

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

PRINTED: 12/03/2012  
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  11/15/2012
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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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F 000	<p><b>INITIAL COMMENTS</b></p> <p>A standard health survey was conducted 11/13/12 through 11/15/12 and a Life Safety Code survey was conducted 11/14/12. Deficiencies were cited with the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p>	F 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>	
F 241 SS=E	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review it was determined the facility failed to provide bedpans and privacy covers on catheters for three (3) of nineteen (19) residents. Residents #7, #3 and #17 and fifteen (15) of twenty-nine (29) residents sitting in the Blue and Green Dining rooms were observed to not have the same dining experience as the residents in the Main Dining room.</p> <p>The findings include:</p> <p>The facility provided no policy for usage of bedpans.</p> <p>Interview, on 11/14/12 at 2:00 PM, with Resident #7 revealed the resident had frequently asked for a bedpan because he/she took a diuretic. He/she had been given a bed pan on admission, but the</p>	F 241	<p>On 11-15-12 staff were instructed that Resident #7 is able to use a bedpan by the Assistant Unit Manager. Therapy staff were instructed by the DON to review and revise their plan of care for the resident. The care plan for resident #7 was reviewed by The Assistant Unit Manager on 11/19/12 to ensure it reflected the appropriate plan for the resident in regards to continence.</p> <p>Covers were placed on the catheter bags for resident #3 and #17. CNA assignment sheets were reviewed to ensure the covers for the catheter bags were noted.</p> <p>On 11/16/12 the Administrator, DON, and Director of Social Services met to review procedures related to the dining rooms and to make a plan to ensure each resident has the best dining experience possible.</p> <p>It is currently the practice of the facility to put tablecloths on all tables for meals, these are typically white except for special occasions as was observed during the survey. All residents are provided with a napkin but some residents request use of clothing protectors, this will continue to be the practice. Going forward, all food dishes will be placed on the table and not left on the tray, and fluids will be offered to residents prior to meals being served.</p>	12/28/12

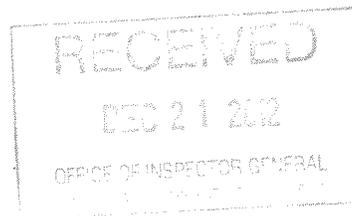
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE  Administrator	(X6) DATE  12/21/12
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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 241	<p>Continued From page 1</p> <p>bedpan was removed after a contract was initiated with the physical therapy department for the resident not to use a bedpan. The resident was only to use a bedside commode for elimination. Because the resident is a two (2) person assist for transfers there had been delays in transferring the resident to the bedside commode. The delay had lead to the resident being incontinent. When the resident was talking about not being able to use a bedpan, he/she stated to be incontinent was embarrassing.</p> <p>Review of the plan of care revealed there are no interventions or goals to ensure Resident #7's elimination needs were met.</p> <p>Review of the contract titled "Do and Don'ts" that was initiated with Resident #7 on 10/25/12 and interview with the assistant in the physical therapy department stated, the resident was to always use a bedside commode for elimination.</p> <p>Interview with Registered Nurse (RN) #4, on 11/15/12 at 10:20 AM, revealed Resident #7 had asked several times for a bedpan order. The order had been denied due to the Do and Don't contract.</p> <p>Interview with Physical Therapy (PT) assistant, on 11/15/12 at 11:20 AM, who initiated the contract revealed a contract was initiated with Resident #7 when he/she was admitted. The date on the contract was 10/25/12. To date, 11/15/12, the contract was still in effect and the assistant acknowledged the therapy department was not following the resident to see if the contract needed revisions or updating. In addition, at the time of the contract the PT assistant stated, she</p>	F 241	<p>The DON met with the therapy department on 11/16/12 to review all residents on therapy caseload to determine if there were any other residents affected by therapy requesting no use of the bedpan. No other residents were identified. The DON interviewed both Unit Managers on 11/16/12 to ensure that there were no other residents that they were aware of that had any restrictions in place to include bedpan use, brief use.</p> <p>The Assistant Unit Managers checked all residents identified as having a catheter to ensure they all had catheter bag covers, that they were on and that the CNA assignment sheet noted the use of the catheter bag covers. This was completed on 12/17/12.</p> <p>All interviewable residents having their meals served in the unit dining rooms were interviewed on 11/30/12 by Director of Social Services to solicit their input regarding how the facility could improve their dining experience.</p> <p>The DON and Director of Staff Development Coordinator will provided education to nursing staff on responding to resident needs, ensuring a residents dignity, answering call lights, following the care plan, use of labels when talking about a resident, use of catheter bag covers, hydration pass and placing water pitchers in resident rooms unless contraindicated as noted on the care plan. Education will be completed by 12/28/12.</p>		



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F 241	<p>Continued From page 2</p> <p>did not research if the resident was on any medication(s) that would impact Resident #7 needing to us a bedpan such as a diuretic/water pill.</p> <p>Interview, on 11/15/12 at 1:40 PM, with the Director of Nursing (DON) revealed she was unaware of the contract initiated by the therapy department and that Resident #7 had been requesting a bedpan.</p> <p>Record review of Resident #7's Do's and Don't contract revealed after he/she was admitted, an assistant in the physical therapy department approached him/her about a contract. The contract stated the resident was to: (1) always use the bedside commode, (2) up in a wheelchair for all meals, (3) use a walker to transfer, (4) transfer counterclockwise, (5) fracture boot for transfers, (6) Sarah lift for transfers to shower chair, (7) no bedpan use, and (8) set up for oral care.</p> <p>Observations, on 11/15/12 at 4:10 PM, revealed Resident #7 pushed his/her call light to request assistance for the bedside commode. A Dietary Aide told Resident #7's nurse he/she needed assistance to go to the bathroom. The nurse continued talking and he called for two(2) aides to assist the resident. It was six minutes before one (1) staff member came. She had to get another aide (resident was a two (2) person lift) to help her. It was another six to seven minutes before two (2) aides assisted the resident to the bedside commode.</p> <p>Interview with the DON, 11/25/12 at 4:20 PM, revealed all nursing staff were responsible to</p>	F 241	<p>All newly hired nursing staff will receive this education during orientation by the Director of Staff Development.</p> <p>It is currently the practice of the facility to put tablecloths on all tables for meals, these are typically white except for special occasions as was observed during the survey. All residents are provided with a napkin but some residents request use of clothing protectors, this will continue to be the practice. Going forward, all food dishes will be placed on the table and not left on the tray, and fluids will be offered to residents prior to meals being served. Residents requiring individualized dining interventions will have a care plan to address these needs. Nursing will be instructed on the facility practice by 12/28/12 by the DON or the Director of Staff Development.</p> <p>Unit Managers/Nurse Manager to make rounds daily for 2 weeks then weekly to ensure that all residents with catheters have catheter bag covers on. All non-compliance will be addressed at the time it is noted. Non-compliance will be reported to the DON who will report on compliance no less than quarterly to the facility QA Committee. DON, Director of Staff Development, and Administrative Nursing Staff will</p>	
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F 241	<p>Continued From page 3</p> <p>respond to call lights. This included the Registered Nurses, Licensed Practical Nurses and Certified Nursing Assistants.</p> <p>Observation of the main dining room and the Green and Blue dining rooms on 11/13/12 at 5:30 PM, 11/14/12 at 12:00 Noon, and on 11/15/12 at 8:30 AM revealed there were an average number of thirty-two (32) residents in the main dining room, an average of fifteen (15) residents in the the Blue dining room and an average of fourteen (14) residents in the Green dining room over the three (3) mealtimes observed. The Blue and Green dining rooms were located at each of two (2) nursing units. Specifically, the main dining room was decorated with colorful tablecloths, cloth napkins, and lowered lighting whereas the Blue and Green dining rooms had bright lighting, plain white tablecloths and no cloth napkins (the residents in the Blue and Green dining rooms wore clothing protectors and the residents in the main dining room did not. The residents in the main dining room had drinks provided to them while waiting for their meal and the residents in the Blue and Green dining rooms had no drinks or attention given to them for the thirty (30) to forty (40) minute wait for their meal. In addition, the residents in the main dining room had their food dishes placed directly on the tables while the residents in the Blue and Green dining rooms had their food dishes served on trays placed on their tables.</p> <p>Interview with Registered Nurse (RN) #3, on 11/14/12 at 9:00 AM, revealed it was her understanding the residents needing assistant</p>	F 241	<p>observe dining service in the unit dining rooms daily for 2 weeks then no less than 3 times per week for 2 weeks Then weekly for one month to ensure compliance with the facility practice. Non-compliance will be addressed as it is noted. Findings will be recorded on an audit sheet and brought to the Quality Assurance Committee Meeting not less than quarterly.</p>	

