

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

PRINTED: 05/14/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185138</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/02/2013</b>
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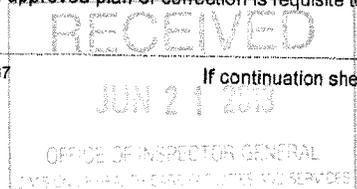
NAME OF PROVIDER OR SUPPLIER  <b>NAZARETH HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2000 NEWBURG ROAD LOUISVILLE, KY 40205</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was initiated on 04/30/13 and concluded on 05/02/13 and a Life Safety Code survey was initiated on 04/30/13 and concluded on 05/01/13 deficiencies were cited with the highest scope and severity of a F. The facility had the opportunity to correct the deficiencies before remedies would recommended for imposition.</p>	F 000	This plan of correction is submitted for the accompanied statement of deficiencies. This documented plan submitted does not constitute agreement with the statement of deficiencies nor does it document agreement with the stated conclusions from the interviews written as a part of the deficiencies. This plan of correction is submitted as our duty as outlined in the requirements of the law.	
F 371 SS=F	<p><b>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</b></p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to serve food under sanitary conditions in two (2) of five (5) auxiliary kitchenettes on the Second Floor Sunrise and the Woodside Dining Rooms.</p> <p>The findings include: Review of the facility's Food Services Department Policy and Procedure titled Food Service Infection Control and Sanitation, (Revised 09/2012), revealed personnel were to meet standards for hygiene, safe food preparation, handling, and</p>	F 371		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Dandrea King* TITLE: *Asst. Administrator* (X6) DATE: *6/24/2013*

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.



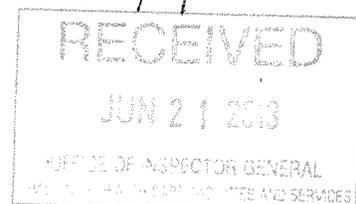
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F 371	<p>Continued From page 1</p> <p>storage to prevent food-borne illness. All equipment, counters, and tables would be sanitized before and after use, and hand washing would be done frequently and correctly by all food service personnel. A five step process for hand washing technique was outlined in the policy. Step 4 stated hands should be rinsed from finger tips to wrists.</p> <p>Observation, on 05/01/13 at 12:25 PM, in the second floor Sunrise Dining Room, revealed Dietary Aide #7, washed her hands at the kitchenette's sink, but touched the inside of the sink while washing her hands and vigorously shook water from her hands in such a way that water droplets landed on the counter tops around the sink bowl.</p> <p>Observations, on 05/04/13 at 12:30 PM, 12:45 PM, and 12:50 PM, revealed Dietary Aide #7 washed her hands in the same manner, shaking her hands vigorously while rinsing them.</p> <p>Observation, on 05/01/13 at 12:27 PM, revealed Dietary Aide #7 prepared a glass of ice water for calibrating the thermometers to be used for obtaining temperatures of the foods delivered from the main kitchen. Dietary Aide #7 placed the cup of ice water with thermometers in the sink where staff had been washing their hands, and then she picked up the cup of thermometers. In the process, one of the thermometers fell out of the cup and landed on the counter top beside the sink. Dietary Aide #7 did not sanitize the thermometer before putting it back in the cup of ice water, took it to the steam table, and proceeded to take the temperature of the foods. The first three items were pork, sweet potatoes,</p>	F 371	<p>1. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p><b>Observation: 5/1/13 dietary aide #7</b> in second floor sunrise dining room washing hands, hands touched inside of sink, observed vigorously shake water from hands after rinsing hands. No specific residents identified. When brought to the dietary manager's attention on 5/2/13, dietary staff on duty (i.e., supervisors, cooks, aides, dishwasher) were re-educated regarding proper hand washing procedure by dietary manager.</p> <p>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents in that dining room have the potential to be affected.</p> <p>On 5/3/13, dietary supervisors continued the education process with remaining dietary staff and was completed by 5/7/13. On 5/10/13, dietary staff (i.e., supervisors, cooks, aides, dishwasher) were required to complete educational program entitled: "Preventing food borne illness in the kitchen" with a completion date of May 31, 2013. Attached is a description of the "Course: Preventing Food borne Illnesses in the Kitchen" identifying the objectives. (See attachment B)</p>	6/15/13	

*Molly Harper,*

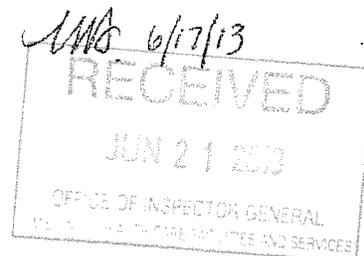
*MS. 6/17/13*



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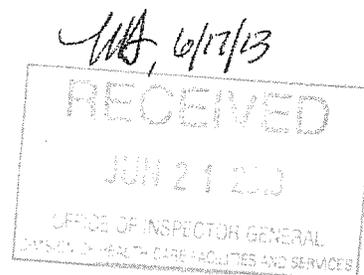
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F 371	<p>Continued From page 2</p> <p>and zucchini. After recording the temperatures, Dietary Aid #7 placed the thermometers briefly back in the ice water then pulled them back out to take the temperature of the creamed potatoes, tomato soup, and grilled cheese sandwiches. Dietary Aide #7 did not sanitize the thermometers between uses. A box of alcohol prep pads were on a counter top near the steam table.</p> <p>Interview, on 05/01/13 at 1:10 PM with Dietary Aid #7, revealed she always shook her hands when she washed them, but stated she understood shaking water from her hands, and touching the inside areas of the sink during handwashing would be unsanitary. Her last handwashing in-service occurred January 2013, but no one had corrected her technique. Dietary Aid #7 stated she had been trained to clean the thermometers with an alcohol prep pad between each food as the temperature was taken, but she thought she forgot to clean them this time because she was nervous. Dietary Aid #7 stated she should have sanitized the thermometer that fell on the counter before using it, and that the thermometers should have been wiped with the alcohol prep pads after each use to prevent any cross-contamination.</p> <p>Interview, on 05/02/13 at 9:35 AM, with the Dietary Manager revealed dietary staff received in-service education in sanitary procedures for meal prep and service upon hire, annually, and as needed. The Dietary Manager stated new employees had to satisfactorily demonstrate proficiency in sanitary procedures upon hire before a required checklist was completed by the dietary manager and the dietary supervisors. The Dietary Manager also stated staff should follow the steps in the dietary policy for hand washing,</p>	F 371	<p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>To validate dietary staff's comprehension, competency testing will be required for dietary staff. Competency testing will be conducted by dietary manager, consulting registered dietician, and dietary supervisors beginning May 23, 2013 with completion date of June 7, 2013. See "Neighborhood Dining Room Observation - Appendix A" form, which reflects employee demonstrates proper hand washing technique. This form will be kept on file by the dietary manager.</p> <p>In addition, new employees hired effective May 20, 2013, will be required to demonstrate hand washing competency during orientation process, using form entitled "Neighborhood Dining Room Observation - Appendix A" form. This competency demonstration will be conducted by dietary supervisors and information will be filed by dietary manager.</p> <p>4. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>Annual hand washing competency, using Appendix A form (see attached) will be required of dietary staff and documentation will be placed in the employee's file by dietary manager.</p> <p>Starting June 3, 2013 monitoring of</p>		



