients and any other time</p>	F 371		



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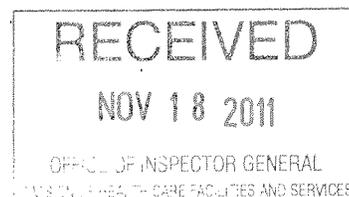
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F 371	<p>Continued From page 16</p> <p>deemed necessary. Interview with the Assistant Director of Dietary Services, on 10/13/11 at 3:25 PM, revealed staff were to wash hands every time their hands were soiled.</p> <p>Observation of the meal service in the 3 North dining room, on 10/11/11 at 12:20 PM, revealed the food service assistant was observed touching the meal spreadsheet binder and clothing multiple times without washing hands or donning clean gloves before preparing the resident meals.</p> <p>Interview with food service assistant #1, on 10/13/11 at 11:55 AM, revealed dietary staff are not to touch items or clothing during tray line due to the potential for cross contamination which can lead to food borne illness.</p> <p>Interview with Food Service #2, on 10/13/11 at 3:20 PM, revealed staff were to wash before and after touching food items.</p> <p>Interview with the Assistant Director of Dietary services, on 10/13/11 at 3:25 PM, revealed staff can put bacteria into food and can contaminate food items.</p> <p>4. No policy was provided for Tray delivery.</p> <p>Observation of the Lunch tray pass, on 10/11/11 at 12:00 PM, revealed Certified Nursing Assistant (CNA) #1 placing a tray into room 216. CNA #2 then took the tray out of room 216 and placed it back into the food cart with other trays that were not yet delivered. Two (2) other resident trays were placed back into the food cart after sitting in the small waiting area by CNA #1 which was then delivered to the rooms of both residents.</p>	F 371		



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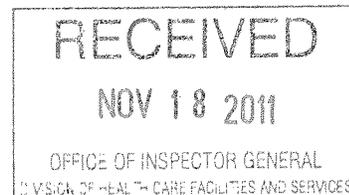
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F 371	Continued From page 17  Interview with CNA #1, on 10/11/11 at 12:00 PM, revealed she was taught to not walk trays down, we have to hand deliver them. She stated she knew that trays lying in the dining area and the resident's room, and then placed into the food cart was considered dirty.  Interview with the Assistant Director of Health Services (ADHS), on 10/13/11 at 2:20 PM, revealed trays are considered clean until placed into resident's rooms, then they are considered dirty. Continued interview with CNA #1, on 10/11/11 at 12:00 PM, revealed she was taught by dietary to transport each tray to each room by cart and not to walk trays to rooms.  Interview with the ADHS, on 10/13/11 at 2:20 PM, revealed the tray was suppose to stay in the cart, then walk the cart to deliver food, but not to place trays back on to the food cart and that this was an infection control issue.  Interview with the Director of Nursing (DON), on 10/13/11 at 4:10 PM, revealed she was not teaching staff to place dirty trays into clean carts and staff were not taught they could not walk the trays to resident rooms. The DON further stated cross contamination could occur to the other trays in food cart.	F 371		
F 431 SS=E	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	F 431	The facility will ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include	



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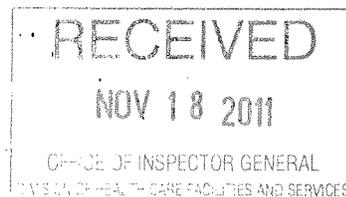
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F 431	<p>Continued From page 18</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>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.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of 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, record review, and review of the facility's policy titled Specific Medication Administration Procedures, it was determined the facility failed to ensure drugs and biologicals used in the facility were monitored for expiration dates in two (2) of the four (4)</p>	F 431	<p>the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>The facility will ensure expired IV fluids and IV medication is discarded and not administered to the residents. The DHS checked the IV fluid and IV medication at the facility for expiration dates and discarded appropriately. The DHS trained nurses on 11/8/11 and 11/9/11 on checking medication and IV fluid expirations dates before administering to a resident and discarding if out of date. The House Supervisor will monitor expiration dates of medications and IV fluid monthly and take immediate action if found to be out of date. The House Supervisor will submit audit to the Director of Health Service for review and submission to the Q.A. Committee monthly. The Q.A. Committee will review, trend, and analyze and take corrective action if needed.</p>
			(X5) COMPLETION DATE  11/24/11