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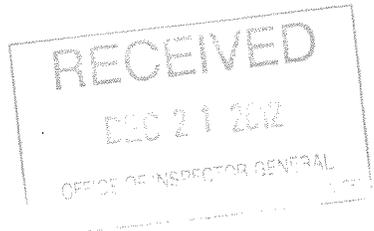
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F 241	<p>Continued From page 4</p> <p>with their meals and monitoring for choking risk were required to eat in either the Blue or Green dining rooms for the facility to meet their needs. However, she also stated there were not enough CNA staff at meal time to be in the main dining room prior to meal service as they were busy getting residents ready to go to the dining rooms. She stated she could understand it would be a comfort to the residents to be offered fluids and there was other nursing staff available at mealtime to assist the residents with their meals/fluids. RN #3 stated she was in the facility at the two (2) mealtimes and also in the facility were the DON, another unit manager and a Minimum Data Set (MDS) nurse and all of them could assist at mealtime but usually did not.</p> <p>Interview with CNA #4, on 11/14/12 at 12:50 PM, revealed she called the residents in the Green dining room "feeders" out loud and in the presence of ten (10) residents. When questioned about using the term "feeders" to refer to the residents, CNA #4 stated she was aware it was wrong to refer to the residents as "feeders" but she forgot.</p> <p>Interview with the Dietary Director, on 11/14/12 at 2:30 PM, revealed she confirmed with the DON just a couple of months ago the rule for residents who could eat in the main dining room was the residents eating there had to be dressed in street clothes and had to be able to eat without assistance. She stated the residents in the main dining room had their fluids served prior to their meals because they did not present as a choking risk and the facility wanted them to have a restaurant style dining experience. She further stated the CNA's could take the dishes off of the</p>	F 241		

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F 241	<p>Continued From page 5</p> <p>trays for the residents in the Blue and Green dining rooms and she did not know why they didn't do so.</p> <p>Interview with the Director of Nursing (DON), on 11/14/12 at 2:45 PM, revealed any resident could eat in the main dining room if he/she was dressed in street clothes and could feed his or herself. She stated there was no policy or anything in the admission packet to signify this but it was a facility rule. The DON explained the reason for this practice was the residents who needed assistance with their meals needed to be on the nursing units for the staff to assist with their meals. She further stated the facility used it's Certified Nursing Assistants (CNA's) to assist residents with their meals and there was no reason the CNA's could not walk to the main dining room except it was convenient for the CNA's to stay on the units as they were busy with other tasks. She stated the residents in the Blue and Green dining rooms could not have fluids prior to their meals because some of them were on thickened liquids and would have to be monitored by nursing for possible choking.</p> <p>Interview with the Green Unit Manager Registered Nurse (RN #2), on 11/15/12 at 8:35 AM, revealed she called the residents "feeders" twice during the course of her conversation with the surveyor and within hearing of several residents. She stated she recognized it was a mistake to call the residents "feeders" and especially not within their hearing as it was a demeaning term. RN #2 stated she thought fluids should be offered to the residents in the nursing unit dining rooms while they were waiting for their meals to serve three purposes: 1) encourage fluid</p>	F 241			



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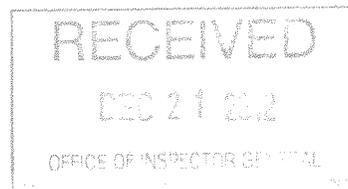
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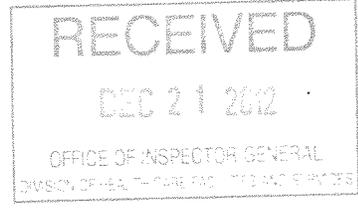
F 241	<p>Continued From page 6</p> <p>intake, 2) build activities of daily living skills, and 3) be involved in a more homelike dining experience. She stated she thought the reason the residents in the Green Unit dining room did not get fluids prior to their meals was because there was not enough staff to help the residents prior to the meal delivery. However, she did state any nursing personnel could assist with meals and monitor residents for choking.</p> <p>Interview with the DON, on 11/15/12 at 1:00 PM, revealed she had taught the nursing staff it was no longer appropriate to refer to residents as "feeders"; however, sometimes they would forget. She stated she knew it was a demeaning and undignified way to refer to a resident in the facility.</p> <p>Interview with the Administrator, on 11/15/12 at 3:50 PM, revealed the facility had nothing in writing regarding which residents could go to the main dining room to eat. However, some residents could not eat in the main dining room due to their needs of meal assistance and choking risk. He also stated those residents needing assistance with their meals could not go to the main dining room due to staff needing to stay on the nursing units to do their work.</p>	F 241		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>A comprehensive care plan must be developed</p>	F 280	<p>The Care Plan for Resident #7 was reviewed and revised as indicated by an Interdisciplinary Team on 12/17/12. The dietician reviewed the chart on 11/19/12 &amp; 12/3/12. The physician was consulted on 11/14/12 by the Assistant Unit</p>	12/28/12