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F 371	<p>Continued From page 3</p> <p>and that shaking water from the hands while rinsing them would increase the risk of contaminating clean kitchen surfaces. The Dietary Manager further stated food thermometers should be cleaned with alcohol if they came in contact with any unclean surfaces, and between taking temperatures of each food item on the steam table. The Dietary Manager indicated the cleaning of the thermometers would be necessary to prevent the likelihood of any type of cross-contamination during the process of serving food to the residents.</p> <p>Review of the facility's policy regarding Food Service Infection Control, Safety, and Sanitation, revised 09/2012, revealed all food service personnel would wash hands thoroughly and frequently before starting work, after handling soiled dishes, and anytime hands became soiled.</p> <p>Observation, on 05/01/13 at 12:10 PM, of the Woodside dining room and kitchenette revealed Server/Dietary Aide #1 used hand sanitizer on re-entry into the kitchenette after pouring coffee from the coffee pot located in the dining room. The Dietary Aide then proceeded to obtain food temperatures for the lunch meal. Continued observation, on 05/01/13 at 12:32 PM, revealed the Dietary Manager entered the Woodside kitchenette and sanitized her hands.</p> <p>Interview with Dietary Aide #1, on 05/02/13 at 9:20 AM, revealed she used sanitizer after handling the dining room coffee pot. She stated she was trained to use hand sanitizer up to three</p>	F 371	<p>staff will occur twice a week by consulting registered dietician or dietary supervisor to ensure compliance utilizing "Appendix A" form (see attached). To ensure compliance is sustained, effective June 10, 2013, the dietary manager Will utilize "Appendix A" form to conduct observations twice a month.</p> <p>Summary of findings will be reported in the quarterly Continuous Quality Improvement meeting by dietary manager. The Continuous Quality Improvement Committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted.</p> <p>1. Address what corrective action will be accomplished for those residents found to be have been affected by the deficient practice:</p> <p><b>Observation: 5/1/13</b> dietary aide #7 in second floor sunrise dining room prepared glass of ice water for calibrating thermometer to be used for obtaining temperature, observed thermometer fall out of cup and landed on counter top, did not sanitize, and proceeded to take temps. Employee was also observed not to sanitize thermometer between uses.</p> <p>No specific resident identified</p>	

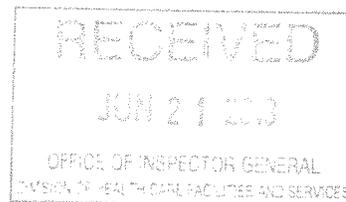


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F 371	<p>Continued From page 4</p> <p>(3) times before washing her hands. The Dietary Aide stated the entire area from which she serves food from the steam table was part of the kitchenette. She stated the purpose of the half wall between the dining room and the kitchenette was to provide a barrier for the kitchen serving area. She stated using hand sanitizer in the kitchen area could make residents sick.</p> <p>On 05/02/13 at 10:00 AM, interview with the Dietary Manager revealed dietary staff were trained to change gloves and sanitize their hands three (3) times before they needed to wash their hands. She stated she was not aware that hand sanitizer could not be used in a food service setting. The Dietary Manager stated it was possible for sanitizer to get into the residents food and contaminate it.</p> <p>Review of the facility's policy regarding Food Service Infection Control, Safety, and Sanitation, revised 09/2012, revealed food service personnel should wear a hair net or hair restraint. Also, only food service personnel would be permitted in the food preparation area and all outside persons in the department would wear a hat or hair restraint.</p> <p>Observation, on 05/01/13 at 12:48 PM, revealed Licensed Practical Nurse (LPN) #2 was in the Woodside dining room assisting with serving residents the lunch meal. The LPN entered the Woodside kitchenette and washed her hands in the kitchenette sink without her hair restrained.</p> <p>Interview, on 05/02/13 at 9:10 AM, with LPN #2 revealed she would wash her hands in the kitchenette and she would not wear a hair restraint. She stated she had been trained to</p>	F 371	<p>When brought to the dietary manager's attention on 5/2/13, dietary staff on duty (i.e., supervisors, cooks, aides, dishwasher) were re-educated regarding proper procedure for temperature logging of foods and sanitizing process by dietary manager.</p> <p>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents in that particular dining room have the potential to be affected.</p> <p>On 5/3/13, dietary supervisors continued the education process with remaining dietary staff and was completed by 5/7/13.</p> <p>On 5/10/13 dietary staff (i.e., supervisors, cooks, aides, dishwasher) were required to complete educational program entitled: "Preventing food borne illness in the kitchen," with a completion date of May 31, 2013. Attached is a description of the "Course: Preventing Food borne Illnesses in the Kitchen" identifying the objectives (see Attachment B).</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>To validate dietary staff's comprehension, competency testing will be required for dietary staff. Competency testing will be</p>		

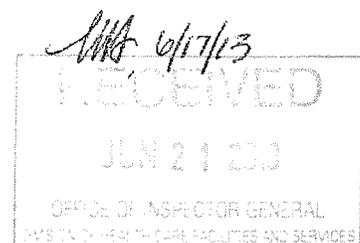
*MSB, 6/17/13*



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F 371	<p>Continued From page 5</p> <p>wash her hands in the kitchenette sink if needed.</p> <p>Interview with Dietary Aide #2, on 05/02/13 at 9:20 AM, revealed nurses were allowed to enter the kitchenette to wash hands if needed. She stated the half wall was a barrier between the dining room and the kitchenette and if there was was food present then everyone in the kitchenette needed to have a hair restraint. She stated hair restraints were not kept in the kitchenette for staff to use when entering the kitchenette.</p> <p>On 05/02/13 at 10:00 AM, interview with the Dietary Manager revealed nurses used the sink in the Woodside kitchenette to wash their hands. She stated only dietary staff used hair nets. She stated the entire area was considered a food preparation area during the process of meal service. The Dietary Manager stated without hair restrained, hair could fall into residents food and contaminate it.</p> <p>Review of the facility's policy regarding Food Preparation and Service Guidelines, revised 08/2004, revealed tongs or other utensils should be used in handling food whenever possible. If it was necessary to use hands, hands should be washed and gloves worn.</p> <p>Observation, on 05/01/13 at 12:42 PM, of the Woodside Dining Room tray line service revealed the Server/Dietary Aide #1 wore gloves for meal service. The Dietary Aide placed a meal ticket onto a tray and then, with the same soiled gloves on, tore a grilled cheese sandwich in half and served half of the sandwich on two (2) plates. After placing the sandwich on the plate, the Dietary Aide then washed her hands and put on</p>	F 371	<p>conducted by dietary manager, consulting registered dietician, and dietary supervisors beginning May 23, 2013 with completion date of June 7, 2013. See "Neighborhood Dining Room Observation - Appendix A" which reflects staff checks temperature of food on steam table utilizing proper infection control techniques (i.e., proper sanitizing of thermometers). This form will be kept in a file by dietary manager.</p> <p>In addition, new employees hired effective May 20, 2013, will be required to demonstrate competency related to checking temperatures of food on steam table and utilizing proper infection control techniques during orientation process. This competency demonstration will be conducted by dietary supervisor using form entitled: "Neighborhood Dining Room Observation - Appendix A" and form will be filed in employee file by dietary manager.</p> <p>4. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>Annual infection control procedure for checking temperatures of food competency testing, using Appendix A form, will be required for dietary staff and documentation will be placed in the employee's file by dietary manager.</p> <p>Starting June 3, 2013 monitoring of of staff will occur twice a week by consulting registered dietician or dietary supervisor to ensure</p>		

