

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

PRINTED: 01/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185169	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2012
NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222	
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F 000	INITIAL COMMENTS	F 000		
F 253 SS=E	<p>A standard health survey was conducted 1/4/12 through 1/6/12 and a Life Safety Code survey was conducted on 1/4/12. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>483.16(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain a clean, sanitary environment for residents, staff, and visitors. The floor around the refrigerator in the Blue Unit Utility room was found soiled as well as the refrigerator was soiled and the seal was loose and dragging the floor. The entry lounge ceiling was stained, cracked and peeling. The baseboards in the Green Unit Lounge were covered in black areas, Shower room 2 on the Green Unit had cracked and broken floor tile.</p> <p>The findings include: Review of the facility's policy for the Housekeeping Department's function (no date) revealed the policy to state ... to contribute to the</p>	F.253	<p>On 1/6/12 the floor around and under the refrigerator in the Blue Unit storage room was cleaned by the floor tech. The entry lounge ceiling is scheduled to be repaired by the Maintenance Assistant by 2/6/12. The baseboards in the Green Unit Lounge were cleaned on 1/13/12 by the floor tech. The tiles in the Green Unit shower room were replaced on 1/18/12. The wheelchair brake for Resident #11 was replaced by the Maintenance assistant on 1/6/12. The seal on the refrigerator in the Blue Unit utility room was replaced on 1/12/12 by the Maintenance Assistant.</p> <p>On 1/6/12 the Director of Housekeeping inspected all storage areas to ensure floors were clean. By 2/6/12 the Maintenance Director and Assistant will complete an inspection of all ceiling areas to determine if any other areas are cracked, stained or peeling. Any repairs necessary will be made. All baseboards were inspected by the Director of Housekeeping on 1/6/12 to identify any other areas needing cleaning.</p>	2/11/12

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

TITLE

(X6) DATE

X [Signature]

X DON

X 2/2/12

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

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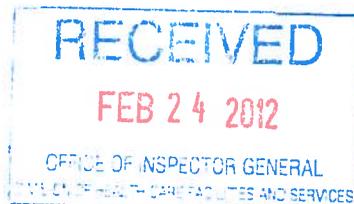
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F 253	<p>Continued From page 1</p> <p>good health of our patients by providing a clean, safe and sanitary environment.</p> <p>1. Observation, on 01/05/12 at 8:44 AM, revealed the Blue Unit storage room had a brown stain on the floor next to the refrigerator. The stain was also observed on 01/06/12 at 1:56 PM and at 2:45 PM.</p> <p>Interview, on 01/06/12 at 1:56 PM, with Registered Nurse (R.N.) #5 and Resident Assistant (RA) #7 revealed, the stain on the floor had been there for a couple of weeks and had been reported to the unit manager. Housekeeping was responsible for cleaning the floor.</p> <p>Interview with Housekeeper #4, on 01/06/12 at 2:26 PM, revealed housekeeping was responsible for mopping the floor. If there was something that needed cleaning the nurse aides reported it to the housekeeping staff on the floor.</p> <p>Interview, on 01/16/12 at 2:45 PM, with the Director of Housekeeping/Laundry revealed there was a clipboard on each unit for issues which the Housekeeping Director checked daily.</p> <p>2. Observation, on 01/05/12 at 8:50 AM, revealed the entry lounge ceiling had a yellow stain, cracked, and peeling paint.</p> <p>Interview with the Director of Maintenance, on 01/06/12 at 2:45 PM, revealed moisture from the attic and collecting condensation caused the ceiling to yellow and crack, with peeling paint. He had known about it for one to two weeks, and was last repaired in 2010. He stated potential problems could include drywall falling, water and</p>	F 253	<p>All tiled areas will be inspected by 2/6/12 by the Maintenance Director and Assistant to identify any other broken tiles. These will be replaced if found.</p> <p>The unit secretaries will check all wheelchairs for broken brake levers, missing legs, etc. by 1/27/12. The Maintenance Director will inspect all refrigerators by 2/6/12 to ensure that all seals are intact.</p> <p>The staff will be re-educated by the Staff Development Coordinator of Director of Nursing by 2/10/12 regarding the procedure for reporting work orders for the Housekeeping and Maintenance Departments. The Housekeeping Director has developed a schedule for the routine cleaning of the floors and has included instruction on moving and cleaning under refrigerators. Wheelchairs are on a weekly cleaning schedule, completed by the 11-7 CNA's, DON will re-educate staff on reporting any needed repairs to maintenance.</p> <p>The Director of Housekeeping will perform a monthly audit to ensure that the floors are without stains or spills for 3</p>	



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F 253	<p>Continued From page 2</p> <p>moisture could harbor bacteria the residents could breathe.</p> <p>3. Observation of the baseboards In the Green Unit Lounge, on 01/05/12 at 9:20 AM, revealed black marks along the entire back wall.</p> <p>Interview, on 01/06/12 at 3:05 PM, with the Director of Housekeeping and the Maintenance Director revealed the baseboards did not look clean but looked like wax buildup. The Director of Housekeeping stated there was someone who comes in to clean the floors. She also stated the floors are stripped once every three months and were last stripped in September or October. The Director of Maintenance scraped a black mark off the floor, and stated the floor looked cleaner.</p> <p>Interview, on 01/06/12 at 4:30 PM, with Housekeeper #6 revealed the floor machine sprays everywhere when the floor is stripped and the stripper mx is black. He stated he had not reported the black marks to anyone and they were from the last time he had stripped the floor.</p> <p>4. Observation of the Green Unit Shower Room 2, on 01/05/12 at 9:13 AM, revealed cracked floor tile at the wall.</p> <p>Interview with the Director of Maintenance and the Director of Housekeeping, on 01/06/12 at 3:50 PM, revealed they were unaware of the cracked floor tile. The Director of Housekeeping stated everyone was responsible to report maintenance issues and the cracked tile had the potential for germs. The Director of Maintenance stated there was a potential for a resident to cut themselves.</p>	F 253	<p>months if no deficient practice is noted audits will be performed on a quarterly basis.</p> <p>Findings will be reported to the Quality Assurance Committee</p> <p>The facility uses a computer program (TELS) to help schedule routine checks and the Maintenance Director will add a quarterly audit of ceilings and tiled areas to the TELS program. These audits will be reported to the Quality Assurance Committee.</p>	



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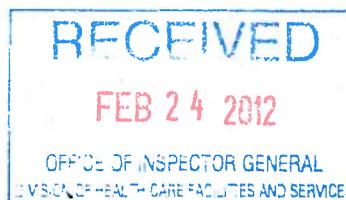
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F 253	Continued From page 3 5. Observation, on 01/04/12 at 10:30 AM and 12:50 PM, and continued observation on 01/05/12 at 8:30 AM, and 11:10 AM, revealed Resident #11's wheelchair brake lever was not covered with a rubber cap, exposing a sharp edge. During interview, on 01/05/12 at 8:30 AM, Resident #11 voiced that the sharp edge on the wheelchair brake could cause a resident to have a scrape. The resident was concerned he/she might bump into it or someone else might bump into the sharp edge. The resident said he/she had asked for it to be repaired several days ago but nothing had been done so far. The resident was uncertain who he/she had talked to. Interview with LPN #4, on 01/05/12 at 11:10 AM, during a skin assessment observation revealed the LPN stated the brake lever definitely needed to be fixed. A resident could be scraped by it. Interview, on 01/06/12 at 9:00 AM, with the Maintenance Director revealed he was unaware of the need for the protective cover on Resident #11's wheelchair brake lever. The Maintenance Director said the nurses had not informed him of the need for this repair. The Maintenance Director said he does not routinely check the wheelchairs. He follows up on repairs when a work order was on the unit clipboard or someone called and left a message. The Maintenance Director said the nursing staff was suppose to fill out a work order when a repair was needed and he checked the clipboard daily. Interview, on 01/06/11 at 9:30 AM, with the Green	F 253			



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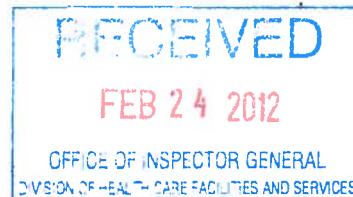
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F 253	<p>Continued From page 4</p> <p>Unit Manager revealed a resident could be injured by the exposed brake lever.</p> <p>6. Observation of the refrigerator in the utility room of the Blue Unit, on 01/05/12 at 8:44 AM, revealed the rubber seal on the bottom of the refrigerator door cracked, broken into two pieces and dragging the floor. The seal contained a brown, crusty substance along the entire strip.</p> <p>Interview, on 01/06/12 at 1:56 PM, with RN #5 and RA #7 revealed the third shift (11:00 PM to 7:00 AM) RA was responsible for checking and cleaning the refrigerator. The 11-7, RA Check Off List, Blue Unit form was completed nightly and had Clean and Straighten Frig/Freezer Discard Items Over 24 hrs as an assigned task. Although it was the RA responsibility to clean the refrigerator, the third shift nurse was responsible for checking the refrigerator temperature and checking that the RA had cleaned it. RA #7 stated the cracked and broken seal had the potential to not keep food cold.</p> <p>Interview with RN #5, on 01/06/12 at 2:06 PM, revealed the unit had a phone call list to call maintenance as well as a form to complete which someone from the maintenance department checks every morning. She also stated she knew about the refrigerator seal for a couple of weeks and did not notify maintenance.</p> <p>Interview with Blue Unit Manager, on 01/06/12 at 2:15 PM, revealed staff and families use the refrigerator. The Unit Manager was not aware of the broken seal. She stated the 11:00 PM to 7:00 AM aides are responsible for cleaning and the</p>	F 253			