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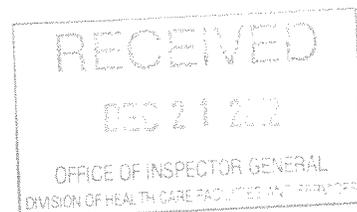
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F 280	<p>Continued From page 7</p> <p>within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other 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 and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review it was determined, the facility failed to review and revise the care plan to meet the nutritional needs of one (1) of seventeen (17) residents, Resident #7.</p> <p>The findings include:</p> <p>Observations of Resident #7's dietary tray slip on 11/14/12 at 11:50 PM, revealed he/she was on a dietetic diet.</p> <p>Review of the diet orders for Resident #4 revealed the diet order was changed to a double portion regular diet by RN #4.</p> <p>Review of the physician orders for Resident #4 revealed a dietitian consult was written on 09/15/12 and an order was written for a dietitian</p>	F 280	<p>Manager. The plan for the resident was changed on 11/14/12 to provide the resident with double portions and then changed on 11/20/12 (per the residents request) to 1 ½ portions.</p> <p>The Assist Unit Mangers, DON and Dietary Manger will review care plans for all residents by 12/28/12 to ensure that the care plans were accurate and reflected the current needs of the residents, with emphasis on the nutritional needs of each resident. Revisions were made if indicated.</p> <p>Corporate Consultant to provide re-education on care planning and care plan revisions to Care Plan Team on 12/21/12. The DON or Director of Staff Development will provide re-education to licensed staff on updating care plan interventions by 12/28/12. Care Plans are to be reviewed with any change in physicians orders, change in functional status of resident, and updated as indicated to continuously reflect the current needs of each resident.</p> <p>Assistant Unit Mangers, DON and MDS Coordinators to review 25 % of resident care plans weekly for 4 weeks then 25% monthly for 4 months to ensure</p>



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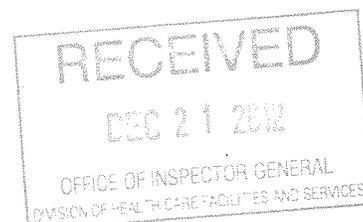
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F 280	Continued From page 8 consult again on 11/13/12. To date 11/15/12 the resident had dietitian intervention on the care plan or assessment note in the medical record.  Interview with Resident #7, on 11/14/12 at 2:00 PM, revealed he/she had notified the nurse practitioner and the unit assistant manager of being hungry after meals.  Interview with Licensed Practical Nurse (LPN) #3, on 11/14 at 2:20 PM, revealed Resident #7 had said he/she was still hungry after receiving his/her meals to LPN #3. She stated, the information had been reported to the nurse practitioner.  Interview with the Director of Nursing (DON), on 11/15/12 at 1:40 PM, revealed Resident #7 had asked for a soup bowl of peanut butter for an evening snack, and she was not aware the resident said he/she was still hungry after meals.  Interview with Registered Nurse (RN) #4, on 11/15/12 at 10:20 AM, revealed she had not adjusted the residents diet because Resident #7 is diabetic and obese.	F 280	care plans reflect the current needs of the resident and that the interventions are reflective of the care being provided. Dietary Manager to review the nutritional care plans of 25% of all residents weekly for 4 weeks then 25% monthly for 4 months to ensure the nutritional needs of each resident is identified and interventions are in place to address the nutritional needs of each resident. Results of these reviews will be reported to the facility QA Committee for review.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by:	F 282	A water pitcher with ice and water was placed in the room for Resident #4 on 11/15/12 by CNA #2. CNA #2 assigned to Resident #4 was re-educated on following the residents individual plan of care by The Unit Manager on 11/15/12. The Assistant Unit Managers and DON reviewed all RA Care Plans on 12/17/12 to identify all residents with an intervention to encourage	12/28/12



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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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F 282	<p>Continued From page 9</p> <p>Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to follow the nursing care plan for one (1) of nineteen (19) sampled residents. The facility did not follow the Resident Assistant Care Plan for Resident #4 as related to encouraging fluids between meals for Resident #4.</p> <p>Review of the facility's policy for Resident Assistant (RA) Responsibilities stated RA assignment sheets were to be read over thoroughly prior to providing care for the resident. RA's were to fill water pitchers with fresh ice water each shift. RA's was to make note of such things specified for the resident's care such as when the resident was to be toileted, what and when enablers were to be used, what kind of diet they were on and if they need assist with meals, etc.</p> <p>Review of the clinical record for Resident #4 revealed the facility readmitted Resident #4 on 5/12/05 with diagnoses of Dementia with Behavior Disturbances, Anxiety Disorder, Generalized Weakness and a history of Brain Bleeding. The facility completed an annual Minimum Data Set (MDS) assessment on 8/01/12 that revealed the resident was severely cognitively impaired on the Brief Interview for Mental Status (BIMS) assessment.</p> <p>Record Review of the RA Care Plan for Resident #4 revealed the RA was to encourage fluids before and with meals.</p> <p>Review of Resident #4's Physician's Routine Orders for 11/01/12 through 11/30/12 revealed</p>	F 282	<p>fluids . These instructions will placed on the MAR by 12/28/12 to include the amount of fluids to be offered and how often each day. All rooms were checked and if not contraindicated (residents on fluid restrictions, thickened liquids, NPO, or with swallowing problems) water pitchers, glasses and straws were placed in the room on 11/15/12 by the CNA's.</p> <p>The DON and Director of Staff Development will provide education to nursing staff on responding to resident needs, ensuring a residents dignity, answering call lights, following the care plan, use of labels when talking about a resident, use of catheter bag covers, hydration pass and placing water pitchers in resident rooms unless contraindicated as noted on the care plan. All newly hired nursing staff will receive this education during orientation by the Director of Staff Development.</p> <p>Unit Mangers are to review 25 % of RA Care Plans/nurse aide assignment sheets weekly for 4 weeks then 25% monthly for 4 months to ensure care plans/assignment sheets reflect the current needs of the resident and that the interventions are reflective of the care being provided. Any changes needed will be made to reflect the individualized needs of the residents.</p>	