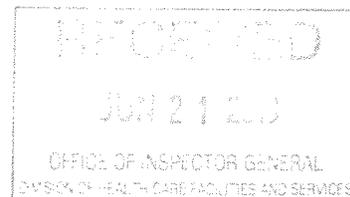


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F 371	Continued From page 6 new gloves. The Dietary Aide then placed a meal ticket on a tray, tore a grilled cheese sandwich in half, and served half the sandwich on (2) plates with the same soiled gloves.  Interview, on 05/02/13 at 9:20 AM, with Dietary Aide #1 revealed she usually used tongs when serving sandwiches and had tongs to use; however, she stated she had forgotten to use them. She stated using the same gloves she used to handle the meal tickets was not sanitary and had the potential to make residents sick.  On 05/02/13 at 10:00 AM, interview with the Dietary Manager revealed tongs should be used to serve sandwiches. The Manager stated she monitored dietary service with spot checks for food temperatures and if resident's were pleased with meals. She stated resident meal tickets were not sanitary and using the same gloves to handle meal tickets and then the grilled cheese sandwich's could contaminate the resident's food.	F 371	compliance utilizing "Appendix A" form (see attached). To ensure compliance is sustained, effective June 10, 2013, the dietary manager will utilize "Appendix A" form to conduct observations twice a month. Summary of findings will be reported in the quarterly Continuous Quality Improvement meeting by dietary manager. The Continuous Quality Improvement Committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted.  See pages attached (8 - 15) F371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	This plan of correction is submitted for the accompanied statement of deficiencies. this document plan submitted does not constitute agreement with the statement of deficiencies nor does it document agreement with the stated conclusions from the interviews written as a part of the deficiencies. this plan of correction is submitted as our duty as outlined in the requirement of the law.		

*Handwritten signature and date: 6/17/13*



1. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:

**Observation: 5/1/13** dietary aide # 1 used hand sanitizer upon re-entry into Woodside kitchenette and proceeded to obtain food temperatures for lunch meal and also an observation of dietary manager entering Woodside kitchenette sanitizing her hands.

No specific residents identified.

When brought to the dietary's manager's attention by surveyor on 5/2/13, that hand sanitizer could not be used in food preparation area, dietary manager educated dietary staff (i.e., supervisors, cooks, aides, dishwasher).

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents in Woodside dining area, have the potential to be affected.

On 5/3/13, dietary supervisors continued the education process with dietary staff not to use hand sanitizer in food prep area, and this education was completed by 5/7/13. On 5/10/13, dietary staff (i.e., supervisors, cooks, aides, dishwasher) were required

*MW* 6/17/13

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OFFICE OF INSPECTOR GENERAL	
STATE OF CALIFORNIA, DEPARTMENT OF HEALTH AND SERVICES	

to complete educational program entitled: "Preventing food borne illness in the kitchen," with a completion date of May 31, 2013. Attached is a description of the "Course: Preventing food borne illnesses in the Kitchen" identifying the objectives. (see attachment B)

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

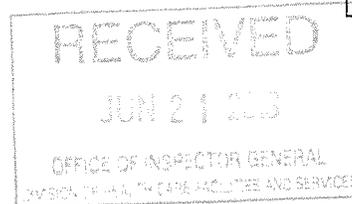
Competency hand washing testing will be conducted by dietary manager, consulting registered dietitian, and

dietary supervisors beginning May 23, 2013 with completion date of June 7, 2013 using Attachment A. As part of this competency, dietary staff will be questioned to reflect knowledgeable that hand sanitizer is not permitted in food prep area. This will be validated on form entitled: "Appendix A" form. This form will be placed in the employee's file by dietary manager.

New employees hired effective May 20, 2013, will be required to demonstrate hand washing competency during orientation and as part of competency will demonstrate knowledgeable that hand sanitizer is not permitted in food prep area by dietary supervisor. This will be documented on "Appendix A"

*MA, 6/17/13*

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form. (see attached). This form will be placed in the employee's file by dietary manager.

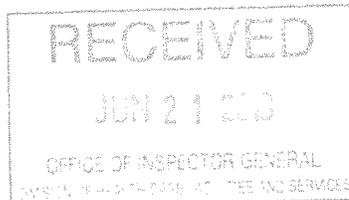
4. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.

Annual hand washing competency will be required of staff, documentation will be placed in employee's file by dietary manager.

Starting June 3, 2013, monitoring of staff will occur twice a week by consulting registered dietician or dietary supervisor to ensure compliance related to not using hand sanitizer in food prep area in Woodside dining room utilizing "Appendix A form. (see attached) To ensure compliance is Sustained, effective June 10, 2013, the Dietary manager will utilize "Appendix A" Form to conduct observations twice a month. Summary of findings will be reported in the quarterly Continuous Quality Improvement meetings by dietary manager. The Continuous Quality Improvement committee will analyze the effectiveness of this system And determine if any further actions to maintain compliance needs to be instituted.

1. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:

*MAA*, 6/17/13



**Observation: 5/1/13 LPN # 2 -**

LPN was in Woodside dining room assisting with serving residents the lunch meal. Observed LPN enter Woodside kitchenette, wash hands without hair restrained.

No specific residents identified.

Nursing staff, (nurse aides, unit manager, charge nurses) were instructed by assistant administrator if they needed to enter area where food is being

prepared in Woodside dining room during meal service, they were to wear hair restraint effective May 17, 2013. Hair restraints have been made Available to staff.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

No other dining area affected.

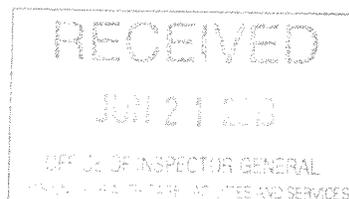
Education of nursing staff regarding hair restraint usage continued May 18 → May 24, 2013 per charge nurses.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

Dietary staff (i.e., aides, supervisors, dishwasher, cooks)

*MM*, 6/17/13

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education related to hair restraint usage in Woodside dining room for food prep was also provided effective May 22, 2013 through May 27, 2013 per dietary manager. Monitoring of staff will occur four times effective May 27, 2013 through June 3, 2013 by the Assistant Administrator and findings will be recorded on "Appendix A" form.

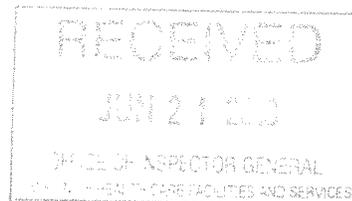
4. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.

Starting June 3, 2013 monitoring of staff will occur twice a week by consulting registered dietician or dietary supervisor to ensure compliance utilizing "Appendix A" form (see attached). To ensure compliance is sustained, effective June 10, 2013, the dietary manager will utilize "Appendix A" form to conduct observations twice a month. Summary of the findings will be reported in the quarterly Continuous Quality Improvement meetings. The Continuous Quality Improvement Committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted.

1. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:

*MA, 6/17/13*

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**Observation: 5/1/13** observed dietary aide #1 in Woodside dining room place meal ticket onto a tray, and with same gloves tore a grilled cheese sandwich in 1/2 and served 1/2 of the sandwich on (2) plates. After serving, dietary aide washed her hands and put on new gloves.

No specific residents were identified.

When brought to the attention of dietary manager on 5/2/13, dietary staff on duty (i.e., supervisors, cooks, aides, dishwasher) were re-educated regarding when to remove contaminated gloves, wash hands, apply clean gloves, and using utensils to cut food appropriately.