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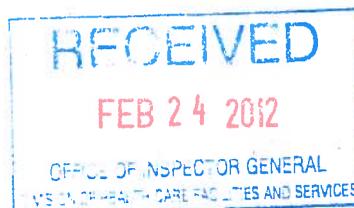
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F 253	Continued From page 5 11:00 PM to 7:00 AM nurse was responsible for monitoring the refrigerator had been cleaned. There was a board for maintenance issues at the nurse's station. The Unit Manager stated she did spot checks but had not checked the refrigerator in a couple of weeks. A potential problem with the broken seal could be food not maintained at proper temperature. Interview, on 01/16/12 at 2:45 PM, with the Director of Housekeeping/Laundry revealed nursing was responsible for cleaning the refrigerator. The Director of Maintenance stated he was unaware of the broken seal on the refrigerator until this survey. There was a form at each nurse's station for maintenance issues that was checked daily. He stated a potential problem with a broken seal could be the refrigerator loses its coldness. On 01/06/12 at 4:40 PM, interview with the Director of Nursing (DON) revealed the 11:00 PM to 7:00 AM shift unit staff was responsible for cleaning the refrigerator and no auditing was being done. She stated patient food was stored in the refrigerator and there was a potential for infection.	F 253		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279	On 1/25/12 communication was added to the comprehensive care plan for resident #1 by the Green Unit Assistant Manager. The problem and interventions for falls on Resident #4 has been on the care plan since 7/21/11. On 1/25/12 the care plan on Resident # 12 was updated by the Green Unit Assistant Manager to include	2/11/12



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F 279	<p>Continued From page 6</p> <p>needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on Observations, interview, and record review, it was determined the facility failed to use the results of the Resident assessment to develop a comprehensive plan of care for four (4) of nineteen (19) residents, #1, 4, 8, and 12.</p> <p>The findings include:</p> <p>Review of facility policy on CAA Process and Care Planning revealed facilities were responsible for assessing and addressing all care issues that were relevant to individual residents, regardless of whether or not they were covered by the Resident Assessment Instrument (RAI).</p> <p>Review of Resident #1's Minimal Data Set (MDS) revealed Resident #1 was a right sided Cardio Vascular Accident (CVA) and had Dysphagia. The CAA's on 06/14/11 identified a care plan should have included interventions to maintain communication. Communication was not</p>	F 279	<p>the monitoring for side effects related to antipsychotic use. The comprehensive care plan was revised by the Green Unit Assistant Manager on 1/6/12 for resident #8 to include the colostomy.</p> <p>All comprehensive care plans to be reviewed by IDT by 2/10/12 to ensure that all needs are addressed and that all care plans are current and applicable to the resident. Any updates or revisions will be completed as indicated.</p> <p>Nursing staff including IDT will be re-educated on the use of the care plan to direct care and the need to include special procedures on the individual care plan. This will be completed by the DON or Staff Development Coordinator by 2/10/12. IDT reviewed the corporate presentation on care planning on 2/2/12 this was confirmed by the DON.</p> <p>The DON will review 25% of care plans each week for 8 weeks to ensure all care plans are reviewed a second time within the quarter to ensure that they are accurate and individualized for each resident. The DON will then review a minimum of 25% of care plans each month to ensure our procedure for development and review of care plans is implemented. The DON will report any issues she finds to the facility QA committee for follow-up.</p>



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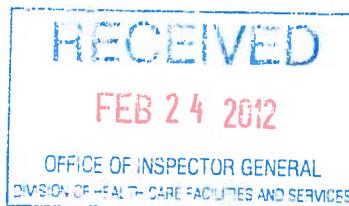
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F 279	<p>Continued From page 7 developed on the care plan.</p> <p>Review of Resident #4's MDS revealed Resident #4 was at a risk for falls. The CAA's on 01/28/11 identified the care plan should have had interventions to prevent a Resident from falling.</p> <p>Review of Resident #12's MDS revealed the resident was ordered psychotropic medications. The CAA's on 07/5/11 identified the care plan should have included interventions to monitor for medication side effects.</p> <p>Interview, on 01/06/12 at 4:00 PM, with LPN #1 revealed the care plan for Resident #1 should have included communication.</p> <p>Interview with Nurse #2, on 01/16/12 at 8:35 AM, revealed Nurse #2 confirmed communication should have been included in the care plan. Nurse #2 also, confirmed Resident #4 should have had fall interventions and Resident #12 should have been care planned for psychotropic medications.</p> <p>Review of the medical record for Resident #8 revealed the facility admitted the resident on 03/04/11 with diagnoses of Hypertension, Toxic Gastroenteritis, Intestinal Obstruction and Paralytic Ileus and s/p Colostomy.</p> <p>Observation, on 01/05/12 at 8:30 AM, revealed Resident #8 had a colostomy. Resident #8 referred to the colostomy as "that thing" and would not look at or touch the colostomy.</p> <p>Review of the care plan for Resident #8 revealed</p>	F 279	<p>A subcommittee of QA members and other staff as needed will meet no less than monthly to track compliance with the POC and the effectiveness of the POC. If the plan is not effective the sub-committee will recommend changes to the full QA Committee which will continue to meet no less than quarterly</p>		



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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280	The care plan for resident #4 had the tube feeding highlighted but did not include the date the feeding tube was discontinued. On 1/25/12 the care plan was updated to include a date that the tube feeding was discontinued by the Green Unit Assistant Manager. On 1/25/12 the care plan on Resident #12 was updated by the Green Unit Assistant Manager to include the monitoring for side effects related to antipsychotic use. All comprehensive care plans to be reviewed by IDT by 2/10/12 to ensure that all needs are addressed and that all care	2/11/12



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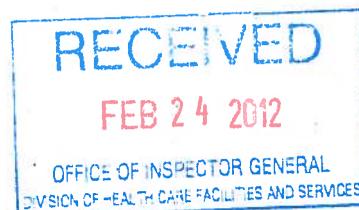
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F 280	<p>Continued From page 9 and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews it was determined, the facility failed to update/revise the care plan for two (2) of nineteen (19) sampled residents, Resident # 4 and Resident #12. Resident #4 had an intervention that had been discontinued. Resident #12's care plan was not revised to reflect the discontinuation of a Gtube.</p> <p>The findings include:</p> <p>Record review revealed, the facility admitted Resident #4 on 07/21/11 with diagnoses of CVA, Increased Lipids, Dysphagia, Arthritis, L Hemiplegia, Abnormal Gait, and Diabetes.</p> <p>Review of the care plan initiated on 07/21/11 revealed a care plan for a gastric tube due to dysphagia. The gastric tube was discontinued in September 2011. This intervention was still on the care plan 01/05/12.</p> <p>Record review revealed the facility admitted Resident #12 on 05/26/11 with diagnoses of Brain Cancer, Right Hemiplegia, Subdural Hemorrhage, Deep Venous Thrombosis, Reflux, Depression, Abnormal Gait, Fractures of T12 anT13, Seizures, Steroid Diabetes, and a Colostomy.</p> <p>Review of the care plan for Resident #12 revealed there were no intervention to monitor for</p>	F 280	<p>plans are current and applicable to the resident. Any updates or revisions will be completed as indicated.</p> <p>Nursing staff including IDT re-educated on the use of the care plan to direct care and the need to include special procedures on the individual care plan. This will be completed by the DON or Staff Development Coordinator by 2/10/10. IDT reviewed the corporate presentation on care planning on 2/2/12, this was confirmed by the DON.</p> <p>The DON will review 25% of care plans each week for 8 weeks to ensure all care plans are reviewed a second time within the quarter to ensure that they are accurate and individualized for each resident. The DON will then review a minimum of 25% of care plans each month to ensure our procedure for development and review of care plans is implemented. DON will report any issues she finds to the facility QA committee for follow-up. A subcommittee of QA members and other staff as needed will meet no less than monthly to track compliance with the POC and the effectiveness of the POC. If the plan is not effective the sub-committee will recommend changes to the full QA Committee which will continue to meet no less than quarterly.</p>	