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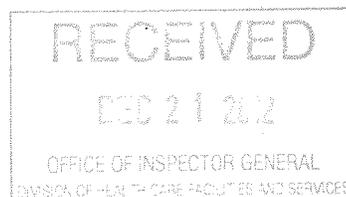
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NAME OF PROVIDER OR SUPPLIER  JEFFERSON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222
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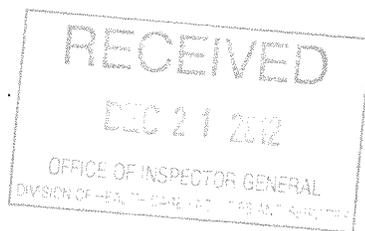
F 282	<p>Continued From page 10</p> <p>the resident had orders to offer additional fluids between and with meals.</p> <p>Observation of Resident #4's room, on 11/14/12 at 2:40 PM, revealed the room had no water carafe, no drinking cup and no straw at the bedside table.</p> <p>Observation of Resident #4's room, on 11/14/12 at 4:30 PM, revealed the room had no water carafe and no straw at the bedside table. There was a small plastic cup filled with ice chips on the bedside table.</p> <p>Observation of Resident #4's room, on 11/15/12 at 8:10 AM, revealed the room had a small plastic cup, half full with room temperature water on the bedside table. There was no carafe observed in the room.</p> <p>Observation of Resident #4's room, on 11/15/12 at 11:10 AM, revealed the room had a small plastic cup, half full with room temperature water on the bedside table. There was no carafe observed in the room.</p> <p>Interview with Licensed Practical Nurse (LPN) #7, on 11/15/12 at 1:30 PM, revealed Resident #4 should have a water pitcher, with a cup, and straw in the resident's room because Resident #4 was not on fluid restrictions. LPN #7 said she was unsure the reason there was not a water pitcher in the residents's room and the staff was supposed to encourage fluids whenever they entered the residents' rooms. LPN #7 said there was not a designated time for water pitchers to be filled. LPN #7 said we are suppose to check all water pitchers whenever they entered a resident's</p>	F 282	<p>Results of these reviews will be reported to the facility QA Committee for review. Unit Managers/Nurse Manager to make rounds daily for 2 weeks then weekly to ensure that all residents have a water pitcher, cup and straws available if not contraindicated. All non-compliance will be addressed at the time it is noted. Non-compliance will be reported to the DON who will report on compliance no less than quarterly to the facility QA Committee.</p>	
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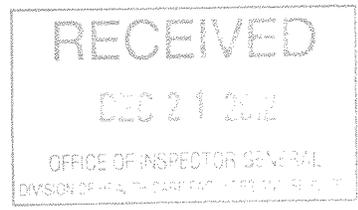
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F 282	<p>Continued From page 11</p> <p>room. LPN #7 confirmed the staff would be much more likely to encourage fluids if there was a water pitcher with a cup and straw in Resident #4's room.</p> <p>Interview with CNA #5 on 11/15/12 at 1:35 PM revealed she was responsible for filling the water pitchers on the 300 Hall on 11/15/12. CNA #5 stated if the resident had a water pitcher in their room, she checked to see if the pitcher needed to be filled whenever she went in the room. CNA #5 stated she was uncertain why some residents on the 300 Hall did not have water pitchers.</p> <p>Interview with CNA #2, on 11/15/12 at 2:00 PM, stated she had taken care of Resident #4 for the past week and there had not been a water carafe in Resident #4's room for the past week during the shifts she had worked. CNA #2 said she assumed Resident #4 was not suppose to have liquids while in bed, because there had not been a water pitcher in Resident #4's room whenever she had started her shifts for the past week. CNA #2 said she read her Resident Assignment Sheet every morning when starting her shift and initialed the RA Sheet at the end of every shift she had worked indicating all task were completed. CNA #2 confirmed the RA Sheet did say she was to encourage fluids between and with meals for Resident #4 and she should have read the RA sheet more carefully and made certain there was a water pitcher in the resident's room.</p> <p>Interview with the Green Unit Manager RN #2, on 11/15/12 at 4:00 PM, confirmed that there was not a designated time set for CNA's to check the water pitchers in the residents' rooms. RN #2 confirmed that all residents that are not on fluid</p>	F 282	



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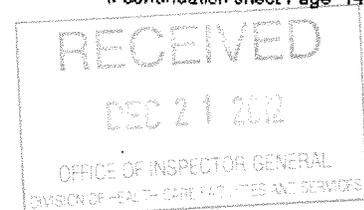
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F 282	Continued From page 12 restrictions should have a water carafe in their rooms and was unsure the reason some residents did not. RN #2 commented that she needed to re-enforce with staff the need to keep water pitchers full and would investigate why some residents did not have water carafes in their rooms. RN #2 confirmed that lack of hydration could cause a resident to become dehydrated or to get a urinary tract infection (UTI). RN #2 confirmed the RA Sheet said to encourage fluids between and with meals for Resident #4.  Interview with the Director Nursing (DON), on 11/15/12 at 4:15 PM, revealed the facility's policy iwa to pass water and ice on every shift and the CNA's are suppose to follow the RA sheet for each resident. The DON stated not having enough water could cause a resident to become dehydrated and possibly develop a UTI.	F 282	
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 observations, interviews, and record review it was determined the facility failed to meet the needs of one (1) of nineteen (19) sampled residents and six (6) unsampled residents.	F 309	On 11/15/12 staff were instructed that Resident #7 is able to use a bedpan, and a bedpan was placed in the room by the Assistant Unit Manager. All rooms were checked and if not contraindicated (residents on fluid restrictions, thickened liquids, NPO, or with swallowing problems) water pitchers, glasses and straws were placed in the room on 11/15/12 by CNA's. The DON met with the therapy department on 11/16/12 to review all residents on therapy caseload to determine if there were any other residents affected by therapy requesting no use of the bedpan.  12/28/12



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F 309	<p>Continued From page 13</p> <p>Resident # 7 had incontinent episodes from not having a requested bedpan. The six (6) residents on the Green Unit were observed to have either no water in the water pitcher or no water pitcher.</p> <p>The findings are:</p> <p>Interview, on 11/14/12 at 2:00 PM, with Resident #7 revealed he/she had requested the facility provide him/her with a bedpan and the facility did not provide the requested bedpan.</p> <p>Observation of the residents living area, on 11/14/12 at 2:20 PM, revealed the resident had an oversized bedside commode next to his/her bed. The resident did not have a bedpan.</p> <p>Interview with Registered Nurse (RN) #4, on 11/15/12 at 10:20 AM, revealed the resident had requested a bedpan because of the two (2) person transfer. The ARNP denied the request because of a Physical Therapy department contract.</p> <p>Interview with the Occupational Therapist (OT), on 11/15/12 at 11:20 AM, revealed the resident had signed a contract with this Physical Therapy (PT) department staff member to not use a bedpan, but to use a bedside commode. The contract was signed on 10/25/12. The PT department did not identify if the resident was on any medication that could cause urinary incontinence. In addition, the resident is a two (2) person transfer and after the signing of the contract th PT department did not follow the resident.</p> <p>Review of the contract revealed the contract</p>	F 309	<p>No other residents were identified. The DON interviewed both Unit Managers on 11/16/12 to ensure that there were no other residents that they were aware of that had any restrictions in place related to bedpan use or brief use. All rooms were checked and if not contraindicated (residents on fluid restrictions, thickened liquids, NPO, or with swallowing problems) water pitchers, glasses and straws were placed in the room on 11/15/12 by the CNA's.</p> <p>The DON and Director of Staff Development will provide education to nursing staff on responding to resident needs, ensuring a residents dignity, answering call lights, following the care plan, use of labels when talking about a resident, use of catheter bag covers, hydration pass and placing water pitchers in resident rooms unless contraindicated as noted on the care plan. This education will be completed by 12/28/12. All newly hired nursing staff will receive this education during orientation by the Director of Staff Development.</p> <p>Unit Managers/Nurse Manager to make rounds daily for 2 weeks then weekly to ensure that all residents have a water pitcher, cup and straws available if not contraindicated. All non-compliance will be addressed at the time it is noted. Non-compliance will be reported to the DON. Findings will be recorded on an audit sheet and brought to the QA Committee no less than quarterly.</p>	