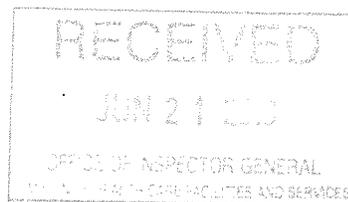
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

No other residents identified as being potentially affected.

On 5/3/13, dietary supervisors continued the education process with remaining dietary staff and process completed by 5/7/13. On 5/10/13, dietary staff (i.e. supervisors, cooks, aides, dishwasher) were required to complete educational program entitled: "Preventing Food borne Illness in the Kitchen," with a completion date of May 31, 2013. Attached is a description of the "Course: Preventing

*MA 6/17/13*

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Food borne illnesses in the Kitchen”  
identifying the objectives.  
(See Attachment B)

3. Address what measures will be  
put into place or systemic changes  
made to ensure that the deficient  
practice will not recur.

To validate dietary staff’s  
comprehension, competency  
testing using “Appendix A form”  
will be required for dietary staff.  
Competency testing will be  
conducted by dietary manager,  
consulting registered dietician,  
and dietary supervisors beginning  
May 23, 2013 with completion  
date of June 7, 2013.  
See “Appendix A” form which reflects  
employee demonstrates knowledge  
related to removing contaminated  
gloves, washing hands, applying  
clean gloves, and using utensils to  
cut food. This form will be kept on  
file by dietary manager.

In addition, new employees hired  
effective May 20, 2013, will be  
required to demonstrate hand  
washing competency during  
orientation process, using form e  
entitled “Appendix A” form  
(see attachment). This competency  
demonstration will be conducted  
by dietary supervisors and  
information will be placed in their

*WMS 6/17/13*

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employee file by dietary manager.

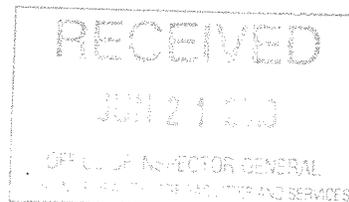
4. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.

Annual competency will be required of dietary staff and documentation will be placed in the employee's file by dietary manager that reflects employee demonstrates knowledge related to removing contaminated gloves, followed by washing of hands, then applying clean gloves, and usage of utensils to cut food. This form will be placed in the employee's file by dietary manager.

Starting June 3, 2013 monitoring of staff will occur twice a week by consulting registered dietician or dietary supervisor to ensure compliance utilizing "Appendix A". To ensure compliance is sustained, effective June 10, 2013, the dietary manager will utilize "Appendix A" form to conduct observations twice a month. Summary of the findings will be reported in the quarterly Continuous Quality Improvement meeting. The Continuous Quality Improvement Committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be implemented.

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*MB, 6/17/13*





F 371

**Neighborhood Dining Room Observation – Appendix A**

Identify Type of Observation Being Conducted:

- Competency Observation as f/u to survey
- Monitoring for Compliance
- Annual Competence Testing
- Orientation Competency Testing

<b>Name of dietary aide:</b>		
<b>Person Conducting Observation and Title:</b>		
<b>Date of Observation:</b>		
<b>Time of Observation:</b>		
<b>Description of Observation</b>	<b>C = compliant NC = noncompliant</b>	<b>Corrective Action Implemented</b>
<i>Dietary staff handling food appropriately:</i> <ul style="list-style-type: none"> <li>• Demonstrates knowledge of examples resulting in contaminating of gloved hands,</li> <li>• Demonstrates knowledge would remove contaminated gloves (i.e., handling of tray card) wash hands, apply clean gloves, and use utensils appropriately to cut food.</li> </ul> <p style="text-align: center;">(C or NC)</p>		
Staff check temperature of food on steam table utilizing proper infection control techniques (i.e. proper sanitizing of thermometers) <p style="text-align: center;">(C or NC)</p>		
<i>Demonstrates proper hand washing technique:</i> <ul style="list-style-type: none"> <li>• Moistens hands and wrists with water, holding them downward over the sink.</li> <li>• Apply soap (do not use bar soap)</li> <li>• Vigorously rub together all surfaces of hands for at least 15-20 seconds, followed by thorough rinsing under a stream of water.</li> <li>• Rinses hands, does not shake hands</li> <li>• Uses paper towel to turn off faucet and discard</li> </ul> <p><b>Note:</b> if employee at any time touches the inside of the sink, the entire process must be restarted.</p> <p style="text-align: center;">(C or NC)</p>		
Question dietary staff regarding usage of hand sanitizer in food prep area. Are they aware this is not an acceptable practice? (indicate yes or no)	Yes  No	
Was employee observed using hand sanitizer in food prep area? (Indicate yes or no)	Yes No	
Appropriate hair restraint usage? (C or NC)		

H: stateforms/dietaryaideobservationdiningrooms/appendixA 2<sup>nd</sup> doc/5-2013

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View:  All  Chapters Only  Tests Only  No Answers

Language: English

Change Language To: English

Course: Preventing Foodborne Illnesses in the Kitchen

Version: 4.00

Current Time: 05/10/2013 11:18 AM

Foodborne illnesses are caused by infectious or toxic microorganisms in food items. This course outlines the federal guidelines that impact the facility's kitchen and its operations. It also covers how to properly store, prepare, serve, and dispose of food to prevent foodborne illnesses in residents.

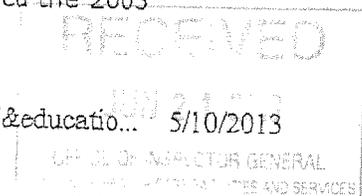
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### Authors

- **Debi Damas, RN** Ms. Damas is responsible for ensuring that Silverchair Learning Systems courses accurately reflect regulations and current standards of practice. She is also responsible for ensuring that new content is developed and maintained on an ongoing basis. She worked on the provider side of senior care for over 18 years prior to coming to Silverchair. She has held positions as Nursing Assistant, Charge Nurse, MDS Nurse, Restorative Nurse, Director of Nursing, Regional Nurse, and Corporate Nurse. She has extensive experience working with the regulations in senior care. She has a certificate in legal nurse consulting.

### Reviewers

- **Linda G. Colleton MSN, RN-BC** Ms. Colleton has been a nurse educator in long term care for over 20 years. She obtained her BSN from Emmanuel College in Boston and her MSN from the University of Phoenix. In 2007, she was certified in Nursing Professional Development by the American Nurses Credentialing Center. She has held positions in long term care as Staff Development Director, Director of Nurses, Nursing Supervisor, and Charge Nurse. She has published articles in two national Lippincott nursing journals and currently works in a for-profit long term care organization, providing educational development and consultation to more than 75 centers in nine states.
- **Linda L. Spaulding, RNC, CIC** Ms. Spaulding holds a degree in nursing, is certified in infection control through the Association of Infection Control Practitioners (APIC), and holds a certification in medical/surgical nursing through the American Nursing Association (ANA). She has experience in medical/surgical nursing, geriatrics, and intensive care. She has provided many presentations for the community and healthcare facilities on various infection-control topics. She provides consulting services to hospitals, nursing homes, home care agencies, prisons, and other local industries and community-based groups. Ms. Spaulding was awarded the 2003



National Educator of the Year Award from Infection Control Today magazine.