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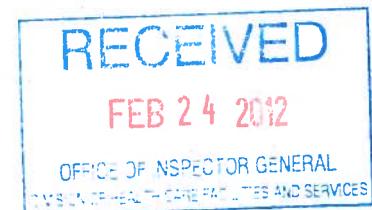
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F 280	Continued From page 10 side effects from psychotropic medications which was triggered from the Minimum Data Set Assessment. Interview, on 01/06/12 at 8:35 AM, with LPN #1 revealed, the care plan of Resident #4 should have had the gastric tube discontinued off the care plan and Resident #12 should have had monitor for the side effects of psychotropic medications added.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to follow physician orders regarding no side rails for one (1) of nineteen (19) sampled residents, Resident #5. The findings include: The facility did not provide a policy on physician orders. Record review for Resident #5 revealed the facility admitted the resident on 10/26/11 with diagnoses of Acute Left Sided Stroke, Diabetes	F 309	The side rails were removed from the bed of resident # 5 on 1/6/12 by the Director of Nursing and Nursing Supervisor. All other residents' charts were reviewed on 1/6/12 by the Unit Manager and Assistant Managers to determine which residents had side rails ordered. The Side Rail Assessment was reviewed on all residents with side rails ordered to ensure safety in the use of the side rails. All side rails were removed from the residents bed if side rails were not ordered, this was completed by 1/9/12 by the Director of Maintenance and Maintenance Assistant The Director of Nursing or Staff Development Coordinator will re-educate all licensed staff on the facility's assessments for side rails and what measures to take if a resident is not to utilize side rails. This will be completed by 2/10/12. All CNA's will be re-educated by the Director of Nursing or the Staff Development Coordinator on	2/11/12



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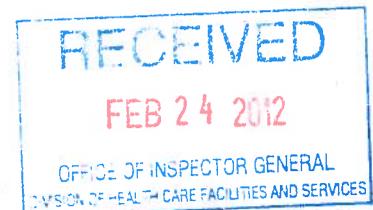
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F 309	<p>Continued From page 11</p> <p>Mellitus Type II, and on 10/28/11 Seizures. The Fall Risk Screen form completed on 10/26/11 and 11/09/11 under Section D. Cognition, noted periods of confusion. A Side Rail Screen was also completed on 10/26/11 which the facility assessed Resident #5 for no side rail use related to cognition. The resident's Initial Care Plan dated 10/26/11 had NONE noted for side rails. The RA Care Plan for January 2012 noted NO for side rails. Review of Resident #5's clinical record revealed the current physician order, upon the Resident's admission to the facility, dated 10/26/11 for no side rails.</p> <p>Observation of Resident #5, on 01/05/12 at 10:05 AM, revealed one quarter side rails on each side were up while the resident was in bed. Additionally, the one quarter side rails were up on each side of the bed when observed on 01/05/12 at 11:25 AM and 4:25 PM, and on 01/06/12 at 9:05 AM, 9:38 AM and 10:05 AM.</p> <p>Interview with Resident Assistant (RA) #8, on 01/06/12 at 11:10 AM, revealed the side rails should not be up, as noted on the RA Care Plan. RA #8 also stated Resident #5 had a history of seizures and the resident could possibly hurt him/herself with the side rails up.</p> <p>Interview with Registered Nurse, RN #5, on 01/06/12 at 11:15 AM, revealed the side rails should not be up. Upon admission, the resident was assessed as confused and could not use the side rails properly. On 01/06/12 at 11:30 AM, RN #5 revealed when the nurses do treatments they also check for side rails every shift, and had not done it today. RN #5 stated she believed the side rails were probably raised during a treatment so</p>	F 309	<p>following each residents plan of care. This will be completed by 2/10/12.</p> <p>The Unit Manager or Assistant Unit Manager will audit the charts of all new admissions quarterly for 4 quarters to ensure that side rails are assessed and used as indicated and ordered. The Unit Manager or Assistant Unit Manager will make rounds weekly for 4 weeks then monthly for 3 months then quarterly to audit for use of side rails Findings will be reported to the Quality Assurance Committee.</p>	



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F 309	Continued From page 12 the resident could help roll to each side, and someone forgot to lower the side rails afterward. Interview with the Blue Unit Manager, 01/06/12 at 11:50 AM, revealed Resident #5 was confused and would not be able to free him/herself if they became wedged in between the side rail and the mattress and if there was a history of seizures then additionally, would not use side rails. She stated the resident did not have safety awareness and could harm him/herself if he/she became wedged and unable to free him/herself. Monitoring was on the Treatment Administration Record (TAR) which staff nurses signed every shift. Every three months residents are re-assessed for side rails on the 3:00 PM to 11:00 PM shift. Interview with the Director of Nursing (DON), 01/06/12 at 5:20 PM, revealed Resident #5 was unable to use side rails properly and the side rails had now been removed. She stated side rails are assessed every quarter and with a significant change. The resident could potentially get caught in the side rails or it could become a restraint.	F 309			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	The Employee who entered the room without PPE was re-educated immediately on the requirement to wear PPE when entering a room where transmission based precautions are being followed by the Unit Manager and DON. On 1/5/12 the bar of soap was removed and discarded by the Green Unit Secretary. The staff member who used improper hand washing techniques during the skin assessment was re-educated on hand washing by the DON.	2/19/12	



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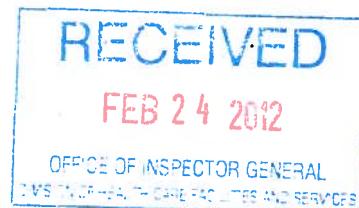
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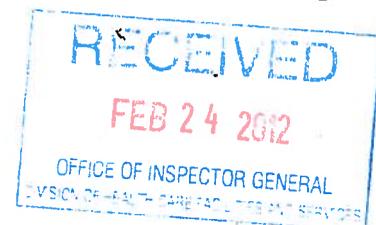
F 441	<p>Continued From page 13 In the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's handout titled Infection Control Precautions, Treatment Skills Checklist, in-service records on Infection Control, review of the Center for Disease Control (CDC) Guideline for Hand Hygiene in Health-Care Settings, and Lippincott's Nursing Procedures 5th edition, it was determined the facility failed to have an effective</p>	F 441	<p>The Staff Development Coordinator or DON will re-educate staff members on Infection Control Practices during dressing changes by 2/10/12. Resident s # 3, 5, and 13 have been monitored by Nursing Supervisor to ensure that the noted practice did not present any complications for the resident. (infection, deterioration in wound, etc)</p> <p>On 2/2/12 all residents who wish to use bar soap were given a soap container labeled with the residents' name. The DON will review lab reports and the wound round reports for past 45 days to ensure that there are no new infections in residents with wounds that may be related to infection control practices. This will be completed by 2/10/12.</p> <p>The Director of Nursing or Staff Development Coordinator will re-educate all staff on the Infection Control Policy including the use of PPE when entering a residents room where transmission based precautions are being observed, hand-washing, and dressing changes. The Lippincott Manual for Nursing Procedures was used as a reference. This education will be repeated monthly for 3 months then quarterly.</p> <p>All licensed and non-licensed nursing staff must attend in-servicing on Infection Control Practices a minimum of 4 times within the next year. All newly hired employees will receive their initial</p>	
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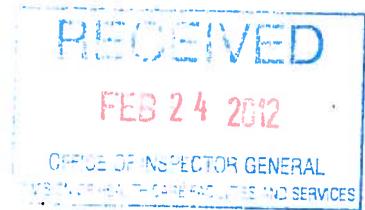
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F 441	Continued From page 14 infection control program. The facility failed to follow infection control guidelines during a dressing change for three (3) of the nineteen (19) sampled residents (Residents #3, #5, and #13). A bar of soap was found in one (1) of the two (2) shower rooms on the green unit. Infection control guidelines were not followed during catheter care for one (1) of the nineteen (19) sampled residents (Resident #15). Staff used improper hand washing techniques during a skin assessment on one (1) or nineteen (19) sampled residents (Resident #7). In addition a staff member was observed entering an isolation room without adhering to isolation precautions. Infection control is a repeat deficiency for the previous three (3) years. The findings include: Review of the CDC Guidelines for Hand Hygiene in Health-Care Settings, dated 10/25/02, revealed the following indications for handwashing and hand antisepsis: Decontaminate hands before having direct contact with patients; Decontaminate hands after contact with body fluids or excretions, mucous membranes, nonIntact skin, and wound dressings; Change gloves during patient care if moving from a contaminated body site to a clean body site; Decontaminate hands after removing gloves. Review of the facility's handout titled Infection Control Precautions revealed hand hygiene must always be performed after removing gloves. Further review revealed if a resident requests to use their personal bar soap, it must be rinsed off before and after use. Do not leave bar soap in the shower or whirlpool rooms and never share	F 441	education during orientation. All licensed staff providing direct care to residents will be in-serviced with return demonstrations on dressing changes, hand washing and glove changes. This will be completed by 2/19/12. Any licensed staff that is on vacation, on a leave of absence or PRN will not be allowed to return to work until they have been in-serviced with return demonstration on dressing changes, hand washing and glove changes. The Assistant Unit Manager will perform audits weekly for 8 weeks on staff members that enter a room where transmission based precautions are being observed. To ensure ongoing emphasis on the appropriate technique for a dressing change, the Nursing Supervisor or Staff Development Coordinator will observe each nurse performing direct care to residents perform a dressing change and skin assessment within the next 6 weeks or until all nurses have been observed a minimum of two additional times. The Nursing Supervisor and Staff Development Coordinator will provide evidence of return demonstrations to DON for reporting to the facility QA Committee.	