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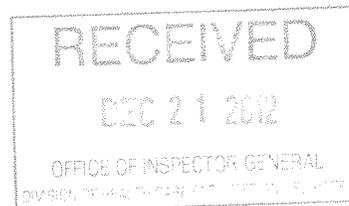
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F 309	<p>Continued From page 14</p> <p>stated the resident was to always use a bedside commode for toileting. Review of the physician orders revealed, the resident was on a routine diuretic, Lasix.</p> <p>Interview, on 11/15/12 at 1:40 PM, with RN #1 revealed she was not aware Resident #7 had contracted with the PT department.</p> <p>Interview with Liscensed Practical Nurse (LPN) #3, on 11/15/12 at 5:30 PM, revealed she had signed the contract.</p> <p>Observation of the three hundred (300) hall, on 11/14/12 at 8:30 AM and 11:00 AM, revealed Room 301 had no water carafe, no drinking cup and no straw at the bedside, Room 306 Bed B had a water carafe but no drinking cup and no straw and the water carafe (without water) was not at the resident's bedside, Room 307 Bed A had a water carafe without water and no drinking cup or straw and Room 310 A had no carafe, no drinking cup and no straw at the resident's bedside. Further observation of those rooms, on 11/14/12 at 11:00 AM, revealed all were the same in regards to water carafes, drinking cups and straws and the rooms with carafes had no ice water in them. Observation of those same rooms, on 11/15/12 at 9:00 AM, revealed all were the same without water carafes, drinking cups, straws or fresh water at the bedside.</p> <p>Observation of Resident #4's room, on 11/14/12 at 2:40 PM, revealed the room had no water carafe, no drinking cup and no straw at the</p>	F 309		

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F 309	Continued From page 15 bedside table.  Observation of Resident #4's room, on 11/14/12 at 4:30 PM, revealed the room had no water carafe and no straw at the bedside table. There was a small plastic cup filled with ice chips on the bedside table.  Observation of Resident #4's room, on 11/15/12 at 8:10 AM, revealed the room had a small plastic cup, half full with room temperature water on the bedside table. No carafe for water was observed in the room.  Observation of Resident #4's room, on 11/15/12 at 11:10 AM, revealed the room had a small plastic cup, half full with room temperature water on the bedside table. No carafe for water was observed in the room.  Interview with Licensed Practical Nurse (LPN) #7, on 11/15/12 at 1:30 PM, revealed the residents should have a water carafe with a cup and straw in the each residents's room, unless the resident is on fluid restrictions. LPN #7 said she was unsure the reason there was not a water pitcher in Resident #4's room and the staff was supposed to encourage fluids whenever they entered Resident #4's room. LPN #7 said there was not a designated time for water pitchers to be filled. LPN #7 said we are suppose to check water pitchers whenever we enter a resident's room. LPN #7 confirmed the staff would be much more likely to encourage fluids if there was a water pitcher with a cup and straw in each resident's room.  Interview with Certified Nursing Assistant (CNA)	F 309		



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F 309	<p>Continued From page 16</p> <p>#5, on 11/15/12 at 1:35 PM, revealed she was responsible for filling the water pitchers on the 300 Hall on 11/15/12. CNA #5 stated if the resident had a water pitcher in their room, she checked to see if the pitcher needed to be filled whenever she went in the room. CNA #5 stated she was uncertain why some residents on the 300 Hall did not have water pitchers.</p> <p>Interview with CNA #2, on 11/15/12 at 2:00 PM, stated she had taken care of Resident #4 for the past week and there had not been a water carafe in Resident #4's room for the past week during the shifts she had worked. CNA #2 said she assumed Resident #4 was not suppose to have liquids while in bed, because there had not been a water pitcher in Resident #4's room whenever she had started her shifts for the past week. CNA #2 stated she checked the water pitchers in the residents' room for ice and water if there was a pitcher in the room.</p> <p>Interview with the Green Unit Manager RN #2, on 11/15/12 at 4:00 PM, confirmed there was not a designated time set for CNA's to check the water pitchers in the residents' rooms. RN #2 confirmed all residents, that are not on fluid restrictions, should have a water carafe in their rooms and was unsure the reason some residents did not. RN #2 confirmed that lack of hydration could cause a resident to become dehydrated or to get a urinary tract infection (UTI). RN #2 confirmed the RA Sheet for Resident #4 said to encourage fluids between and with meals.</p> <p>Interview with the Director Nursing (DON), on 11/15/12 at 4:15 PM, revealed the facility's policy stated the nursing staff was to pass water and ice</p>	F 309			



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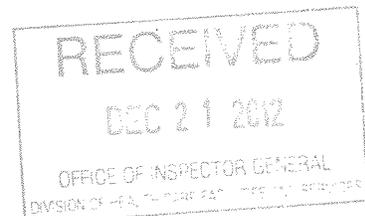
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F 309	Continued From page 17 on every shift. The DON stated not having enough water could cause a resident to become dehydrated and possibly develop a UTI.	F 309		
F 371 SS=D	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's infection control precaution in-service, it was determined the facility failed to prepare and distribute food in a sanitary manner, in the Green Unit Dining room, as it related to staff touching food with gloved hands.  The Findings include:  Review of the facility's Infection Control Precautions, Protect against possible infection at all times, revealed always perform hand hygiene before passing trays and between each tray unless soap and water was required.  Observation of the Green Unit Dining room, on 11/15/12 at 8:34 AM, revealed Certified Nursing Assistant (CNA) #1 touched a banana with gloved hands. Observation of the Green Unit Dining	F 371	CNA#1 was re-educated on 11/15/12 by the Unit Manager on proper hand hygiene between resident contact and when removing gloves. Unit Mangers And DON observed dining service 12/13/12, 12/16/12 and again on 12/17/12 to observe for any other staff not following proper hand hygiene procedures. Any non-compliance was addressed when identified and re-education provided.  DON and Director of Staff Development to re- train and have nursing staff provide return demonstration related to hand hygiene during dining service. This will begin on 12/16/12 and will be completed by 12/28/12  Staff will also complete education on Infection Control and Hand Washing no less than annually with return demonstrations documented. All newly hired nursing staff will receive this education during orientation and will perform a return demonstration to show competency.  DON, Director of Staff Development and Charge Nurse for each unit will observe dining service in the unit dining rooms daily for 2 weeks then no less than 3 times per week for 2 weeks then weekly to ensure compliance.	12/28/12

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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  11/15/2012
NAME OF PROVIDER OR SUPPLIER  JEFFERSON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222	
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F 371	Continued From page 18 room, on 11/15/12 at 8:47 AM, revealed CNA #1 touched another banana and donut with the same gloved hands. CNA #1 was observed touching a resident's napkin and then proceeded to retrieve a new food tray for another resident. CNA #1 was observed to not remove her gloves at this time. Observation of the Green Unit Dining room, on 11/15/12 at 8:50 AM, revealed CNA #1 touching a resident's back and asking them if they needed anything for their meal. CNA #1 then proceeded to cut the residents banana and donut with the same gloved hands. All three observations revealed the use of the same glove.  Interview with CNA #1, on 11/15/12 at 8:59 AM, revealed no one had educated her on touching food with hands and she had always known to wear gloves when passing trays. CNA #1 stated she had never looked at the use of gloves from an infection control stand point. CNA #1 further stated what would be the use of wearing gloves and going person to person, you would still pass germs from person to person.  Interview with CNA #2, on 11/15/12 at 9:05 AM, revealed during orientation staff was taught to wear gloves and remove them after each tray delivery. CNA #2 further stated the Staff Development Coordinator was the one who was responsible to educate staff on infection control.  Interview with the Staff Development Coordinator, on 11/15/12 at 9:09 AM, revealed she educated staff to sanitize hands between each tray delivery. The Staff Development Coordinator stated when in the dining room, staff could serve the trays without gloves, but if they were to handle food, they would need to wear gloves. Once the staff	F 371	Non-compliance will be addressed as it is noted and re-education provided. DON to report on staff compliance no less than quarterly to the facility QA Committee.	