**Target Audience:** All workers in long term care

**Course Completion Time:** 60

**Objectives**

A: a result of completing this course, the learner will be able to:

- State how to properly store food
- Describe how hand washing helps prevent foodborne illnesses in residents
- Describe how maintaining a clean kitchen helps prevent foodborne illnesses in residents

---

**Bibliography**

- Centers for Disease Control and Prevention. Hand Hygiene in Healthcare Settings.  
<http://www.cdc.gov/handhygiene/>
- Centers for Disease Control and Prevention. Hand Hygiene Saves Lives.  
<http://www.cdc.gov/Features/HandHygiene/>
- 42 CFR 483.35(i) (F371) Sanitary Conditions – update effective September 1, 2008

**Course Content**

**Chapters**

Chapter 1 of 7

According to the U.S. Food and Drug Administration (FDA), there are 76 million foodborne illness cases in the United States every year, resulting in 325,000 hospitalizations and 5,000 deaths.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/02/2013
NAME OF PROVIDER OR SUPPLIER  NAZARETH HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 NEWBURG ROAD LOUISVILLE, KY 40205	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 6 new gloves. The Dietary Aide then placed a meal ticket on a tray, tore a grilled cheese sandwich in half, and served half the sandwich on (2) plates with the same soiled gloves.  interview, on 05/02/13 at 9:20 AM, with Dietary Aide #1 revealed she usually used tongs when serving sandwiches and had tongs to use; however, she stated she had forgotten to use them. She stated using the same gloves she used to handle the meal tickets was not sanitary and had the potential to make residents sick.  On 05/02/13 at 10:00 AM, interview with the Dietary Manager revealed tongs should be used to serve sandwiches. The Manager stated she monitored dietary service with spot checks for food temperatures and if resident's were pleased with meals. She stated resident meal tickets were not sanitary and using the same gloves to handle meal tickets and then the grilled cheese sandwich's could contaminate the resident's food.	F 371	compliance utilizing "Appendix A" form (see attached). To ensure compliance is sustained, effective June 10, 2013, the dietary manager will utilize "Appendix A" form to conduct observations twice a month. Summary of findings will be reported in the quarterly Continuous Quality Improvement meeting by dietary manager. The Continuous Quality Improvement Committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted.  See pages attached (8 - 15) F371	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	This plan of correction is submitted for the accompanied statement of deficiencies, this document plan submitted does not constitute agreement with the statement of deficiencies nor does it document agreement with the stated conclusions from the interviews written as a part of the deficiencies. this plan of correction is submitted as our duty as outlined in the requirement of the law.	

*Mary Haynes 6-21-13*

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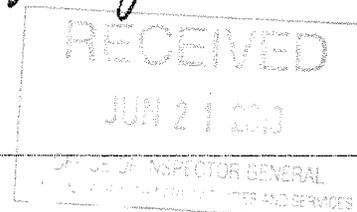
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NAME OF PROVIDER OR SUPPLIER  NAZARETH HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 NEWBURG ROAD LOUISVILLE, KY 40205	
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F 441	Continued From page 7 (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and the Center for Disease Control (CDC) Guideline for Hand Hygiene, it was determined the facility failed to follow infection control hand washing guidelines during a dressing change and during a skin assessment for one (1) of twenty-three (23) sampled residents. Staff used improper hand washing and gloving techniques during a dressing change and skin assessment for Resident #14.	F 441	1. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:  <b>Observation:</b> LPN #3 on 5/1/2013, Observed not to follow infection control hand washing guidelines during dressing change and during skin assessment for resident #14.  When brought to DON's attention, re-education with LPN #3 occurred regarding proper dressing change procedure, skin assessment procedure and usage of proper hand washing guidelines. Staff Development coordinator conducted competency observation with LPN #3 regarding proper infection control techniques for hand washing, skin assessment, and dressing change on 5/1/2013. This information was communicated to surveyor on 5/1/13 by Director of Nursing and Education Staff Development Coordinator.  2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.  We reviewed residents assigned to LPN #3 on 5/1/13 and there were three (3). The two (2) remaining residents received their dressing change after the competency testing was completed and established.	

*Mary Dwyer 6-21-13*



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NAME OF PROVIDER OR SUPPLIER  NAZARETH HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 NEWBURG ROAD LOUISVILLE, KY 40205		
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F 441	<p>Continued From page 8</p> <p>The findings include:</p> <p>Review of the CDC Guideline for Hand Hygiene in Health Care Setting, 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, excretions, mucous membranes, non-intact skin and wound dressings; change gloves during patient care if moving from a contaminated body site to a clean body site; and decontaminate hands after removing gloves.</p> <p>Review of the facility's Infection Control Policy titled Hand Hygiene revealed hand hygiene should be performed after contact with blood, body fluids, excretions, mucous membranes, non-intact skin or wound dressings.</p> <p>Review of the facility's reference book, that was presented by the Director of Nursing (DON) during the survey, titled Smith-Temple Johnson, 6th Edition, stated to use the Center for Disease Control and Prevention Policy for Hand Hygiene infection prevention.</p> <p>Review of Resident #14's clinical record revealed Resident #14's stool specimen was positive for Clostridium Difficile (C-Diff) and the resident was placed in isolation related to C-Diff.</p> <p>Observation with Licensed Practical Nurse (LPN) #3 of Resident #14's skin assessment and dressing change, on 05/01/10 at 10:15 AM, revealed the resident had a Stage 2 that measured 3.5 centimeters (cm) x 4.2 cm, with a fluid-filled blister on the left heel and a 3.5 cm x</p>	F 441	<p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>This requirement was met, staff received education and competency demonstration regarding proper, infection control practices related to hand hygiene during dressing changes and skin assessment. Education was completed by 6/14/2013 and was conducted by Staff development coordinator or a licensed nurse deemed competent. Any licensed staff who had not completed education prior to 6/14/13 was required to complete prior to next scheduled working day.</p> <p>See attachment C entitled: "Competency Evaluation – Hand Hygiene, dressing change, skin Assessment" form which will be used as competency evaluation.</p> <p>4. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>Once staff have established their education and competency, the facility will monitor to ensure compliance is sustained using Attachment C and complete by 8-9-2013. Monitoring will be conducted by</p>		

*Mary Daynes*  
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NAME OF PROVIDER OR SUPPLIER  NAZARETH HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 NEWBURG ROAD LOUISVILLE, KY 40205		
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F 441	<p>Continued From page 9</p> <p>4.2 cm with a fluid filled blister on the right heel. LPN #3 removed the resident's gripper socks, the old dressing, cleansed the blister with Normal Saline using a 4 x 4 gauze, applied antibiotic ointment using a cotton tip applicator, reapplied a clean Kerix dressing and then reapplied the residents gripper socks. The LPN proceeded to do the sample procedure with the right foot. The LPN checked the pulses in both feet wearing the same gloves. The LPN did not change gloves or wash her hand through out the entire procedure. The LPN wearing the same gloves proceeded with the skin assessment opening the resident's brief, touching the buttocks, the upper inner thighs and then touched the residents hands, arms, chest, ears and neck without washing her hands or changing the gloves. The LPN adjusted the resident's clothing, bedding and touched the resident's hands at the end of the procedure and did not perform hand hygiene or glove changes through out the entire procedure.</p> <p>Interview with LPN #3, on 05/01/13 at 10:45 AM, revealed she was aware that she should have washed her hands and changed her gloves after touching the gripper socks because there was a possibility the socks could have touch the floor and would be contaminated. The LPN revealed she should have washed her hands and changed gloves after touching the resident's brief, buttocks and inner thighs because she would spread the C-Diff.</p> <p>Interview with the Director of Nursing (DON), on 05/02/13 at 10:15 AM, revealed if the gripper sock had touched the floor it could contaminate a glove and was uncertain if Resident #14's gripper socks had ever touched the floor. The DON was</p>	F 441	<p>the Staff Development Coordinator, Unit Manager or Assistant Administrator.</p> <p>Summary of the findings will be reported in the quarterly Continuous Quality Improvement (CQI) meeting. The CQI committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted.</p>	6/15/13	