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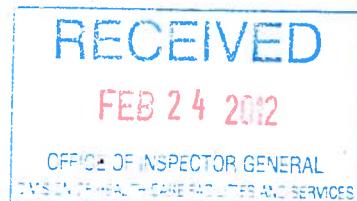
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F 441	<p>Continued From page 15 bar soap.</p> <p>Review of the facility's reference book Lippincott's Nursing Procedures, 2009, revealed the reference did not contain information on clean dressing change technique.</p> <p>Interview with the Nursing Supervisor, on 01/12/12 at 1:50 PM, revealed the Lippincott's Nursing Procedures was the only resource available to staff for dressing change techniques and guidelnes.</p> <p>1. Observation of Hall tray pass during meal service, on 01/04/12 at 12:00 PM, revealed Resident Assistant (RA) #4 delivered the lunch tray to Resident #13 in a room labeled as contact isolation. Signage posted outside the room on the doorframe listed the following information: wear gowns when entering the room and providing direct care; wear gloves while having direct contact, when toileting; wash hands with soap and water before and after direct care and when leaving the room; use isolation barrels for all linens and trash. The RA was observed entering the room without washing her hands and donning Personal Protective Equipment. The RA was observed setting up the Residents tray, repositioning the Resident and the Resident's pillow then exiting the room without washing hands.</p> <p>Interview with RA #4, on 01/06/12 at 10:55 AM, revealed she did not know the resident was in isolation and did not notice the signage posted outside the room. The RA revealed she did not realize what she had done till other staff members informed her of the contact precautions that were</p>	F 441	<p>The 3-11 Charge Nurse on each unit will perform audits of the shower rooms to ensure the bar soap is not left in the shower room. Audits will be performed on a weekly basis for 3 months, with finding reported to the facility QA Committee.</p> <p>The facility designated a QA subcommittee to meet no less than monthly to review all activities related to the POC. They will review audits and education offerings completed each month and will determine from reviewing these if there is a need for additional education, demonstration, disciplinary action or additional audits to ensure sustained compliance, The subcommittee will direct those additional activities needed and will report on their actions no less than quarterly to the facility Quality Assurance Committee.</p>		



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F 441	<p>Continued From page 16</p> <p>not followed during the meal service. The RA revealed there was a potential to pass on the infection the resident has to others.</p> <p>Observation of Resident #13's dressing change, on 01/06/12 at 9:40 AM, revealed Licensed Practical Nurse (LPN) #6 donning PPE outside of the resident's room. The LPN entered the room without washing or disinfecting the hands prior to donning gloves, entering the Resident's room, and beginning dressing change techniques.</p> <p>Interview with LPN #6, on 01/06/11 at 10:10 AM, revealed she was not aware of the CDC guideline for hand hygiene and revealed she just forgot to wash hands prior to initiating the dressing change and entering the room. The LPN revealed a potential for infection control by not following hand hygiene and isolation precautions.</p> <p>Observation of the skin assessment and wound care to Resident #3, on 01/05/12 at 10 AM, revealed LPN #6 did not wash or sanitize hands with glove change. The LPN did not wash hands when exiting the room to access the medication cart and upon reentry twice during wound care.</p> <p>Interview with LPN #6, on 01/06/12 at 10:50 AM, revealed she did remember leaving the room and forgot to wash hands upon reentry. The LPN stated a potential for infection spread to other residents.</p> <p>Interview with Blue Unit Manager, on 01/06/11 at 11:35 AM, revealed handwashing on entry and exiting rooms and between dressing changes are imperative. The Unit Manager revealed a potential for contamination to themselves and</p>	F 441		



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F 441	<p>Continued From page 17</p> <p>others, as well as risking wounds not healing or becoming worse, especially with isolation. The Unit manager revealed she has not monitored the nursing staff for hand hygiene during skin assessments and wound care. In regards to isolation precautions, the Unit Manager revealed she witnessed the RA enter the room and not adhere to isolation precautions. The Unit Manager revealed precautions are listed on the RA assignment sheets and posted outside the room. She revealed she did correct the staff if she noticed a problem.</p> <p>Interview with the Staff Development Coordinator (SDC), on 01/06/12 at 11:55 AM, revealed the isolation policy had been revamped since the last survey and the facility staff had been reeducated twice. The SDC revealed the new infection control policy was attached to the in-service provided 11/15/10 and 8/23/11. The SDC revealed all new employees are checked off on dressing change techniques. She revealed isolation related infection control audits are audited by spot checking staff on procedures and monitoring them entering and exiting rooms. The reports were reported to the DON.</p> <p>Review of the In-service records revealed the attached "policy" was the handout titled Infection Control Precautions.</p> <p>Review of the Treatment Skills Check List revealed Handwashing was to be done prior to and after treatment.</p> <p>interview with the Director of Nursing (DON), on 01/06/12 at 4:20 PM, revealed she had not been made aware of any concerns regarding hand</p>	F 441		



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F 441	<p>Continued From page 18</p> <p>hygiene and dressing changes. The DON revealed there was not a competency check-off for the nursing staff. In regards to isolation precautions, the DON revealed audits were performed and had decreased to monthly audits, until Resident #13 arrived. The DON revealed audits were increased to dally related to the number of people entering the room without adhering to isolation procedures and precautions. The DON revealed the potential for spreading infection by not following proper infection control guidelines</p> <p>2. Observation of a skin assessment on Resident #7, on 01/04/12 at 11:40 AM, revealed LPN #9 did not wash her hands after removing gloves. During the skin assessment on Resident #7, LPN #9 removed the resident's brief, examined the peri-rectal area, changed gloves and completed the skin assessment. LPN #9 did not wash her hands between glove changes. After completing the skin assessment on Resident #7, LPN #9 removed her gloves, left the room, completed the skin assessment paperwork, touched another resident, all without washing her hands.</p> <p>Interview with the Director of Nursing (DON), on 01/06/12 at 4:30 PM, revealed numerous in-services on handwashing were conducted at the facility since last year's survey. She stated nurses are taught to wash their hands after removing gloves and by not following the proper hand washing techniques infections could spread throughout the building to both residents and staff.</p> <p>3. Observation of Resident #15's indwelling urinary catheter (urinary drainage) care, on</p>	F 441		



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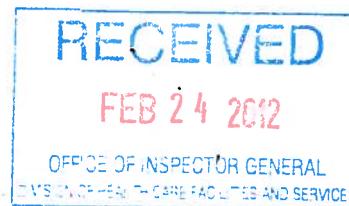
PRINTED: 01/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185169	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2012
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NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 441	<p>Continued From page 19</p> <p>01/09/12 at 11:45 AM, revealed RA #3 did not wash or santize her hands with the glove change after cleansing the resident's perineal area. After cleansing the perineum the RA removed the soiled gloves and donned clean gloves. The RA then proceeded to tie the soiled linen bags shut and then applied a medicated powder to the resident's perineum. The RA pulled up the resident's trousers and then tranferred the resident to the wheelchair, wearing the same gloves she had worn to administer the medicated powder to the perineum.</p> <p>Interview with RA #3, on 01/06/12 at 12:00 PM, revealed she was aware she should have washed her hands and applied clean gloves when moving from dirty to clean but had forgotten to do so. She revealed her actions were a potential to pass on infection to others who came into the resident's room. The RA said she could not remember when she last attended an inservice on indwelling catheter care.</p> <p>Interview with The Green Unit Assistant Manager, on 01/06/12 at 4:30 PM, revealed the RA's should always change gloves when going from a dirty area to a clean area and should always wash their hands between glove changes. They are trained in handwashing inservices. Not washing hands and changing gloves after applying cream to the peri-area could spread germs and bacteria.</p> <p>Interview with the Green Unit Manager, on 01/06/12 at 2:30 PM, our policy is to wash hands between glove changes and to always change gloves when going from dirty to clean.</p>	F 441		
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F 441	Continued From page 20 4. Observation, on 01/05/12 at 9:13 AM, revealed a used bar of Dove soap in the open box on the sink in the Green Unit Shower Room 2. The soap did not have a name on it. At 1:05 PM the bar soap in the box had been moved from the sink onto a shelf with washcloths, toilet paper, and paper towels. The soap was again observed on the shelf in the shower room at 3:50 PM. Interview with RA #5, on 01/05/12 at 3:50 PM, revealed the facility did not use bar soap and if it belonged to a resident it should have a name on it. She stated showers on the Green Unit are assigned to RAs and after being used it should have been taken out of the shower. She stated a potential problem could be the spread of disease if someone else were to use it. Interview with LPN #7, on 01/05/12 at 4:00 PM, revealed an aide was assigned every shift to look for items left in the shower room and everyone was supposed to check behind themselves. She stated the bar soap should have a resident name or be thrown away. She stated a potential problem could be another resident used the soap and do not know what they may have on their skin. On 01/05/12 at 4:10 PM, an interview with the Unit Secretary revealed there was not to be bar soap left in the shower room. If a resident used bar soap it was to be taken out of the shower room. She stated an aide was assigned to check the shower room and every aide was responsible to clean up after themselves. She was not aware of any audits being done. A potential problem could be cross contamination if another resident	F 441		