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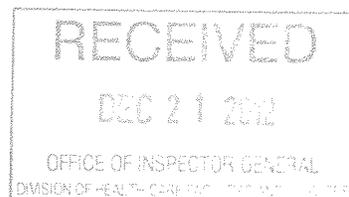
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F 371	Continued From page 19 member handled the food, they were to take their gloves off and wash their hands and start the process over again for the next resident. The Staff Development Coordinator further stated every staff member had been in-serviced on infection control.  Review of the Infection Control in-service, dated 11/07/12 through 11/09/12, revealed CNA #1's name was not on the list for having received the in-service.	F 371		
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F 431 SS=F	Interview with the Director of Nursing (DON), on 11/15/12 at 3:23 PM, revealed CNA's have to make sure they washed their hands and used hand sanitizer between residents. The DON stated it was not their practice to tell staff to wear gloves, only if staff were going to touch food. The DON stated they try to educate the department geared to their tasks and monitor meal pass on the unit. The DON further stated they wash their hands to prevent the spread of infection.  483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431	On 11/15/12 all multi dose containers were checked and if no date was found the container was discarded and reordered from the pharmacy. This was completed by Charge Nurses.  The DON and Director of Staff Development will re-educate all licensed staff and CMT's on the procedure to date and initial all multi-dose containers by 12/28/12.  Unit Mangers have been assigned the task of ensuring there is a monthly audit of all multi dose containers to	12/28/12
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F 431	<p>Continued From page 20</p> <p>appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's record Multi-dose Container Check Off, and the facility's policy for Specific Procedures For All Medications, it was determined the facility failed to ensure all medications were labeled in accordance with currently accepted professional principles. Four (4) of Four (4) medication carts were found to have multi-dose medication containers without the open date.</p> <p>Findings include:</p> <p>1. Review of the facility's policy for Specific Medication Administration Procedures, dated</p>	F 431	<p>ensure they are dated and initialed when opened.</p> <p>The DON to review the monthly audit sheets monthly to ensure the audits are completed as directed. Pharmacy Representative to do an audit quarterly to check for dates and initials on multi dose containers. All audit reviews to be presented to facility QA Committee for review no less than quarterly.</p>



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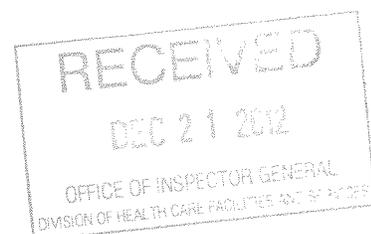
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F 431	<p>Continued From page 21</p> <p>03/01/07, revealed open date should be placed on all multi-dose medication containers, to ensure medications are administered in a safe and effective manner.</p> <p>2. Review of the facility's Multi-dose Container Check Off Sheet start date 07/23/12, revealed if you are working on the day the medications are to be checked, staff must complete all multi-dose containers (insulin vials, multi-dose vials, eye drops, liquid medication, nasal sprays, inhalers, ect.) must be checked to ensure that every container has a date when it was opened along with the nurses initials.</p> <p>Observation, on 11/15/12, at 3:40 PM, of the 100-200 Green Unit medication cart with Licensed Practical Nurse (LPN) #2 revealed open containers: five (5) liquid Miralax; one (1) liquid Lactulose; (1) liquid Robitussin; and (1) liquid Colace with no open date. Continued observation of the medication cart revealed, one (1) open bottle of Megace, with no open date.</p> <p>Observation, on 11/15/12 at 3:50 PM, of the 300-400 Green Unit medication cart with LPN #2 revealed open containers: two (2) liquid Miralax; two (2) liquid Mylanta; and one (1) bottle chewable TUMS.</p> <p>Interview, on 11/15/12 at 3:55 PM, with LPN #2 revealed staff are trained to place an open date and nurse initials on all multi-medication containers. She further stated the facility had a monthly multi-dose container check off tool to ensure every medication container had an open date. She stated she was unsure of who was responsible to ensure the accuracy of the</p>	F 431	

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F 431	<p>Continued From page 22</p> <p>medication check off tool. LPN #2 said without and open date on multi-dose medication containers the nurse had no way to ensure the medication expiration date and the resident may not get the correct potency dosage.</p> <p>Interview, on 11/15/12 at 4:00 PM, with Green Unit Manager Registered Nurse (RN) #2 revealed staff are trained to place the open date on all multi-dose medication containers. She further stated the purpose of placing the open date on the multi-dose medication container was to ensure the medication had not expired. She further stated the monthly multi-dose container check off tool was used to ensure every container had a date when it was opened. She continued to state she did not audit the medication check off tool and was unaware the month of September was omitted. She further stated the current system for multi-dose medications check off tool was not effective.</p> <p>Review of the Multi-dose Container Check Off sheet for the 100-200 and 300-400 medication carts revealed on 09/23/12 no check was preformed.</p> <p>Observation, on 11/15/12 at 4:10 PM, of the 500-600 Blue Unit medication cart with LPN #4 revealed open multi-dose medication containers: one (1) liquid Potassium; one (1) liquid Metoclopramide; one (1) liquid Benadryl; one (1) liquid Multivitamin; one (1) liquid Carafate; one (1) Oral Solution Escitalopram Oxalate; five (5) Miralax; and one (1) liquid Haloperidol.</p> <p>Interview, on 11/15/12 at 4:15PM, with LPN #4 revealed she had been trained to place a label on</p>	F 431		



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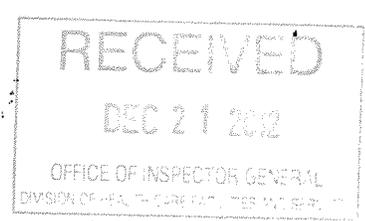
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F 431	<p>Continued From page 23</p> <p>mult-dose medications with the open date. She further stated the purpose was to ensure the medication in the multi-dose container had not expired which could indicate the resident would not get the effective medication dose.</p> <p>Observation, on 11/15/12 at 4:10 PM, of the 700-800 Blue Unit medication cart with Assistant Blue Unit Manager LPN #3 revealed open multi-dose medication containers: seven (7) liquid Miralax; one (1) liquid Robitussin DM; one (1) liquid Acetaminophen; one (1) liquid Haloperidol; one (1) container Gas X tablets; and one (1) container TUMS.</p> <p>Interview, on 11/15/12 at 4:15 PM, with LPN #3 revealed staff are trained to place the open date on all multi-dose containers. She further stated the purpose of placing the open date is to ensure the correct shelf life and expiration of the multi-dose medication. She continued to state without the open date on multi-dose medication the resident could get a non-effective medication dose. The Assistant Blue Unit Manager stated the multi-dose container check off tool was used to check expiration dates of medications. She further stated she was responsible to ensure the monthly multi-dose container check off was followed. She had no explanation as to why the month of October was omitted.</p> <p>Review of the Multi-dose Container Check Off sheet for the 500-600 and 700-800 medication cart revealed, on 10/23/12 no checks were performed.</p> <p>Interview, on 11/16/12 at 2:30 PM, with Director of Nursing (DON) revealed staff are trained to place</p>	F 431		
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F 431	Continued From page 24 the open date on all multi-dose medication containers. She further stated the monthly multi-dose container check off was not a policy but for the purpose of Quality Assurance (QA). She further stated the multi-dose container check off tool had never been audited by her or the QA committee. She stated the purpose of labeling an open date on multi-dose medication was to ensure residents get safe and effective medications.	F 431		
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to utilize resources of administrative staff to ensure the needs of the residents were met during meal time in two (2) of three (3) dining rooms affecting approximately thirty (30) residents who received their meals in the Blue and Green dining rooms.  The findings include:  There was no policy provided by the facility regarding utilization of resources to meet the needs of the residents.  Observation of the main dining room and the	F 490	On 11/16/12 the Administrator, DON, and Director of Social Services met to review procedures related to the dining rooms and to make a plan to ensure each resident has the best dining experience possible. Going forward, all food dishes will be placed on the table and not left on the tray, and fluids will be offered to residents prior to meals being served.  All interviewable residents having their meals served in the Unit Dining Rooms were interviewed on 11/30/12 by the Director of Social Services to solicit their input regarding how the facility could improve their dining experience. It is currently the practice of the facility to put tablecloths on all tables for meals, these are typically white except for special occasions as was observed during the survey. All residents are provided with a napkin but some residents request use of clothing protectors, this will continue to be the practice. Going forward, all food dishes will be placed on the table and not	12/28/12