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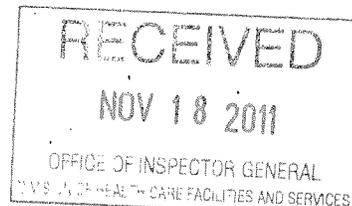
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F 431	<p>Continued From page 19</p> <p>medication rooms as evidenced by expired intravenous (IV) fluids in the floor stock.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Specific Medication Administration Procedures, which is dated 02/01/2010, revealed nursing staff were responsible to check the expiration date on package/container before administering any medication.</p> <p>Observation of the second (2nd) floor North medication room, on 10/13/11 at 10:35 AM, revealed the following expired IV fluids found in a cabinet in the medication room: two (2) liter bags of Normal Saline which had expired 10/01/2011; one (1) liter bag of Lactated Ringers which expired 04/01/2011; a liter bag of D51/4 Normal Saline which expired 08/01/2011; a liter bag of 1/2 Normal Saline which expired 10/01/2011. A black tower drawer filled with IV stock contained a liter bag of 1/2 Normal Saline with 20 milliequivalents of Potassium Chloride which expired 09/2011.</p> <p>Interview with Registered Nurse (RN) #2, on 10/13/11 at 10:35 AM, revealed the night shift was responsible to check the medication and utilize an auditing tool. She stated the pharmacy also monitored the stock medication for expiration dates. The RN revealed there was a potential for a resident to get the expired IV fluids that may no longer be at the correct strength.</p> <p>Review of the Dated Medication Audit tool revealed the only items included on the auditing tool were bottles in the medication cart, eye drops in medication cart, treatment cart medications,</p>	F 431		



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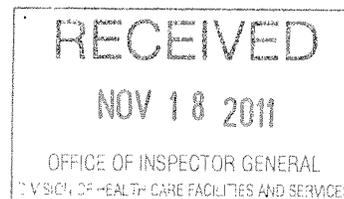
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 20</p> <p>insulln bottles, and medications separated top medication cart. Stock medications and IV fluids were not included on the auditing tool.</p> <p>Observation of the thirld (3rd) floor South medication room, on 10/13/11 at 10:45 AM, revealed the following expired IV fluids in a black drawer tower: three (3) 100 milliliter bags of D5Wwhich expired 10/01/2011; a liter bag of 1/2 Normal Saline which expired 10/01/2011, and a liter bag of D5W which expired 10/01/2011.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 10/13/11 at 10:45 AM, revealed second shift was responsible to monitor the medication room as well as pharmacy. The LPN revealed having expired IV fluids in stock could potentially delay treatment to a resident.</p> <p>Interview with the Pharmacy Consultant, on 10/13/11 at 2:10 PM, revealed the pharmacy audits include monitoring the IV stock for expiration dates, however, this was not always done every month. Expired fluids are removed at that time and reordered. The Pharmacist stated a list of upcoming expired medications was left with the Director of Health Services (DHS). The Pharmacist revealed IV fluids were last intensely gone through in either July or August. The Pharmacist further revealed she only monitored the stock in the black drawer tower and not the cabinets. The Pharmacist stated both the facility and the Pharmacy were responsible to monitor IV fluids for expiration dates. She further revealed each unit has an auditing tool for monitoring expiration dates, but was not aware if IV fluids were included on the auditing tool.</p>	F 431			



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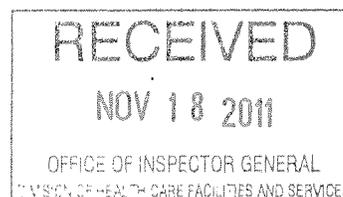
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NAME OF PROVIDER OR SUPPLIER  PARK TERRACE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9700 STONESTREET ROAD LOUISVILLE, KY 40272	
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F 431	Continued From page 21 Interview with the Director of Health Services (DHS), on 10/13/11 at 3:20 PM, revealed all IV fluids should be kept in the black drawer tower and not in the cabinet. The DHS revealed no certain person was assigned to monitor the IV fluids for expiration dates. The DHS stated she thought Pharmacy was responsible to monitor the expiration dates of the IV fluid stock.  Interview with the Administrator, on 10/13/11 at 4:35 PM, revealed all nurses should be checking dates of medications before administering. However, the administrator stated she thought it was understood that the pharmacy would be checking all the medications, including IV fluids, during the monthly audits.	F 431	
F 502 SS=F	483.75(j)(1) ADMINISTRATION  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Clinical Laboratory Services Agreement, it was determined the facility failed to monitor the laboratory supplies on four (4) of the four (4) nursing units as evidenced by expired specimen collection vials, para paks, and culture swabs.  The findings include:  Review of the facility's contract for Clinical Laboratory Services Agreement, dated 10/31/07,	F 502	The facility will obtain laboratory services to meet the needs of its residents. The facility will be responsible for the quality and timeliness of the services.  The DHS checked laboratory supplies and discarded any expired supplies. DHS trained nurse on 11/8/11 and 11/9/11 on checking laboratory supplies before collecting specimens and discarding if supplies were expired. The House Supervisor will audit all laboratory supplies stored in medication rooms