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F 441	<p>Continued From page 21 used the bar soap.</p> <p>Interview, on 01/05/12 at 4:25 PM, with the Green Unit Assistant Manager and Unit Manager revealed ongoing audits on the unit for bar soap twice a week were completed and was last checked on Monday 01/02/12. The Assistant Unit Manager stated the use of bar soap was discussed in the morning huddle and the monthly RA meetings.</p> <p>On 01/05/12 at 4:30 PM, an interview with the Staff Development Coordinator revealed an aide was assigned every shift to check the shower room that everything was taken out. She stated a potential problem could be the spread of infection.</p> <p>Interview, on 01/06/12 at 4:40 PM, with the Director of Nursing (DON) revealed the facility discouraged the use of bar soap and the Green Unit had been audited twice a week for bar soap by the Assistant Unit Manager. She stated the facility specifically discussed the use of bar soap in training. A potential problem was the spread of infection.</p> <p>5. Observation of a dressing change for Resident #5, on 01/05/12 at 10:05 AM, revealed RN #8 did not wash hands between glove changes. The RN changed her gloves six times.</p> <p>Interview with RN #8, on 01/06/12 at 1:15 PM, revealed gloves are to be changed before and after completion of the dressing change and gloves are sufficient as long as they are changed during the dressing change. She stated the facility's policy was to wash hands prior to and at</p>	F 441		



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F 441	<p>Continued From page 22</p> <p>the end of treatment. She stated she had inservice training at the facility and were monitoring each other.</p> <p>Interview, on 01/06/12 at 4:40 PM, with the Director of Nursing (DON) revealed infection control and hand washing were discussed in inservices. She stated the wound nurse observed a dressing change if a new dressing was started and the unit nurse had not done it before. The wound nurse had not reported any issues with dressing changes.</p> <p>Review of the inservice Training record revealed RN #8 attended trainings for infection control on 08/23/11 and 11/16/11.</p>	F 441		
F 520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the</p>	F 520	<p>On 1/25/12 communication was added to the comprehensive care plan for resident #1 by the Green Unit Assistant Manager. The problem and interventions for falls on Resident #4 has been on the care plan since 7/21/11. On 1/25/12 the care plan on Resident # 12 was updated by the Green Unit Assistant Manager to include the monitoring for side effects related to antipsychotic use. The comprehensive care plan was revised by the Green Unit Assistant Manager on 1/6/12 for resident #8 to include the colostomy.</p> <p>The care plan for resident #4 had the tube feeding highlighted but did not include the date the feeding tube was discontinued.</p>	2/11/12



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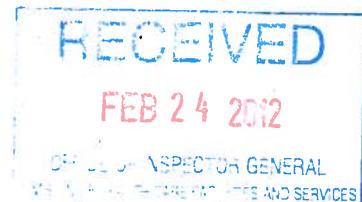
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F 520	<p>Continued From page 23 requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to have an effective Quality Assurance (QA) Committee that was structured to ensure the plan of correction developed for previous deficient practices identified during the survey dated 10/14/10 in the areas of F-279, F-280, F-371 and F-441 were maintained. The facility deemed compliance on 11/26/10 for these deficiencies. The facility was found to be non-compliant in the same areas during the Standard Health Survey concluded on 01/06/12.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 01/06/12 at 4:20 PM, revealed they had been doing numerous audits to follow up on deficiencies from last year. She reported that recent audits had revealed no concerns. She expressed both surprise and disappointment that concerns had been identified by surveyors.</p> <p>Interview with the Administrator, on 01/06/12 at 2:15 PM, revealed the department directors had been conducting audits on areas of deficiencies from last years survey. He stated they bring those audit results to each Quality Assurance meeting. He stated the current system must not</p>	F 520	<p>On 1/25/12 the care plan was updated to include a date that the tube feeding was discontinued by the Green Unit Assistant Manager.</p> <p>On 1/25/12 the care plan on Resident # 12 was updated by the Green Unit Assistant Manager to include the monitoring for side effects related to antipsychotic use.</p> <p>The Employee who entered the room without PPE was re-educated immediately on the requirement to wear PPE when entering a room where isolation precautions are being followed by the DON. On 1/5/12 the bar of soap was removed and discarded by Green Unit Secretary. The staff member who used improper hand washing techniques during the skin assessment was re-educated on hand washing by the DON. The Staff Development Coordinator or DON will re-educate staff members on Infection Control Practices during dressing changes by 2/10/12. Resident s # 3,5, and 13 have been monitored by Nursing Supervisor to ensure that the noted practice did not present any complications for the resident (infection, deterioration in wound, etc.).</p> <p>All comprehensive care plans to be reviewed by IDT by 2/10/12 to ensure that all needs are addressed and that all care</p>	
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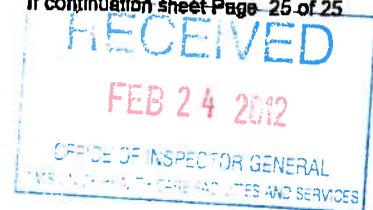
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F 520	Continued From page 24 be working since the identified deficiencies still exist.	F 520	<p>plans are current and applicable to the resident. Any updates or revisions will be completed as indicated.</p> <p>On 2/2/12 all residents who wish to use bar soap were given a soap container labeled with the residents' name. The DON will review lab reports and the wound round reports for past 45 days to ensure that there are no new infections in residents with wounds that may be related to infection control practices. This will be completed by 2/10/12.</p> <p>QA Committee will meet by 2/8/12 to review the current Statement of Deficiencies and Plan of Correction. Specific sub-committee members will be assigned to monitor and ensure the POC is implemented timely and completely. A subcommittee of QA members and other staff as needed will meet no less than monthly to track compliance with the POC and the effectiveness of the POC. If the plan is not effective the sub-committee will recommend changes to the full QA Committee which will continue to meet no less than quarterly.</p> <p>The Quality Assurance subcommittee will have the responsibility to review any audits that are completed monthly, all education offerings and will determine after reviewing these if there is a need for additional education, disciplinary actions, or audits to ensure</p>	
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F 520 continued

sustained compliance. They are charged with reporting their findings to the Quality Assurance Committee but have the authority to have additional education, audits or reviews completed to monitor and ensure sustained compliance. The Administrator is to ensure the subcommittee meets as scheduled and to review their findings monthly. The subcommittee is to meet no less than monthly beginning the week of February 20, 2012 (to review implementation of this POC) for one year and then the role of the subcommittee will be re-evaluated.

The VP of Skilled Operations for the Corporation has instructed the DON and Administrator and approved the above procedure for implementation and monitoring of the POC.

The facility's Corporate Consultant will monitor the progress and compliance of the sub-committee with the implementation of the POC, and report to the VP of Operations any concerns no less than quarterly.

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1982</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (111)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 11/14/12. Jefferson Manor was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has one hundred (100) certified beds with a census of ninety three (93) 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	<p>"The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law."</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *X [Signature]* TITLE *X Administrator* (X6) DATE *X 12/21/12*

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

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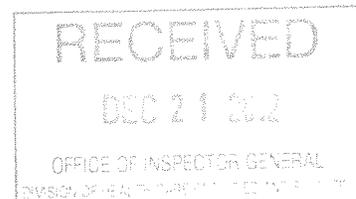
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K 000	Continued From page 1	K 000		
K 025 SS=F	<p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility has one hundred (100) certified beds with a census of ninety three (93) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 11/14/12 between 9:30 AM and 2:30 PM, with the Maintenance Director revealed: the smoke partition, extending above the ceiling</p>	K 025	<p>The Director of Maintenance repaired the penetrations identified on the survey on 12/10/12</p> <p>On 12/10/12 the Director of Maintenance inspected all smoke barrier walls and repaired any penetrations noted.</p> <p>The Director of Maintenance to inspect smoke barrier walls when contractors perform work in these areas and will inspect the smoke barrier walls no less than quarterly. These checks will be recorded in the TELs System.</p> <p>The Regional Director of Facility Management will re-educate the facility Director of Maintenance, 12/27/12, on NFPA 101 Life Safety Code Standard ID prefix K025 cited during the most recent Life Safety Survey of 11/15/12. The Regional Director of Facility Management will provide the facility Director of Maintenance a copy of NFPA 101 (2000 edition) Standards and the Fire Safety Report 2000 code-Health Care Medicare-Medicaid by 12/28/12 for future reference.</p> <p>The Regional Director of Facility Maintenance will review the TELs documentation no less than quarterly and report any missed reviews to the Administrator. The Maintenance Director will report on all TELs review no less than quarterly to the facility Quality Assurance committee.</p>	12/28/12



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K 025	<p>Continued From page 2</p> <p>located in the A Hall had penetrations of wires. Further observation revealed an unsealed penetration around a sprinkler pipe located in the C Hall smoke partition. The penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke</p> <p>Interview, on 11/14/12 between 9:30 AM and 2:30 PM, with the Maintenance Director revealed he was not aware of the penetrations in the smoke partition.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration</p>	K 025		