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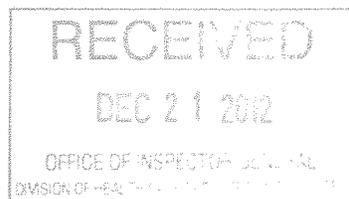
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F 490	<p>Continued From page 25</p> <p>Green and Blue dining rooms on 11/13/12 at 5:30 PM, 11/14/12 at 12:00 Noon, and on 11/15/12 at 8:30 AM, revealed there were an average number of fifteen (15) residents in the the Blue dining room and an average of fourteen (14) residents in the Green dining room over the three (3) mealtimes observed. The Blue and Green dining rooms were located at each of two (2) nursing units. Specifically, the residents in the Blue and Green dining rooms had no drinks or attention given to them during the thirty (30) to forty (40) minute wait for their meal. In addition, the residents in the main dining room had their food dishes placed directly on the tables while the residents in the Blue and Green dining rooms had their food dishes served on trays placed on their tables.</p> <p>Interview with RN #3, on 11/14/12 at 9:00 AM, revealed it was her understanding the residents needing assistance with their meals and monitoring for choking risk were required to eat in either the Blue or Green dining rooms. However, she also stated there were not enough CNA staff at meal time to be in the main dining room prior to meal service as they were busy getting residents ready to go to the dining rooms. She stated she could understand it would be a comfort to the residents to be offered fluids and there was other nursing staff available at mealtime to assist the residents with their meals/fluids. RN #3 stated she was in facility at two (2) mealtimes and also in the facility were the DON, another unit manager and a Minimum Data Set (MDS) nurse and all of them could assist at mealtime but usually did not.</p> <p>Interview with the Dietary Director, on 11/14/12 at</p>	F 490	<p>left on the tray, and fluids will be offered to residents prior to meals being served. Residents requiring individualized dining interventions will have a care plan to address these needs. Nursing will be instructed in the facility practice by the DON or the Director of Staff Development by 12/28/12.</p> <p>DON, Staff Development Coordinator, and Administrative Nursing Staff will observe dining service in the unit dining rooms daily for 2 weeks then no less than 3 times per week for 2 weeks then weekly for a month to ensure compliance with the facility practice. Non-compliance will be addressed as it is noted. Findings will be recorded on a audit sheet and brought to the QA Committee no less than quarterly.</p>	
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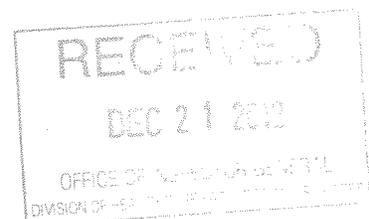
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F 490	<p>Continued From page 26</p> <p>2:30 PM, revealed she confirmed with the DON just a couple of months ago the rule for residents who could eat in the main dining room was the residents eating there had to be dressed in street clothes and had to be able to eat without assistance. She stated the residents in the main dining room had their fluids served prior to their meals because they did not present as a choking risk and the facility wanted them to have a restaurant style dining experience. She further stated the CNA's could take the dishes off of the trays for the residents in the Blue and Green dining rooms and she did not know why they didn't do so.</p> <p>Interview with the Director of Nursing (DON), on 11/14/12 at 2:45 PM, revealed any resident could eat in the main dining room if he/she was dressed in street clothes and could feed his or herself. She stated there was no policy or anything in the admission packet to signify this, but it was a facility rule. The DON explained the reason for this practice was the residents who needed assistance with their meals needed to be on the nursing units for the staff to assist with their meals. She further stated the facility used it's Certified Nursing Assistants (CNA's) to assist residents with their meals and there was no reason the CNA's could not walk to the main dining room except it was convenient for the CNA's to stay on the units as they were busy with other tasks. She stated the residents in the Blue and Green dining rooms could not have fluids prior to their meals because some of them were on thickened liquids and would have to be monitored by nursing for possible choking.</p> <p>Interview with the Green Unit Manager</p>	F 490		
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F 490	<p>Continued From page 27</p> <p>Registered Nurse (RN #2), on 11/15/12 at 8:35 AM, revealed she thought fluids should be offered to the residents in the nursing unit dining rooms while they were waiting for their meals to serve three purposes: 1) encourage fluid intake, 2) build activities of daily living skills, and 3) be involved in a more homelike dining experience. She stated she thought the reason the residents in the Green Unit dining room did not get fluids prior to their meals was because there was not enough staff to help the residents prior to the meal delivery. However, she did state any nursing personnel could assist with meals and monitor residents for choking.</p> <p>Interview with the Administrator, on 11/15/12 at 3:50 PM, revealed the facility had nothing in writing regarding which residents could go to the main dining room to eat. However, some residents could not eat in the main dining room due to their needs of meal assistance and choking risk. He also stated those residents needing assistance with their meals could not go to the main dining room due to staff needing to stay on the nursing units to do their work.</p>	F 490	



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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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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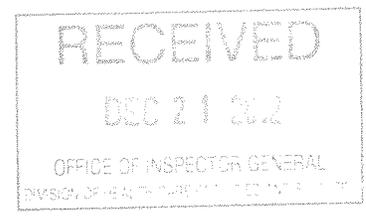
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NAME OF PROVIDER OR SUPPLIER  <b>JEFFERSON MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 LYNN WAY LOUISVILLE, KY 40222</b>
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K 000	Continued From page 1	K 000		
K 025 SS=F	<p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></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"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <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"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration</p>	K 025		

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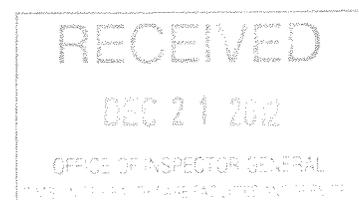
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K 025	Continued From page 3 into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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