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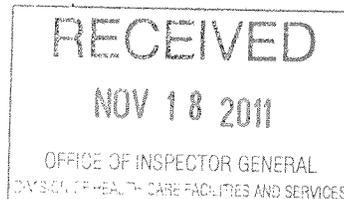
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F 502	<p>Continued From page 22</p> <p>revealed the contracted entity would provide as part of its charges for services, such necessary items and supplies that are solely used to collect, process or store those specimens to be submitted for laboratory services.</p> <p>A facility policy for Laboratory supplies was not provided.</p> <p>Interview with the Administrator, on 10/13/11 at 4:35 PM, revealed she was not aware expired laboratory supplies was a problem. She stated there was no current system in place to monitor the supplies and no facility policy. The administrator revealed she was under the impression the contracted lab would be supplying the facility with equipment as well as monitoring.</p> <p>Observation of the third (3rd) floor North medication room, on 10/13/11 at 9:15 AM, revealed eighty-nine (89) blue top specimen collection tubes expired 07/2011 and ninety-eight (98) green top specimen collection tubes expired 09/2011.</p> <p>Observation of the three (3) North treatment cart, on 10/13/11 at 9:22 AM, revealed a blue top specimen collection tube expired 07/2011.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 10/13/11 at 9:25 AM, revealed she thought the lab usually monitored the lab supplies for expiration dates. The LPN revealed the third shift should be checking the treatment cart for expired medications and supplies. The LPN further revealed using expired laboratory specimen vials could potentially cause inaccurate results and/or lead to multiple venipunctures on the residents.</p>	F 502	<p>on the units monthly and take immediate corrective action and discard any expired supplies. The House Supervisor will submit audit to DHS monthly for review and monitoring. The DHS will submit audit to the Q.A. Committee monthly to review, trend and analyse. The Q.A. Committee will take corrective action if deficit practice is identified.</p>	11/24/11



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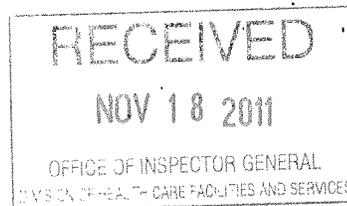
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F 502	Continued From page 23  Observation of the second (2nd) floor South medication room, on 10/13/11 at 10:25 AM, revealed two (2) culture and sensitivity para paks which expired 10/2008, two (2) ova and parasite para paks expired 07/2011, and a purple top specimen collection tubes expired 07/2011.  Interview with LPN #3, on 10/13/11 at 10:30 AM, revealed expired laboratory supplies could potentially cause an inaccurate result or a false reading. The LPN further revealed she did not know who was responsible to monitor the laboratory supplies for expiration dates.  Observation of the second (2nd) floor North medication room, on 10/13/11 at 10:35 AM, revealed a purple top specimen collection tube expired 06/2011.  Interview with Registered Nurse (RN) #2, on 10/13/11 at 10:35 AM, revealed expired laboratory supplies could potentially be contaminated and give a false reading.  Observation of the third (3rd) floor South medication room, on 10/13/11 at 10:45 AM, revealed three (3) para pak ova and parasite specimen collection bottles expired 04/2010.  Interview with LPN #4, on 10/13/11 at 10:45 AM, revealed expired laboratory supplies could potentially cause inaccurate results and delay treatment. The LPN further revealed the second shift was responsible to check the supplies.  Interview with the Director of Health Services (DHS), on 10/13/11 at 3:20 PM, revealed a	F 502		