*Mary Daynes*

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F 441	Continued From page 10 uncertain if the resident's peri-area could have been moist and was uncertain of the specifics of the hand hygiene practice used by the facility during dressing changes and skin assessments. The DON commented she had not read the resource book the facility used for hand hygiene cover to cover and made no further comment.	F 441			

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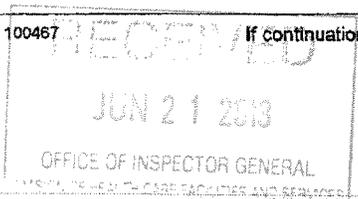
NAME OF PROVIDER OR SUPPLIER  NAZARETH HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 NEWBURG ROAD LOUISVILLE, KY 40205
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1976, 1999</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Three (3) stories, Type II (222)</p> <p>SMOKE COMPARTMENTS: Thirteen (13) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator, fuel source is diesel.</p> <p>A standard Life Safety Code survey was initiated on 04/30/13 and concluded on 05/01/13. Nazareth Home was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one hundred eighteen (118) beds with a census of one hundred fifteen (115) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<p>This plan of correction is submitted for the accompanied statement of deficiencies. This documented plan submitted does not constitute agreement with the statement of deficiencies nor does it document agreement with the stated conclusions from the interviews written as a part of the deficiencies. This plan of correction is submitted as our duty as outlined in the requirements of the law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Mary W. Zayner</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>X 6/21/13</i>
--	---------------------------------	-------------------------------

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/15/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185138	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  05/01/2013
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NAME OF PROVIDER OR SUPPLIER  NAZARETH HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 NEWBURG ROAD LOUISVILLE, KY 40205
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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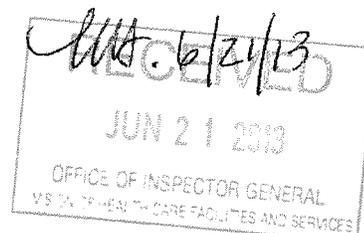
K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000		
K 012 SS=D	Deficiencies were cited with the highest deficiency identified at an "F" level. NFFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire wall was in accordance with NFPA standards. The deficiency had the potential to affect two (2) of thirteen (13) smoke compartments, residents, staff, and visitors. The facility is certified for one hundred eighteen (118) beds with a census of one hundred fifteen (115) the day of the survey. The facility failed to ensure the fire wall and fire door listed on the blueprint had been built per the blueprints and maintained in accordance with NFPA standards.  The findings include:  Observation, on 04/30/13 at 9:49 AM, with the Facility Director revealed the blueprints for the facility listed the wall next to the Chapel off the main lobby to be a two (2) hour fire wall. Inspection of the fire wall revealed the wall was not continuous from outside wall to outside wall or the floor above. The doors in the corridor were	K 012	1. No residents, staff, visitors identified as affected. The practice identified as having the potential to affect the residents in two of the 13 smoke compartments has been corrected. Corrective action – fire barrier not required at referenced location in corridor. The facility smoke compartment plan has been adjusted not to include wall of chapel next to main lobby as a smoke partition.  2. Other residents, staff, visitors, having the potential to be affected – maintenance staff have inspected all facility smoke compartments and are found to be in compliance with NFPA standards as of 5/23/13.  3. Systemic measures implemented to ensure deficient practice will not recur – education of staff related to fire safety upon hire by staff development coordinator. Information communicated at Staff Town Hall meetings on 5/22/13 and 5/23/13 by CEO/Administrator. Annual	

*Mary Layner*  
RECEIVED 6/24/13  
JUN 21 2013  
OFFICE OF INSPECTOR GENERAL  
CENTERS FOR MEDICARE AND MEDICAID SERVICES

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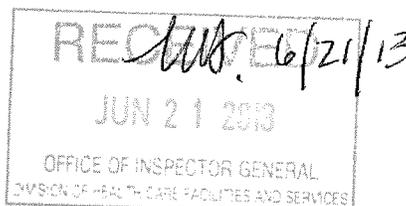
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K 012	<p>Continued From page 2</p> <p>rated for ninety (90) minutes; however, the frame was only rated for twenty (20) minutes.</p> <p>Interview, on 04/30/13 at 9:49 AM, with the Facility Management revealed he was unaware the blueprint listed fire wall was not continuous from floor to ceiling or outside wall to outside wall. Further interview revealed he was not aware the frame for the door did not have the proper rating for a fire wall.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>18.1.1.4 Additions, Conversions, Modernization, Renovation, and Construction Operations. 18.1.1.4.1 Additions. Additions shall be separated from any existing structure not conforming to the provisions within Chapter 19 by a fire barrier having not less than a 2-hour fire resistance rating and constructed of materials as required for the addition. (See 4.6.11 and 4.6.6.) 18.1.1.4.2 Communicating openings in dividing fire barriers required by 18.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire doors. (See also Section 8.2.) 18.1.1.4.3 Doors in barriers required by 18.1.1.4.1 shall normally be kept closed. Exception: Doors shall be permitted to be held open if they meet the requirements of 18.2.2.2.6.</p> <p>8.2.3.2 Fire Protection-Rated Opening Protectives. 8.2.3.2.1 Door assemblies in fire barriers shall be of an</p>	K 012	<p>in-servicing of staff related to fire safety by staff development coordinator and also education that occurs as part of monthly fire drill process by Chief Financial Officer. Maintenance staff will conduct quarterly inspections of all fire and smoke barriers quarterly to monitor and ensure compliance with applicable NFPA standards.</p> <p>4. Results of maintenance inspections will be reported by Chief Financial Officer at Safety Committee meetings from a quality assurance perspective. The safety committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted. In addition, Chief Financial officer will report safety committee recommendations/actions at the Continuous Quality Improvement meetings.</p> <p>Please see response K 048</p>	6/15/13



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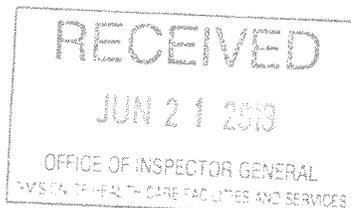
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K 012	Continued From page 3 approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following. (a) * Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Exception: The requirement of 8.2.3.2.1(a) shall not apply where otherwise specified by 8.2.3.2.3.1. (b) Fire doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 and, where used within the means of egress, shall comply with the provisions of 7.2.1. Reference: NFPA 101 (2000 edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. Reference: NFPA 101 (2000 Edition).  8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar	K 012		



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K 012	Continued From page 4 building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 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. (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 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. (c) Where designs take transmission of vibration 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.  19.3.7.4 Not less than 30 net ft2 (2.8 net m2) per patient in a hospital or nursing home, or not less than 15 net ft2 (1.4 net m2) per resident in a limited care facility, shall be provided within the aggregate area of corridors, patient rooms, treatment rooms, lounge or dining areas, and other low hazard areas on each side of the smoke barrier. On stories not housing bed or litterborne patients, not less than 6 net ft2 (0.56 net m2) per occupant shall be provided on each side of the smoke barrier for the total number of occupants in adjoining compartments. 19.3.7.5 Openings in smoke barriers shall be protected by	K 012		