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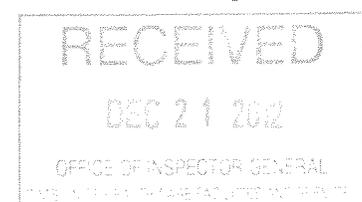
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K 025	Continued From page 3 into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for one hundred (100) beds with a census of ninety three (93) on the day of the survey. The facility failed to provide self-closing devices for doors protecting hazardous areas. The findings include:	K 029	On 12/10/12 The Maintenance Assistant installed a hydraulic door closure to the door between the clean linen and laundry room. The Director of Maintenance inspected the entire facility on 12/10/12 to ensure that all doors meet NFPA Standards. The Maintenance Assistant installed a hydraulic closure to the pantry door in the kitchen on 12/10/12. The Director of Maintenance to make rounds no less than quarterly to inspect all doors requiring door closures to ensure all are on and operational. These reviews will be recorded in the TELs System. The Regional Director of Facility Management will re-educate the facility Director of Maintenance, 12/27/12, on NFPA 101 Life Safety Code Standard ID prefix K029 cited during the most recent Life Safety Survey of 11/15/12. The Regional Director of Facility Management will provide the facility Director of Maintenance a copy of NFPA 101 (2000 edition) Standards and the Fire Safety Report 2000 code-Health Care Medicare-Medicaid by 12/28/12 for future reference.	12/28/12



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185169	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2012
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NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222
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K 029	<p>Continued From page 4</p> <p>Observation, on 11/14/12 between 9:30 AM and 2:30 PM, with the Maintenance Director of Maintenance revealed the door located between the Laundry Room and the Clean Linen Room did not have a self-closing device.</p> <p>Interview, on 11/14/12 between 9:30 AM and 2:30 PM, with the Maintenance Director revealed they were not aware The door was required to be self-closing.</p> <p>8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions</p>	K 029	<p>The Regional Director of Facility Maintenance will review the TELs documentation no less than quarterly and report any missed reviews to the Administrator. The Maintenance Director reports on all TELs reviews no less than quarterly to the facility Quality Assurance Committee.</p>	
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K 029	Continued From page 5 and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were	K 045	On 12/14/12 the Maintenance Assistant replaced the light fixture outside the Therapy exit door with a twin bulb fixture and installed a twin bulb fixture outside of the main dining room exit door. All Exit lighting was inspected by the Director of Maintenance on 12/14/12 and there were no others identified as not meeting this NFPA Standard.	12/28/12

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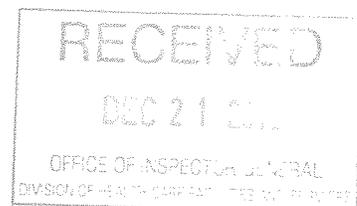
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K 045	<p>Continued From page 6</p> <p>equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, patients, staff and visitors. The facility is certified for one hundred (100) beds with a census of ninety three (93) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/14/12 between 9:30 AM and 2:30 PM, with the Maintenance Director revealed the exterior exit located in the Main Dining Room and the Therapy Exit only had one light bulb outside to light the egress path.</p> <p>Interview, on 11/14/12 between 9:30 AM and 2:30 PM, with the Maintenance Director revealed they were not aware the exits did not have the required illumination for egress lighting.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes</p>	K 045	<p>The Maintenance Director to make rounds no less than quarterly to inspect and ensure that all exit lights are operational. These reviews will be recorded in the TELs System.</p> <p>The Regional Director of Facility Management will re-educate the facility Director of Maintenance, 12/27/12, on NFPA 101 Life Safety Code Standard ID prefix K045 cited during the most recent Life Safety Survey of 11/15/12. The Regional Director of Facility Management will provide the facility Director of Maintenance a copy of NFPA 101 (2000 edition) Standards and the Fire Safety Report 2000 code-Health Care Medicare-Medicaid by 12/28/12 for future reference.</p> <p>The Regional Director of Facility Maintenance will review the TELS documentation no less than quarterly and report any missed reviews to the Administrator. The Maintenance Director will report on all TELS reviews no less than quarterly to the facility Quality Assurance committee.</p>	
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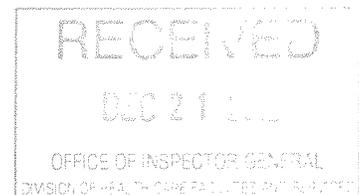
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K 045	<p>Continued From page 7</p> <p>of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way.</p> <p>7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units.</p> <p>7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels.</p> <p>7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2</p>	K 045		
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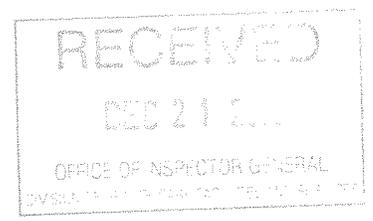
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<p>K 045</p> <p>K 050 SS=F</p>	<p>Continued From page 8</p> <p>ft-candle (2 lux) in any designated area.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware 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. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, one hundred (100) residents, staff and visitors. The facility is certified for one hundred (100) beds with a census of ninety three (93) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times.</p> <p>The findings include:</p> <p>Fire Drill review, on 11/14/12 at 11:00 AM, with the Maintenance Director revealed the facility failed to conduct fire drills at unexpected times on first and third shifts.</p>	<p>K 045</p> <p>K 050</p>	<p>To ensure compliance with this standard the Director of Maintenance will conduct fire drills on all shifts at varied and unexpected times.</p> <p>The Director of Maintenance will record these fire drills in the TELS System.</p> <p>The Regional Director of Facility Management will re-educate the facility Director of Maintenance, 12/27/12, on NFPA 101 Life Safety Code Standard ID prefix K050 cited during the most recent Life Safety Survey of 11/15/12. The Regional Director of Facility Management will provide the facility Director of Maintenance a copy of NFPA 101 (2000 edition) Standards and the Fire Safety Report 2000 code-Health Care Medicare-Medicaid by 12/28/12 for future reference.</p> <p>To monitor this action the Regional Director of Facilities Management will review the TELS documentation no less than quarterly and report any missed reviews to the facility Administrator. The Director of Maintenance will report on the TELS review no less than quarterly to the facility Quality Assurance Committee</p>	<p>12/28/12</p>
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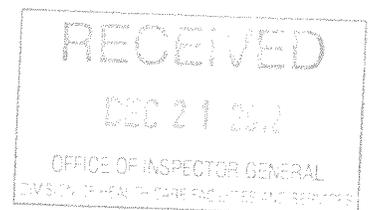
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K 050	Continued From page 9 Interview, on 11/14/12 at 11:00 AM, with the Maintenance Director revealed they were not aware the fire drills were not being conducted as required.	K 050		
K 056 SS=F	Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts. NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, installed in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, patients, staff and visitors. The facility is certified for one hundred (100) beds with a census of ninety three	K 056	Kentuckiana Sprinkler Company installed sprinkler heads in the three sky-light atriums, the rear door porch area, the enclosing areas of the kitchen refrigerator units and the front entrance canopy on 12/21/12. The Director of Maintenance and Special Projects Manager reviewed the facility blue prints and performed a thorough walk through of the facility on 12/12/12 to ensure all sprinkler heads were reviewed. No other sprinkler heads were identified as needing adjustment.	2/15/13