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F 502	<p>Continued From page 24</p> <p>contracted entity provided the laboratory services for the facility, but the nursing staff collect the specimens on the holidays and the weekends. The DHS revealed she assumed the lab was checking the supplies for expiration dates. She further revealed she was not aware of a facility policy on monitor the laboratory supplies and stated no one had been assigned to perform that task. The DHS revealed she thought the contract with the company stated they would check the supplies for expiration dates as well as supply the necessary equipment and supplies.</p> <p>Interview with the Administrator, on 10/13/11 at 4:35 PM, revealed she was not aware expired laboratory supplies was a problem. She stated there was no current system in place to monitor the supplies and no facility policy. The administrator revealed she was under the impression the contracted lab would be supplying the facility with equipment as well as monitoring.</p>	F 502		



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NAME OF PROVIDER OR SUPPLIER  PARK TERRACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 9700 STONESTREET ROAD LOUISVILLE, KY 40272
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K 000	<p>INITIAL COMMENTS</p> <p>OFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1974</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Three (3) stories, Type II protected</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Two (2) Type II generators installed in 1976. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 10/11/11. Park Terrace Health Campus was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for eighty eight (88) beds with a census of eighty three (83) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<div data-bbox="974 1428 1331 1659" style="border: 1px solid black; padding: 5px; text-align: center;"> <p>RECEIVED</p> <p>NOV 18 2011</p> <p>DEPARTMENT OF INSPECTOR GENERAL CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</p> </div>	
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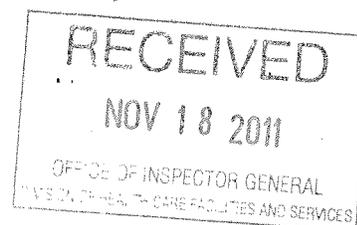
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ DATE 11/18/11

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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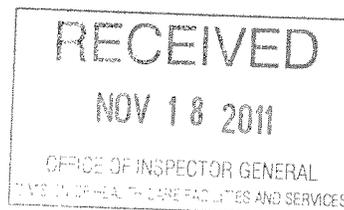
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K 000	Continued From page 1	K 000		
K 018 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for eighty eight (88) beds with a census of eighty three (83) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/11/11 between 9:30 AM and 4:00 PM, with the Director of Plant Operations revealed the corridor door to resident room #244, 249, and 307 would not latch when closed.</p>	K 018	<p>The facility will have doors protecting corridor openings that are constructed to resist the passage of smoke. Doors will be provided with positive latching hardware. The Director of Plant Operations repaired doors to resident room number #244, #249 and #307 so they would latch when closed. DPO will check doors at the campus to ensure doors latch according to requirements identified under NFPA 101 Life Safety Code Standard. The facility will add to DPO's preventative maintenance monthly audit to check latching of campus doors. DPO will take immediate action if any deficit practice is identified. DPO will submit monthly audit to Q.A. Committee for review and corrective action plan as needed.</p>	11/15/11



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K 018	<p>Continued From page 2</p> <p>Interview, on 10/11/11 between 9:30 AM and 4:00 PM, with the Director of Plant Operations revealed he was not aware the doors would not latch; however, stated he had to adjust the fire doors regularly to ensure closure because the facility was built on an old pond and the building shifted frequently.</p> <p>This is a repeat deficiency from 2009.</p> <p>Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means</p>	K 018		

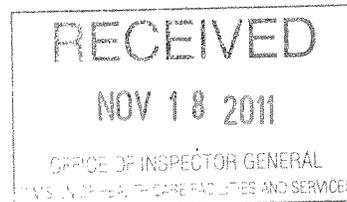


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K 018	Continued From page 3 suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.  19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.  A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware	K 050	The facility will hold fire drills at unexpected times under varying conditions, at least quarterly on each shift.	



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K 050	<p>Continued From page 4</p> <p>that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire drill review, it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility is licensed for eighty eight (88) beds with a census of eighty three (83) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 10/11/11 at 3:45 PM, with the Director of Plant Operations revealed the fire drills were not being conducted at unexpected times under varied conditions.</p> <p>Interview, on 10/11/11 at 3:45 PM, with the Director of Plant Operations revealed they were not aware the fire drills were not being conducted as required.</p> <p>Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied</p>	K 050	<p>The Executive Director trained Director of Plant Operations on 10/31/11 on requirements for fire drills to be held at unexpected times under varying conditions, at least quarterly on each shift. The DPO will conduct fire drills at unexpected times under varying conditions at least quarterly on each shift. DPO will submit monthly log to Q.A. Committee Monthly for review. Q.A. Committee will take immediate action if deficit practice is identified to ensure continued compliance.</p>	11/15/11