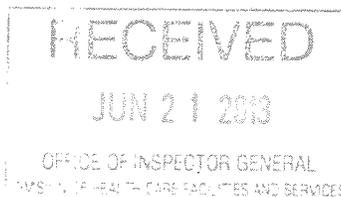


*MT, 6/21/13*

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K 012	Continued From page 5 fire-rated glazing; by wired glass panels and steel frames; by substantial doors, such as 13/4-in. (4.4-cm) thick, solid-bonded wood core doors; or by construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted. Exception: Doors shall be permitted to have fixed fire window assemblies in accordance with 8.2.3.2.2.	K 012		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by:	K 018	1. Corrective action implemented for residents in room 234, 272, 273, 274, 284, 293, 295. Pemko silicon seal fire/smoke gasketing ordered from Willis Klein on 5/22/13. Gaps around the face of doors and jams were corrected to resist the passage of smoke in accordance with NFPA applicable standards as of June 14, 2013.  2. Other residents, staff, visitors having the potential to be affected, none identified – all facility doors have been inspected for proper latching and resistant to passage of	

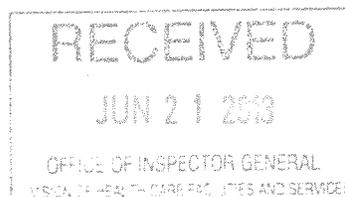


*MA, 6/21/13*

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K 018	<p>Continued From page 6</p> <p>Based on observation and interview, it was determined the facility failed to ensure doors protecting corridor openings were constructed to resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect three (3) of thirteen (13) smoke compartments, residents, staff and visitors. The facility is certified for one hundred eighteen (118) beds with a census of one hundred fifteen (115) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 04/30/13 between 10:00 AM and 3:10 PM, with the Facility Management revealed the corridor doors to room's 234, 272, 273, 274, 284, 293, and 295 had a gap too large around the jamb where the door meets the doorstop and would not resist the passage of smoke.</p> <p>Interview, on 04/30/13 between 10:00 AM and 3:10 PM, with the Facility Management revealed he was not aware the doors had a gap that was too large.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the</p>	K 018	<p>smoke as of June 14, 2013 and found to be in compliance.</p> <p>3. Systemic measures implemented to ensure deficient practice will not recur – maintenance staff will inspect all corridor doors every six months for proper latching and resistance to smoke passage. Documentation will be kept on file in maintenance department.</p> <p>4. Results of maintenance inspections will be reported by Chief Financial Officer at Safety Committee meetings from a quality assurance perspective. The Safety Committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted. In addition, Chief Financial Officer will report Safety Committee recommendations/actions at the Continuous Quality Improvement meetings.</p>	6/15/13

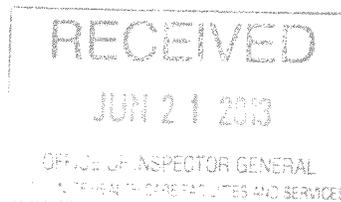


*MS. 6/21/13*

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K 018	Continued From page 7 passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018			
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 025	1. No residents, staff, visitors, identified as affected. The practice identified as having the potential to affect residents in four of the thirteen smoke compartments has been corrected.		

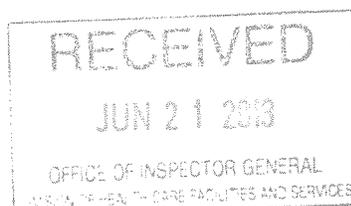


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K 025	<p>Continued From page 8</p> <p>floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met 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 thirteen (13) smoke compartments, residents, staff and visitors. The facility is certified for one hundred eighteen (118) beds with a census of one hundred fifteen (115) on the day of the survey. The penetrations of pipes and wires through the smoke barriers were not sealed with material rated or equal to the wall.</p> <p>The findings include:</p> <p>Observations, on 04/30/13 between 9:00 AM and 10:00 AM, with the Facility Management revealed the smoke barriers, extending above the ceiling had penetrations of pipes and wires. The penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. The locations of the penetrations are as follows:</p> <p>1) Above the cross corridor doors next to the balcony on the second floor was an unsealed pipe and the use of expandable foam to seal penetrations.</p>	K 025	<p>Corrective Action -</p> <p>maintenance staff removed all expandable foam and filled all penetrations with a material rated equal to the partition. Work completed June 14, 2013.</p> <p>2. Other residents, staff, visitors, identified as having the potential to be affected -</p> <p>Corrective Action -</p> <p>maintenance staff have inspected all cross corridor smoke barriers and removed all expandable foam and filled all penetrations with a material rated equal to the partition. Work completed June 14, 2013.</p> <p>3. System measures implemented to ensure deficient practice will not recur - Chief Financial Officer/Facility Director educated maintenance staff on June 12, 2013 regarding NFPA requirement for maintenance of cross corridor smoke barrier. Maintenance staff will inspect smoke barriers quarterly to ensure smoke</p>	

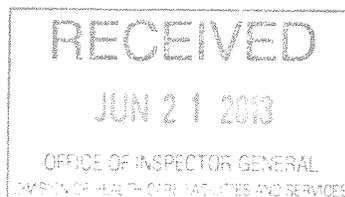


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K 025	Continued From page 9 2) The smoke partition located on the third floor had expandable foam used to seal penetrations.  Interview, on 04/30/13 between 9:00 AM and 10:00 AM, with the Facility Management revealed he was not aware of the penetration. Further interview revealed he was not aware the expandable foam was not rated for use in the smoke barriers.  Reference: NFPA 101 (2000 Edition).  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: (a) The space between the penetrating item and the smoke barrier shall 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. (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 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. (c) Where designs take transmission of vibration 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	compartments are sealed with material rated equal to the partition. Documentation will be kept on file in maintenance department.  4. Results of maintenance Inspections will be reported by Chief Financial Officer at Safety Committee meetings from a quality assurance perspective. Safety Committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted. In addition, Chief Financial Officer will report Safety Committee recommendations/ actions at the Continuous Quality Improvement meetings.	6/15/13
K 027	NFPA 101 LIFE SAFETY CODE STANDARD	K 027		

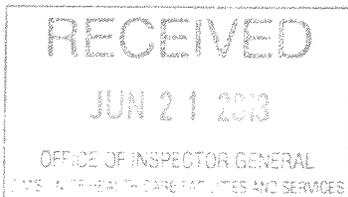


*MA 6/20/13*

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K 027 SS=E	<p>Continued From page 10</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of thirteen (13) smoke compartments, patients, staff and visitors. The facility is certified for one hundred eighteen (118) beds with a census of one hundred fifteen (115) on the day of the survey. The facility failed to ensure doors located in a smoke barrier would close completely and resist the passage of smoke.</p> <p>The findings include:</p> <p>Observation, on 04/30/13 between 10:00 AM and 3:10 PM, with the Facility Management revealed the cross corridor doors in the smoke barrier located next to rooms 306, 206, and 176, had a gap too large and would not resist the passage of smoke. Further observation revealed the cross</p>	K 027	<ol style="list-style-type: none"> <li>1. No residents, staff, visitors, identified as affected. The practice identified as having the potential to affect residents in smoke compartments containing rooms 306, 206, 176, and 2-north corridor have been inspected and repaired to resist the passage of smoke in accordance with NFPA guidelines. Bottom edge of cross corridor door at 2-North location was repaired on 5/1/2013 by grinding excess metal from bottom edge of door.</li> <li>2. Other residents, staff, visitors, identified as having the potential to be affected. Corrective Action – maintenance staff have inspected and repaired all cross corridor doors to resist the passage of smoke in accordance with NFPA guidelines. All found to be in compliance.</li> <li>3. Systemic changes implemented to ensure that practice will not recur – Chief Financial Officer/ Facility Director educated maintenance staff on June 12, 2013 regarding NFPA requirement for</li> </ol>	