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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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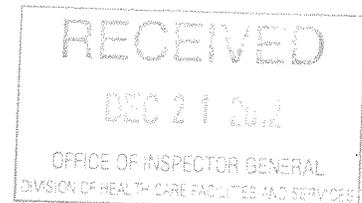
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K 029	Continued From page 5 and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 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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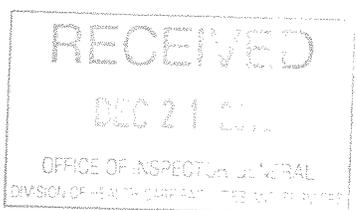
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K 045	<p>Continued From page 6</p> <p>equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, patients, staff and visitors. The facility is certified for one hundred (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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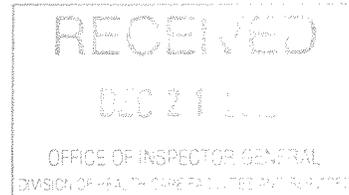
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K 045	<p>Continued From page 7</p> <p>of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way.</p> <p>7.8.1.2 Illumination of means of egress 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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K 045	Continued From page 8	K 045		
K 050 SS=F	<p>ft-candle (2 lux) in any designated area.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></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>	K 050	<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>	12/28/12

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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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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"> <li>1) Three (3) atrium type ceilings located in the Main Lobby, and above each Nurse's Station.</li> <li>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.</li> <li>3) A porch roof extending out greater than forty eight (48) inches located outside the Kitchen Hall exit.</li> <li>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.</li> </ol> <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	<p>Continued From page 11 not aware the building did not have complete sprinkler coverage.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>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.</p> <p>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.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <p>(1) Sprinklers installed throughout the premises (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.</p> <p>Reference: NFPA 13 (1999 edition)</p> <p>5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p>	K 056	<p>receipt. Installation time is about 1 week. Allowing for any setbacks completions should be no later than 2/15/13.</p> <p>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.</p> <p>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.</p>	
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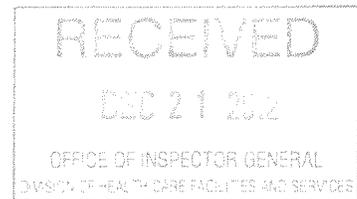
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/14/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>JEFFERSON MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 LYNN WAY LOUISVILLE, KY 40222</b>
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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;">Distance from Sprinklers to above Bottom of Side of Obstruction (A)</td> <td style="text-align: right;">Maximum Allowable Distance of Deflector Obstruction (in.)</td> </tr> <tr> <td style="text-align: right;">(B)</td> <td></td> </tr> <tr> <td>Less than 1 ft</td> <td style="text-align: right;">0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td style="text-align: right;">21/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td style="text-align: right;">31/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td style="text-align: right;">51/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td style="text-align: right;">71/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td style="text-align: right;">91/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td style="text-align: right;">12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td style="text-align: right;">14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td style="text-align: right;">161/2</td> </tr> <tr> <td>5 ft and greater</td> <td style="text-align: right;">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>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector 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		
Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector Obstruction (in.)																											
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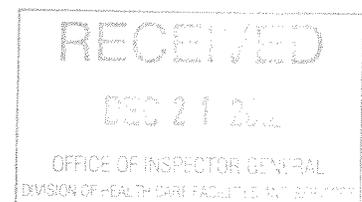
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185169	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  11/14/2012
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K 056	Continued From page 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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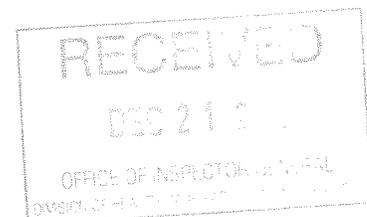
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K 064	Continued From page 14 located in the smoking area.  Reference: NFPA 10 1999  4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction 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	<p>Continued From page 15 or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect 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 the facility failed to provide a metal container with a self-closing lid to dump the ashtrays, located in the designated smoking area.</p> <p>Interview, on 11/14/12 at 1:07 PM, with the</p>	K 066	<p>proper equipment is in place. The audits will be recorded in the TELS System by the Director of Maintenance.</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 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.</p> <p>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>	



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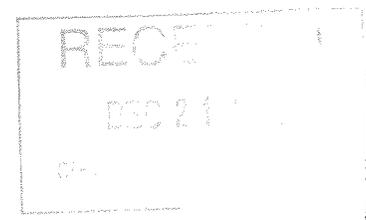
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K 066	Continued From page 16 Maintenance Director revealed they were not aware of the requirement for metal containers with a self-closing lid for dumping ashtrays.  Reference: NFPA Standard 101 (2000 Edition).  19.7.4 Smoking (4) Metal containers 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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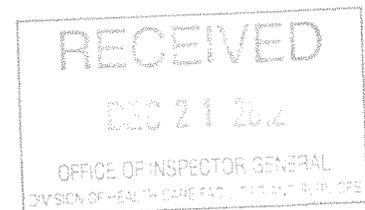
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K 069	<p>Continued From page 17</p> <p>Reference NFPA 101 (2000 Edition)</p> <p><b>19.3.2.6 Cooking Facilities.</b> Cooking facilities shall be protected in accordance with 9.2.3. Exception*: Where domestic cooking equipment is used for food-warming or limited cooking, protection or segregation of food preparation facilities shall not be required.</p> <p><b>9.2.3 Commercial Cooking Equipment.</b> 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><b>11.4 Cleaning of Exhaust Systems.</b> 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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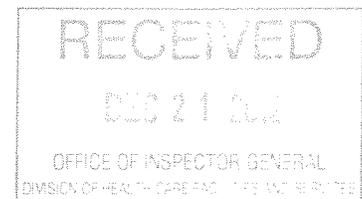
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185169	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  11/14/2012
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NAME OF PROVIDER OR SUPPLIER  JEFFERSON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222
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K 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><b>11.3 Inspection of Exhaust Systems.</b> 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><b>Table 11.3 Exhaust System Inspection Schedule</b> 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><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></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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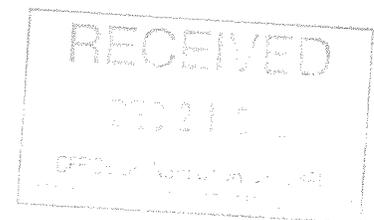
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K 072	Continued From page 21 maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced 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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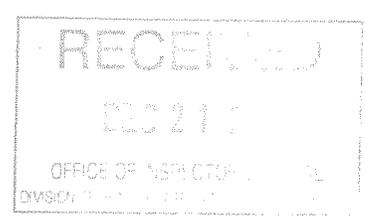
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K 130	Continued From page 22 Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, 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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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"> <li>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.</li> <li>2) Three (3) power strips plugged together located in the Green Nurses Office.</li> <li>3) A power strip plugged into another power strip located at the Blue Nurses Station.</li> <li>4) A refrigerator was plugged into a power strip located in the Blue Med Room.</li> <li>5) Lift battery chargers were plugged into a power strip located in the Blue Med Room.</li> </ol> <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"> <li>(1) As a substitute for the fixed wiring of a structure</li> <li>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</li> <li>(3) Where run through doorways, windows, or similar openings</li> <li>(4) Where attached to building surfaces</li> </ul> <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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