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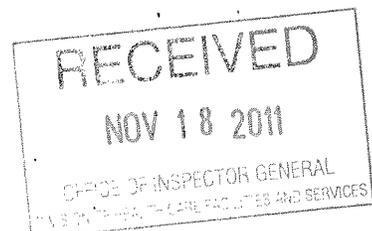
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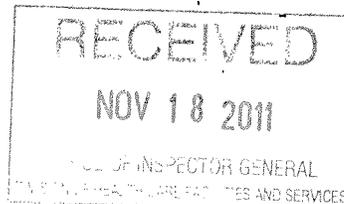
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NAME OF PROVIDER OR SUPPLIER  PARK TERRACE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 9700 STONESTREET ROAD LOUISVILLE, KY 40272		
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K 050  K 062 SS=F	<p>Continued From page 5 conditions on all shifts.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.8, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility is licensed for eighty eight (88) beds with a census of eighty three (83) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/11/11 at 3:35 PM, with the Director of Plant Operations revealed the facility could not provide documentation for the required interior pipe inspection, for the automatic sprinkler system.</p> <p>Interview, on 10/11/11 at 3:35 PM, with the Director of Plant Operations revealed he was not aware the inspection of the automatic sprinkler system was incomplete.</p>	K 050  K 062	<p>The facility will maintain automatic sprinkler systems in reliable operating condition and will have system periodically inspected and tested.</p> <p>The facility had the automatic sprinkler system inspected according to requirements of NFPA 25, 9.7.5. TREK Chief Engineer will schedule the automatic sprinkler system inspection identified under K062 every 5 years with the next inspection due on or before 10/19/16. Chief Engineer has set up automatic sprinkler system on automatic computer preventative maintenance schedule that sends e-mail notification thirty days prior to due date of inspection. The Trilogy Development Team completes an annual of Life Safety Codes inspections and reports result to the campus. The Q.A. Committee will review during monthly meetings and ensure</p>	



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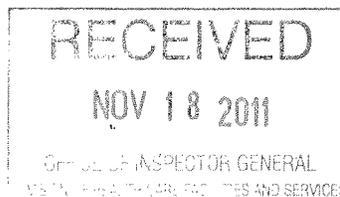
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185462	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PARK TERRACE AT NORT B. WING _____	(X3) DATE SURVEY COMPLETED  10/11/2011
NAME OF PROVIDER OR SUPPLIER  PARK TERRACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 0700 STONESTREET ROAD LOUISVILLE, KY 40272	
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K 062	Continued From page 6  Reference: NFPA 25 (1998 Edition).  10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.  10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. NFPA 101 LIFE SAFETY CODE STANDARD	K 062	inspections due are scheduled and completed timely.	11/24/11
K 070 SS=D	Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 18.7.8  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in	K 070	The facility will prohibit portable space heaters, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). The facility removed portable heaters from Director of Health Services Office and the therapy office.	



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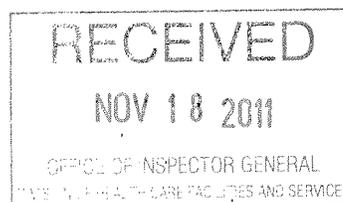
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K 070	Continued From page 7 accordance with NFPA standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, residents, staff and visitors. The facility is licensed for eighty eight (88) beds with a census of eighty three (83) on the day of the survey.  The findings include:  Observation, on 10/11/11 between 9:30 AM and 4:00 PM, with the Director of Plant Operations revealed a portable space heater, located on the second floor, in the Therapy Office. A second heater was located on the third floor, in the Director of Health Services Office.  Interview, on 10/11/11 between 9:30 AM and 4:00 PM, with the Director of Plant Operations revealed the facility was aware of the requirements for portable heaters, but not aware the staff had brought them in the building.  Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).	K 070	The Executive Director trained Directors at the campus on 11/2/11 on the type of portable space heaters approved for use and informed to clear with Director of Plant Operations prior to use. The DPO will monitor compliance through monthly rounds and remove any heaters present not meeting standard 18.7.8. DPO will submit monthly audit to the Q.A. Committee for review and corrective action as needed.	11/24/11
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.	K 076	The facility will ensure medical gas is stored in areas protected in accordance with NFPA 99, Standards for	