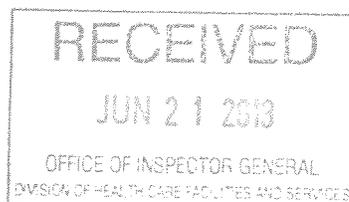


*MA* 6/21/13

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:  <b>185138</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/01/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>NAZARETH HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2000 NEWBURG ROAD LOUISVILLE, KY 40205</b>	
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K 027	Continued From page 11 corridor doors located in 2 North would not close completely due to the door dragging on the floor.  Interview, on 04/30/13 between 10:00 AM and 3:10 PM, with the Facility Management revealed he was not aware the doors had developed a gap that was too large to resist smoke. Further interview revealed he was not aware the door was dragging on the floor.  Reference: NFPA 101 (2000 edition)  8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.  Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.	K 027	maintenance of cross corridor smoke barrier. Maintenance staff will inspect all cross corridor doors quarterly to ensure doors located in the smoke barrier close completely and resist the passage of smoke. Documentation will be kept on file in maintenance department.  4. Results of maintenance inspections will be reported by Chief Financial Officer at Safety Committee meetings from a quality assurance perspective. The safety committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted. In addition, CFO (Chief Financial Officer) will report Safety Committee recommendations/ Actions at the Continuous Quality Improvement meetings.	6/14/13
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	K 029	1. No residents, staff, visitors, identified as affected. The practice identified as having the potential to affect residents in 3 of the 13 smoke compartments has been corrected. Appropriate self-closing devices have	

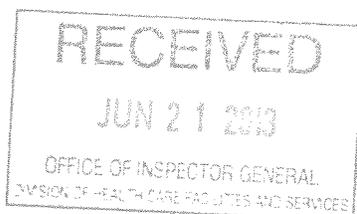


*MMR, 6/21/13*

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K 029	Continued From page 12 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 three (3) of thirteen (13) smoke compartments, residents, staff and visitors. The facility is certified for one hundred eighteen (118) beds with a census of one hundred fifteen (115) on the day of the survey.  The findings include:  Observation, on 04/30/13 between 9:00 AM and 3:10 PM, with the Facility Management revealed the Social Services Office, 2nd Floor Copy Room, and the HR Conference Room had large amounts of combustible paper and the doors were not equipped with a self-closing device. Further observation revealed a hazardous storage room identified as "Comm 9" had penetrations within the room that had been sealed with expandable foam.  Interview, on 04/30/13 between 9:00 AM and 3:10 PM, with the Facility Management revealed he was not aware the doors to hazardous rooms were required to be self-closing or that the expandable foam was not approved for use to seal penetrations.	K 029	been installed as required per applicable NFPA standards for hazardous storage rooms. Penetrations in "comm 9" will be sealed with other material rated equal to the wall. Work completed 6/14/13.  2. Other residents, staff, visitors, identified as having the potential to be affected – Corrective Action – appropriate self-closing devices will be installed as required per applicable NFPA standards for hazardous storage rooms. Entire facility was inspected For compliance by Maintenance with applicable standards for hazardous storage rooms and facility was identified to be in compliance.  3. Systemic changes implemented to ensure that practice will not recur – Chief Financial Officer/ Facility Director educated maintenance staff June 12 regarding NFPA requirement for maintenance of hazardous storage room. Maintenance	

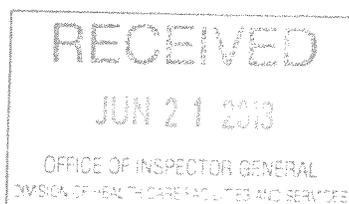


*Mary Dwyne*  
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K 029	Continued From page 13  Reference:  NFPA 101 (2000 Edition).  19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), 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	K 029	staff will inspect all areas quarterly for compliance with protection of hazards in accordance with NFPA. Documentation will be kept on file in maintenance department.  4. Results of maintenance staff inspections will be reported by Chief Financial Offer at Safety Committee meetings from a quality assurance perspective. The safety committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted. In addition, the Chief Financial Officer will report Safety Committee recommendations/actions at the Continuous Quality Improvement meetings.	6/15/13	

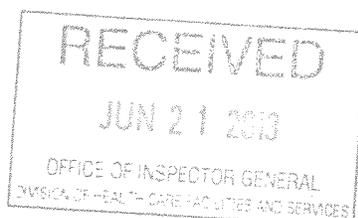


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K 029	Continued From page 14	K 029		
K 038 SS=D	protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		
	<p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of thirteen (13) smoke compartments, residents, staff and visitors. The facility is certified for one hundred eighteen (118) beds with a census of one hundred fifteen (115) on the day of the survey. The facility failed to maintain doors equipped with delayed egress locks.</p> <p>The findings include:</p> <p>Observation, on 04/30/13 at 12:00 PM, with the Facility Management revealed the delayed egress lock on the Sunrise Dining Room exit failed to operate when tested. The door was equipped with a badge swipe that would override the delayed egress lock which did function.</p> <p>Interview, on 04/30/13 at 12:00 PM, with the</p>		<p>1. No residents, staff, visitors, identified as affected. The practice identified as having the potential to affect residents in 2 of the 13 smoke compartments has been corrected. Corrective Action – the delayed egress lock on the Sunrise Dining Room exit was repaired on 5/21/13.</p> <p>2. Other residents, staff, visitors, identified as having the potential to be affected – Corrective Action – maintenance staff have inspected all egress doors and exits in facility for compliance with NFPA standards, facility was in compliance.</p> <p>3. Systemic measures implemented to ensure deficient</p>	

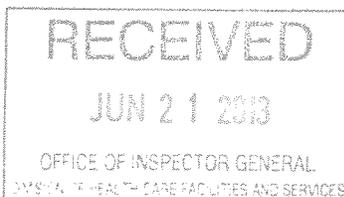


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K 038	Continued From page 15 Facility Management revealed he was unaware the delayed egress lock had stopped working.  Reference: NFPA 101 (2000 edition)  7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.  (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.  (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.	K 038	practice will not recur – Chief Financial Officer/ Facility Director educated maintenance staff on June 12, 2013 regarding NFPA requirement for maintenance of delayed egress locks. Maintenance staff will inspect all egress doors and exits monthly for proper function (proper function defined as 30 second delayed release activated upon attempt to open door) in accordance with NFPA standards. Documentation will be kept on file in maintenance department.  4. Results of maintenance inspections will be reported by Chief Financial officer at Safety Committee meetings from a quality assurance perspective. The Safety Committee will Analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted. In addition, Chief Financial Officer will report Safety Committee recommendations/actions at the Continuous Quality	6/13/13

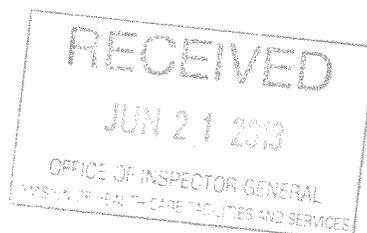


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K 038	Continued From page 16 (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.  (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS  7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm)	K 038	Improvement meetings.	



*MS 6/21/13*