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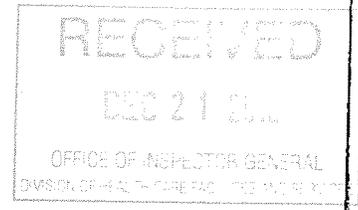
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K 056	<p>Continued From page 10 (93) on the day of the survey. The facility failed to ensure sprinkler heads were not blocked by light fixtures on the ceiling, and the facility had complete sprinkler coverage.</p> <p>The findings include:</p> <p>Observations, on 11/14/12 between 9:30 AM and 2:30 PM with the Maintenance Director revealed the sprinkler heads located in the front office area, Green Shower Room, Blue Shower Room, and the pantry in the Kitchen were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads. Further observation revealed the following areas did not have sprinkler coverage:</p> <ol style="list-style-type: none"> 1) Three (3) atrium type ceilings located in the Main Lobby, and above each Nurse's Station. 2) The canopy over the front drive did not have sprinklers located in the upper most portion of the vault type ceiling, but did have sprinkler coverage located on the lower most part of the vault type ceiling against the beams. 3) A porch roof extending out greater than forty eight (48) inches located outside the Kitchen Hall exit. 4) A covered roof extending out greater than forty eight (48) inches with compressors for the Kitchen installed under located near the Kitchen Hall exit on the back of the building did not have sprinkler coverage. <p>Interview, on 11/14/12 between 9:30 AM and 2:30 PM with the Maintenance Director revealed they were unaware that sprinkler heads could have no obstructions below the deflector within 12 inches of the head. Further interview revealed they were</p>	K 056	<p>The Regional Director of Facility Management will re-educate the facility Director of Maintenance, 12/27/12, on NFPA 101 Life Safety Code Standard ID prefix K056 cited during the most recent Life Safety Survey of 11/15/12. The Regional Director of Facility Management will provide the facility Director of Maintenance a copy of NFPA 101 (2000 edition) Standards and the Fire Safety Report 2000 Code-Health Care Medicare-Medicaid by 12/28/12 for future reference.</p> <p>The Director of Maintenance and Special Projects Manager have been given the go ahead to A M Lighting and Kentuckiana Sprinkler Company to install fixtures that will meet the requirements of this standard. AM lighting Company was given the go ahead 12/20/12, by the Special Projects Manager to order 10 light fixtures for the areas identified in the Life Safety Survey of 11/15/12 for the areas where lights can be replaced to meet this NFPA standard. Delivery for these light fixtures is expected 12/27/12 and 1/3/13. Installation will occur upon receipt. Where light fixtures cannot be moved or replaced Kentuckiana Sprinkler Company will measure each sprinkler head that needs to be adjusted. This work will commence on 12/26/12. After measuring an order will be placed for each. It will take two to three (2-3) weeks to manufacture the sprinkler heads. Delivery is expected the week of 1/21/13. Installation will occur upon</p>	
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K 056	Continued From page 11 not aware the building did not have complete sprinkler coverage. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. Reference: NFPA 13 (1999 edition) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.	K 056	receipt. Installation time is about 1 week. Allowing for any setbacks completions should be no later than 2/15/13. The facility Director of maintenance will be responsible for oversight of the project and will call the OIG Central Office in Frankfort, KY if the project is to exceed the completion date of 2/15/13. The Director of Maintenance will report the status of the sprinkler project to the QA Committee which will meet on 1/23/13 and at least quarterly until the project is completed.	
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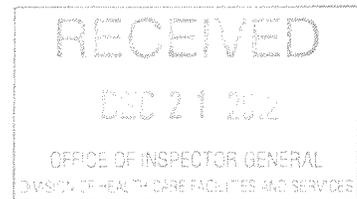
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K 056	<p>Continued From page 12</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0"> <tr> <td style="text-align: right;">Maximum Allowable Distance</td> <td></td> </tr> <tr> <td>Distance from Sprinklers to</td> <td>of Deflector</td> </tr> <tr> <td>above Bottom of</td> <td></td> </tr> <tr> <td>Side of Obstruction (A)</td> <td>Obstruction (in.)</td> </tr> <tr> <td>(B)</td> <td></td> </tr> <tr> <td>Less than 1 ft</td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td>21/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td>31/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td>51/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td>71/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td>91/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td>12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td>14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td>161/2</td> </tr> <tr> <td>5 ft and greater</td> <td>18</td> </tr> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).</p> <p>Reference: NFPA 13 (1999 edition)</p>	Maximum Allowable Distance		Distance from Sprinklers to	of Deflector	above Bottom of		Side of Obstruction (A)	Obstruction (in.)	(B)		Less than 1 ft	0	1 ft to less than 1 ft 6 in.	21/2	1 ft 6 in. to less than 2 ft	31/2	2 ft to less than 2 ft 6 in.	51/2	2 ft 6 in. to less than 3 ft	71/2	3 ft to less than 3 ft 6 in.	91/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	161/2	5 ft and greater	18	K 056		
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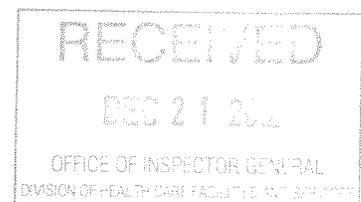
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185169	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2012
NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222	
(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 056	Continued From page 13	K 056		
K 064 SS=D	<p>5-13.8.1. Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that fire extinguishers were maintained in accordance with NFPA standards. The deficiency had the potential to affect resident smokers, staff, and visitors. The facility has one hundred (100) certified beds with a census of ninety three (93) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/14/12 at 1:07 PM, with the Maintenance Director revealed there was no fire extinguisher located in the designated smoking area.</p> <p>Interview, on 11/14/12 at 1:07 PM, with the Director of Maintenance revealed he was not aware that a fire extinguisher was required to be</p>	K 064	<p>On 12/11/12 the Maintenance Assistant installed a fire extinguisher in the designated smoking areas.</p> <p>On 12/12/12 the Director of Maintenance completed a review of all areas of the facility to ensure fire extinguishers were present in all areas where indicated.</p> <p>The Director of Maintenance to make rounds not less than quarterly to inspect all areas for fire extinguishers. Our sprinkler contractor inspects all fire extinguishers annually and the Director of Maintenance inspects them monthly to ensure they are operational. These reviews are recorded in the TELs System.</p> <p>The Regional Director of Facility Management will re-educate the facility Director of Maintenance, 12/27/12, on NFPA 101 Life Safety Code Standard ID prefix K064 cited during the most recent Life Safety Survey of 11/15/12. The Regional Director of Facility Management will provide the facility Director of Maintenance a copy of NFPA 101 (2000 edition) Standards and the Fire Safety Report 2000 code-Health Care Medicare-Medicaid by 12/28/12 for future reference.</p>	12/28/12



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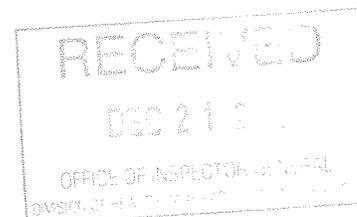
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K 064	Continued From page 14 located in the smoking area. Reference: NFPA 10 1999 4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d)* Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place 4-3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 4-3.2 (a), (b), (h), and (i), immediate corrective action shall be taken.	K 064	The Regional Director of Facility Maintenance will review the TELS documentation no less than quarterly and report any missed reviews to the Administrator. The Maintenance Director will report on all TELS reviews no less than quarterly to the facility Quality Assurance committee.		
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	K 066	The Director of Maintenance placed metal containers with self closing lids in the sited areas. The entire facility was inspected on 11/15/12 during the Life Safety Survey and no other areas were identified. The Director of Maintenance and Director of Housekeeping will inspect all smoking areas at least quarterly to ensure	12/28/12	



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K 066	Continued From page 15 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 the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect resident smokers, staff and visitors. The facility has one hundred (100) certified beds with a census of ninety three (93) on the day of the survey. The findings include: Observation, on 11/14/12 at 1:07 PM, with the Maintenance Director revealed the facility failed to provide a metal container with a self-closing lid to dump the ashtrays, located in the designated smoking area. Interview, on 11/14/12 at 1:07 PM, with the	K 066	proper equipment is in place. The audits will be recorded in the TELS System by the Director of Maintenance. The Regional Director of Facility Management will re-educate the facility Director of Maintenance, 12/27/12, on NFPA 101 Life Safety Code Standard ID prefix K066 cited during the most recent Life Safety Survey of 11/15/12. The Regional Director of Facility Management will provide the facility Director of Maintenance a copy of NFPA 101 (2000 edition) Standards and the Fire Safety Report 2000 code-Health Care Medicare-Medicaid by 12/28/12 for future reference. The Regional Director of Facilities Management will review the TELS documentation no less than quarterly and report any missed reviews to the facility Administrator. The Director of Maintenance will report on the TELS review no less than quarterly to the facility Quality Assurance Committee.	



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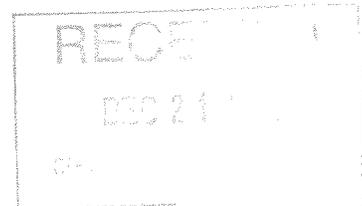
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K 066	Continued From page 16 Maintenance Director revealed they were not aware of the requirement for metal containers with a self-closing lid for dumping ashtrays. Reference: NFPA Standard 101 (2000 Edition). 19.7.4 Smoking (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cooking facilities were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, patients, staff, and visitors. The facility is certified for one hundred (100) beds with a census of ninety three (93) on the day of the survey. The findings include: Observation, on 11/14/12 at 2:05 PM, with the Maintenance Director revealed the gas stove, while in use, was not fully located under the exhaust hood or the hood fire suppression system. Interview on 11/14/12 at 2:05 PM, with the Maintenance Director revealed they must have not pushed it back all the way after cleaning.	K 069	On 11/15/12 the Director of Maintenance with the Director of Dietary Services relocated the equipment, which had been moved for cleaning purposes, to its position under the exhaust hood fire suppression system. On 11/15/12 the Director of Dietary Services instructed the dietary staff to return equipment after cleaning to its proper location under the fire hood suppression system. The Director of Dietary Services will record the equipment placement on a weekly basis for a month and then quarterly. The recorded reviews will be reported to the Facility Administrator and to the facility Quality Assurance Committee.	11/17/12