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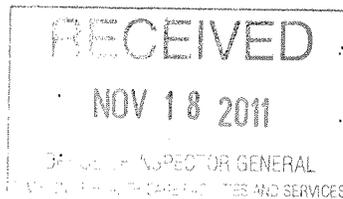
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K 076	<p>Continued From page 8</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored in accordance with NFPA standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for eighty eight (88) beds with a census of eighty three (83) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/11/11 between 9:30 AM and 4:00 PM, with the Director of Plant Operations revealed full and empty oxygen cylinders were stored together, on the floor, not secured, within the oxygen storage rooms on the second and third floor. Another oxygen tank was found stored in the second floor clean linen closet, on the floor, unsecured, with no signage to indicate oxygen was in the room.</p> <p>Interview, on 10/11/11 between 9:30 AM and 4:00 PM, with the Director of Plant Operations revealed he had only been in his position for two (2) months and was not aware of the</p>	K 076	<p>Health Care Facilities. The facility had unsecured oxygen cylinders removed from the facility. The facility removed oxygen tank from the second floor clean linen closet and placed in approved area with correct signs posted. The facility placed cylinder storage racks in oxygen rooms and placed signs indicating full or empty for cylinder storage. The Director of Health services trained DPQ and nursing staff on appropriate storage requirements for oxygen in accordance with NFPA standards on 11/8/11 and 11/9/11. The facility House Supervisor will check oxygen storage during daily rounds and take immediate corrective action if deficit practice is identified and submit findings on daily round sheet to Executive Director for review. The ED will submit finding to the Q.A. Committee monthly and corrective action will be taken if needed.</p>	11/24/11



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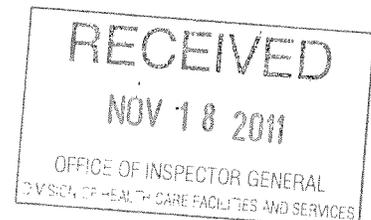
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K 076	<p>Continued From page 9 requirements regarding oxygen storage.</p> <p>This is a repeat deficiency from 2007, and 2008.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>4-3.1.1.2 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation.</p> <p>8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use.</p> <p>4-3.5.2.2 2. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly.</p> <p>4-5.1.1.1 Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over.</p> <p>8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING</p> <p>NFPA 101 MISCELLANEOUS</p>	K 076		
K 130 SS=D		K 130		



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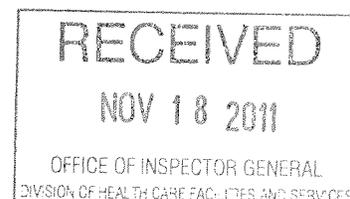
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K 130	Continued From page 10 OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for eighty eight (88) beds, with a census of eighty three (83) on the day of the survey.  The findings include:  Observation, on 10/11/11 at 2:11 PM, with the Director of Plant Operations revealed an unapproved lock (Hasp Type) was installed on the outside of the bathroom door in resident room #337.  Interview, on 10/11/11 at 2:11 PM, with the Director of Plant Operations revealed he was aware of the lock, but not aware the lock could not be used.  Reference: NFPA 101 (2000 Edition) 19.2.2.2.4  Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130	The facility will maintain doors within a required mean of egress. The DPO removed the unapproved hasp type lock from the outside of the bathroom door in resident room #337. DPO completed audit of other doors on 10/12/11 in facility to ensure no other unapproved locks were present and none were found. DHS trained nursing staff on reporting any locks of any type installed at the campus or in resident rooms on 11/8/11 and 11/9/11. DPO will audit room during monthly room inspections and take immediate action if deficient practice is identified. DPO will submit monthly audit to Q.A. Committee for review and corrective action as needed.	11/24/11
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3:4.4.1.	K 144	The facility will maintain emergency generators in accordance with NFPA standards. The facility installed another annunciator panel outside of the	



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K 144	Continued From page 11  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for eighty eight (88) beds, with a census of eighty three (83) on the day of survey.  The findings include:  Observation, on 10/11/11 at 3:00 PM, with the Director of Plant Operations revealed the facility had two (2) generators and only one annunciation panel.  Interview, on 10/11/11 at 3:00 PM, with the Director of Plant Operations revealed he did not know which of the two generators the panel monitored, and did not know if it was the generator that serviced the skilled nursing unit that was being surveyed.  Reference: NFPA 99 (1999 Edition).  3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see	K 144	generating room in a location readily observed by operating personnel at a regular work station on 11/18/11. Plant Operations will train nursing staff on how to monitor the annunciator panel. The DPO completes a weekly check of the generator under load and checks function of annunciator panel and logs. DPO schedules an annual inspection of generator and panel next due in March of 2012. The Q.A. Committee will review the training completed by the DPO at the next Q.A. meeting and will incorporate training as part of the orientation of new hires to the campus.	11/24/11



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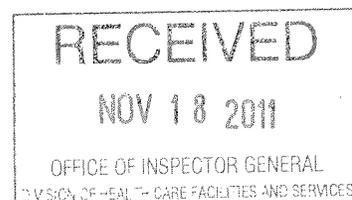
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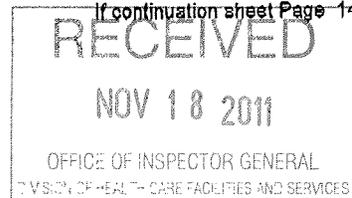
K 144	Continued From page 12 NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]	K 144		
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	The facility will use electrical wiring and equipment in accordance with NFPA 20, National Electrical Code 9.1.2.  The DPO removed electrical extension cords from the campus. The DPO removed	



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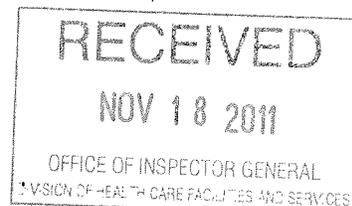
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K 147	<p>Continued From page 13</p> <p>determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect six (6) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for eighty eight (88) beds with a census of eighty three (83) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/11/11 between 9:30 AM and 4:00 PM, with the Director of Plant Operations revealed:</p> <ol style="list-style-type: none"> <li>1) The use of an extension cord in the following areas:             <ol style="list-style-type: none"> <li>a. Assistant Business Office</li> <li>b. Two North Living Room</li> <li>c. Resident Room #308, 314, 337, and 340.</li> <li>d. Social Services Office</li> </ol> </li> <li>2) A microwave, refrigerator, and a toaster plugged into a power strip located in the AP Payroll Office.</li> <li>3) A refrigerator plugged into a power strip located in the Activities Office.</li> <li>4) An oxygen concentrator plugged into a power strip located in resident room #330.</li> <li>5) Light fixtures missing covers exposing electrical wiring in the following areas:             <ol style="list-style-type: none"> <li>a. Bathroom ceiling in resident room #231, 320, 344, and 348.</li> <li>b. Director of Health Services bathroom ceiling.</li> </ol> </li> <li>6) Storage under electrical panels located in Three South Storage Room.</li> </ol> <p>Interview, on 10/11/11 between 9:30 AM and 4:00 PM, with the Director of Plant Operations</p>	K 147	<p>electrical items that are not approved to be plugged into a power strip.</p> <p>DPO ordered replacement covers for light fixtures in DHS bathroom, Rooms #231, #320, #344, and #348. Medical Records Director removed items stored in front of electrical panel in 3 Spring South storage room. Executive Director trained medical records on not placing any items in from of panel on 11/1/11 on NFPA 70, National Electrical Code 9.1.2. Executive Director trained Department Managers on correct use of power strips and extension cords on 11/2/11.</p> <p>DPO will complete monthly rounding to monitor compliance in resident rooms, offices and common areas and take immediate corrective action if deficient practice is identified. DPO will submit monthly audit to Q.A. Committee to ensure corrective action is affective or if corrective action needs to be altered.</p>	11/24/11



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K 147	<p>Continued From page 14</p> <p>revealed he was not aware of the extension cords and power strips being misused. He was also not aware the light fixtures were missing covers. He was aware of the requirement for storage in front of electrical panels, but stated the facility had just received a delivery and staff had just placed the items in front of the panels.</p> <p>The use of extension cords, and open electrical wiring is a repeat deficiency from 2009.</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 adapters.</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>110-26. Spaces</p> <p>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.</p>	K 147		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106462	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PARK TERRACE AT NORT B. WING _____		(X3) DATE SURVEY COMPLETED  10/11/2011
NAME OF PROVIDER OR SUPPLIER  PARK TERRACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 9700 STONESTREET ROAD LOUISVILLE, KY 40272		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 147	Continued From page 15  370.28(c) Covers.  All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147			