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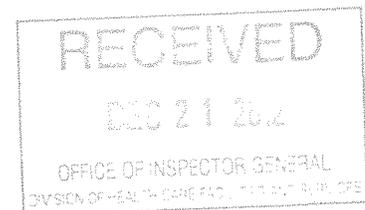
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K 069	<p>Continued From page 17</p> <p>Reference NFPA 101 (2000 Edition)</p> <p>19.3.2.6 Cooking Facilities. Cooking facilities shall be protected in accordance with 9.2.3. Exception*: Where domestic cooking equipment is used for food-warming or limited cooking, protection or segregation of food preparation facilities shall not be required.</p> <p>9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 96</p> <p>11.4 Cleaning of Exhaust Systems. 11.4.1 Upon inspection, if found to be contaminated with deposits from grease-laden vapors, the entire exhaust system shall be cleaned by a properly trained, qualified, and certified company or person(s) acceptable to the authority having jurisdiction in accordance with Section 11.3. 11.4.2* Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal prior to surfaces becoming heavily contaminated with grease or oily sludge. 11.4.3 At the start of the cleaning process, electrical switches that could be activated accidentally shall be locked out.</p>	K 069		
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K 069	<p>Continued From page 18</p> <p>11.4.4 Components of the fire suppression system shall not be rendered inoperable during the cleaning process.</p> <p>11.4.5 Fire-extinguishing systems shall be permitted to be rendered inoperable during the cleaning process where serviced by properly trained and qualified persons in accordance with Section 11.3.</p> <p>11.4.6 Flammable solvents or other flammable cleaning aids shall not be used.</p> <p>11.4.7 Cleaning chemicals shall not be applied on fusible links or other detection devices of the automatic extinguishing system.</p> <p>11.4.8 After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance.</p> <p>11.4.9 All access panels (doors) and cover plates shall be replaced.</p> <p>11.4.10 Dampers and diffusers shall be positioned for proper airflow.</p> <p>11.4.11 When cleaning procedures are completed, all electrical switches and system components shall be returned to an operable state.</p> <p>11.4.12 When a vent cleaning service is used, a certificate showing date of inspection or cleaning shall be maintained on the premises.</p> <p>11.4.13 After cleaning is completed, the vent cleaning contractor shall place or display within the kitchen area a label indicating the date cleaned and the name of the servicing company, and areas not cleaned.</p> <p>11.4.14 Where required, certificates of inspection and cleaning shall be submitted to the authority having jurisdiction.</p> <p>Reference NFPA 96</p>	K 069		
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K 069	<p>Continued From page 19</p> <p>11.3 Inspection of Exhaust Systems. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) acceptable to the authority having jurisdiction in accordance with Table 11.3.</p> <p>Table 11.3 Exhaust System Inspection Schedule Type or Volume of Cooking Frequency Frequency Systems serving solid fuel cooking operations Monthly Systems serving high-volume cooking operations such as 24-hour cooking, charbroiling, or wok cooking Quarterly Systems serving moderate-volume cooking operations Semiannually Systems serving low-volume cooking operations, such as churches, day camps, seasonal businesses, or senior centers Annually</p> <p>Reference: NFPA 96 (1998 edition) 7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other. Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link. Exception No. 2: An automatic sprinkler system.</p>	K 069		
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K 072 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for one hundred (100) beds with a census of ninety three (93) on the day of the survey. The facility failed to ensure the means of egress was free of all obstructions or impediments.</p> <p>The findings include:</p> <p>Observation, on 11/14/12 at 1:53 PM, with the Maintenance Director revealed the storage of three (3) vending machines located in the egress corridor by the Kitchen.</p> <p>Interview, on 11/14/12 at 1:53 PM, with the Maintenance Director revealed the vending machines were permanently stored in this corridor.</p> <p>Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously</p>	K 072	<p>The Director of Maintenance and Project manager removed the vending machines from the egress corridor by the kitchen on 12/14/12.</p> <p>On 12/14/12 the Director of Maintenance checked all egress corridors in the facility and no others were identified as being obstructed.</p> <p>The vending machines have been removed to a permanent location not in a path of egress.</p> <p>The Regional Director of Facility Management will re-educate the facility Director of Maintenance, 12/27/12, on NFPA 101 Life Safety Code Standard ID prefix K072 cited during the most recent Life Safety Survey of 11/15/12. The Regional Director of Facility Management will provide the facility Director of Maintenance a copy of NFPA 101 (2000 edition) Standards and the Fire Safety Report 2000 code-Health Care Medicare-Medicaid by 12/28/12 for future reference.</p> <p>The Director of Maintenance to observe all means of egress monthly for any obstructions. Obstructions will be removed as observed. Safety Committee has added observations of any means of egress to their safety rounds and will report any problem areas to the facility QA Committee no less than quarterly.</p>	2/28/12
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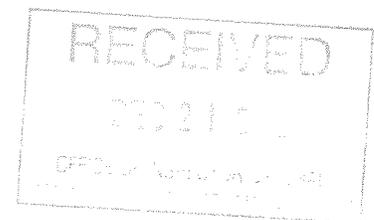
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K 072	Continued From page 21 maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the hazardous areas in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for one hundred (100) certified beds with a census of ninety three (93) on the day of the survey. The findings include: Observation, on 11/14/12 at 2:03 PM, with the Maintenance Director revealed a heavy build-up of lint in the top of the dryers located in the Laundry Room. Interview, on 11/14/12 at 2:03 PM, with the Maintenance Director revealed the top of the dryers are cleaned every thirty (30) days. Further interview revealed he was not aware the lint build up was so excessive. NFPA 101 (2000 Edition) 4.6.12 Maintenance and	K 130	The Director of Maintenance cleaned the dryers on 11/15/12. The Director of Maintenance will inspect the dryers on a weekly basis to ensure lint does not build up, and record in the TELS system. The Regional Director of Facility Management will re-educate the facility Director of Maintenance, 12/27/12, on NFPA 101 Life Safety Code Standard ID prefix K130 cited during the most recent Life Safety Survey of 11/15/12. The Regional Director of Facility Management will provide the facility Director of Maintenance a copy of NFPA 101 (2000 edition) Standards and the Fire Safety Report 2000 code-Health Care Medicare-Medicaid by 12/28/12 for future reference. The Regional Director of Facilities Management will review the TELS system documentation no less that quarterly and report any missed reviews to the facility Administrator. The Director of Maintenance will report on a TELS review no less than quarterly to the facility Quality Assurance Committee.	12/28/12



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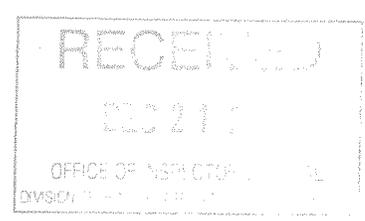
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185169	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2012
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NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222
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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)	(X6) COMPLETION DATE
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K 130	Continued From page 22 Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.	K 130		
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. 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 four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for one hundred (100) beds with a census of ninety three (93) on the day of the survey. The findings include: Observation, on 11/14/12 at 1:43 PM, with the	K 144	On 11/15/12 the Director of Maintenance removed the container of Anti-freeze and motor oil from the emergency generator engine compartment. The Director of Maintenance will check the emergency generator engine compartment on a weekly basis and record findings in the TELS system. The Director of Maintenance will report on a TELS review no less than quarterly to the facility Quality Assurance Committee.	11/17/12



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NAME OF PROVIDER OR SUPPLIER JEFFERSON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222
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K 144	<p>Continued From page 23</p> <p>Maintenance Director revealed the facility was equipped with an emergency generator. Antifreeze and oil were being stored within the generator enclosure.</p> <p>Interview, on 11/14/12 at 1:43 PM, with the Maintenance Director revealed they were not aware the items could not be stored inside the generator enclosure.</p> <p>Reference: NFPA 110 (1999 Edition) 5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. No other equipment, including architectural appurtenances, except those that serve this space, shall be permitted in this room.</p>	K 144		
K 147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by:</p>	K 147	<p>To ensure compliance with NFA 101 Life Safety Code Standard, tag 147, on 12/11/12 the maintenance department removed two power strips, installed a quadplex receptacle, and plugged the refrigerator directly into the quadplex in the Business Office; removed the two power strips and installed a quadplex receptacle in the Green Unit Nurses' Office;</p>	12/12/12



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K 147	<p>Continued From page 24</p> <p>Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, patients, staff, and visitors. The facility is certified for one hundred (100) beds with a census of ninety three (93) on the day of the survey. The facility failed to ensure the proper use of power strips.</p> <p>The findings include:</p> <p>Observation, on 11/14/12 between 9:30 AM and 2:30 PM, with the Maintenance Director revealed:</p> <ol style="list-style-type: none"> 1) A refrigerator plugged into a power strip that was plugged into a power strip that was plugged into another power strip located in the Business Office. 2) Three (3) power strips plugged together located in the Green Nurses Office. 3) A power strip plugged into another power strip located at the Blue Nurses Station. 4) A refrigerator was plugged into a power strip located in the Blue Med Room. 5) Lift battery chargers were plugged into a power strip located in the Blue Med Room. <p>Interview, on 11/14/12 between 9:30 AM and 2:30 PM, with the Maintenance Director revealed they were aware of the proper use of power strips but not aware any had been installed and misused.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric.</p>	K 147	<p>removed a power strip in the Blue Nurses' Office and installed a quadplex receptacle; plugged the lift battery charger directly into a quadplex receptacle; and installed a GFCI receptacle behind the refrigerator in the Blue Unit Medication Room and plugged the refrigerator directly into that.</p> <p>Staff were notified by written memo from the Administrator on 12/17/12 that power strips may not be used inappropriately. They may be used with personal electronics and cannot be piggybacked. This memo will be distributed monthly for 3 months and this information will be included in new employee orientation.</p> <p>The Maintenance Director to observe all office and resident areas monthly for proper use of power strips and record findings in the TELs System. Power strips will be removed if observed being used inappropriately. The Safety Committee has added observations for power strips to their safety rounds and will report any problem areas to the Director of Maintenance no less than quarterly.</p> <p>The Regional Director of Facility Maintenance will review the TELs documentation no less than quarterly and report any missed reviews to the Administrator. The Maintenance Director will report on all TELs review no less than quarterly to the facility Quality Assurance committee.</p>	



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K 147	<p>Continued From page 25</p> <p>Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <ul style="list-style-type: none"> (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces <p>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>	K 147		
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