

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

JUL 02 2010

PRINTED: 06/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2010
NAME OF PROVIDER OR SUPPLIER GEORGETOWN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 900 GAGEL AVENUE LOUISVILLE, KY 40216	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. The plan of correction constitutes our credible allegation of compliance.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. The microwave in the restorative room was in need of cleaning and had what appeared to be rust around the edges. Wheelchairs armrests were cracked and torn. Bathrooms had missing tiles and a soiled shower curtain and wheelchairs, bedside commodes, geri chairs and walkers were stored in a shower stall. The linen room had a sprinkler head covered with debris. Residents' room doors were unable to stay open and walls and ceiling were found to be in disrepair with holes, cracks and water stains. The shower room had missing tile, missing caulking around the sink base and a black/grey substance was around the commode base. In addition, a brown substance was noted midway on a resident's bathroom door frame. A spider web was in the corner of a resident room.	F 253	F-253 I. The microwave in the restorative room was removed. The armrests on the wheelchair in Room 158 have been replaced. The shower curtain in the central bathroom is clean. The tiles in the shower room and Room 184 have been replaced where needed. Bedside commodes, geri-chair, walkers and wheelchairs are not being stored in the shower room. The linen room and sprinkler head have been cleaned. New hinges were ordered for the doors for 12 resident rooms and are to be delivered and installed when received. The walls in Room 165 have been repaired and painted and room has been dusted. The ceiling in Room 141 has been repaired. Room 183, the area around the pipe is sealed and flange replaced, the wood boards were removed and area painted where needed. Room 158, the sink has new caulking and ceiling has been repaired. II. Environmental rounds have been completed in resident rooms, shower rooms and linen closets and have been inspected for cleanliness and repairs completed where needed. III. Education was provided for the Maintenance staff on preventive maintenance rounds and repairs. Education was provided to the Housekeeping staff on cleaning schedules and procedures.	

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

Raymond Bell

TITLE

Administrator

(X6) DATE

7/2/2010

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

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F 253	Continued From page 1 The findings include: Observations during the environmental tour on 06/10/10 at 1:15pm revealed a resident in room 158 had a wheelchair with a torn and cracked arm rest. A microwave in the restorative dining room was dirty with dried food particles and the outer edge was rusty. The Central bath room floor tiles were missing around the drain, the shower curtain was soiled with a brown substance. Two (2) bedside commodes, one (1) walker, three (3) geri chairs and one (1) wheelchair were all stored in the central bathroom in the resident's shower stall. The linen closet located near the central bath was found to have a box of chuxs stored directly on the floor, two used gloves and paper trash on the floor as well. The North linen room sprinkler head was entwined with shreds of material and trash was on the floor. Twelve (12) resident room doors would not stay open without an object to hold them open i.e.: (trash can or door stopper). Room 165 had approximately a three foot crack noted from the top of the ceiling to the window and a two foot crack on the lower end of the window to the floor on an outside wall. The paint was peeling away from the crack. Room 165 also had a spider web in the left top corner of the room. A hole approximately three inches in diameter was noted in the ceiling in room 141 and in room 183 there was an opening around a pipe with the metal flange missing. In addition, two (2) wooden sticks were nailed to the ceiling and water stains were noted around the sprinkler head. In Room 184 there were five (5) tiles chipped and broken on the floor directly under the window. In Room 158 repairs completed to the ceiling directly over a resident bed was sagging with a rough surface and the caulking around the sink was missing.	F 253	IV. The Administrator, Maintenance Director, Housekeeping Supervisor and/or Designee will complete random environmental rounds weekly for 4 weeks, monthly for 2 months, then quarterly for 2 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed. V. Completion Date	6/28/2010	

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F 253	Continued From page 2 An interview conducted on 06/10/10 at 1:15pm with the Housekeeping Supervisor and Maintenance Director revealed the central bathroom shower curtain was dirty and are checked once a week. The wheelchair, bedside commodes, geri chairs had been stored there for a long time and the shower room was not designated as a storage area. The Housekeeping Supervisor revealed that shower curtains were cleaned once a week and the Supervisor was unaware of the dirty shower curtain or that the bathroom was not to be used for storage. The Maintenance Director, revealed he was unaware of the missing tiles, however, explained the facility had plans to remodel soon. The Housekeeping Supervisor revealed that nothing should be placed on the floor of the linen room and that the linen rooms are checked daily. The Housekeeping Supervisor related that the sprinkler head in the linen room had not been cleaned and that linens where piled too high. The Housekeeping Supervisor was unsure how the box and dirty gloves and trash were over looked. The Maintenance Director revealed that twelve (12) resident doors would need adjustment to keep them open. The Maintenance Director revealed that the crack on the outer wall in room 165 was due to an oversight and was not sure when it occurred. He related the repairs would need to be evaluated and discussed with administration. In addition, the Housekeeping Supervisor revealed that the spider web in room 165 would be removed today and the brown substance be cleaned from the door frame of bathroom. The Maintenance Director revealed the bathroom commode needed the wax ring replaced in Room 159 as the toilet was leaking and repairs to the caulking around the sink base	F 253			

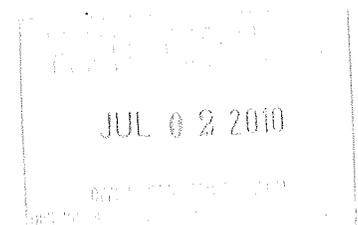
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F 253	Continued From page 3 and ceiling repairs would need to be completed. He stated that although the repair of the wheelchair arms was the physical therapy department's responsibility, they would be fixed today. Review of the facility's housekeeping job description, provided by the facility as their policy revealed housekeeping staff were to maintain cleanliness of curtains, privacy curtains and dispose of trash and clean all equipment and windows. Further review revealed one room daily would be deep cleaned. Review of the facility's preventive maintenance revealed monthly inspections of faucets, paint, furniture and lights. Monthly door checks were also required, including all room doors and a monthly 10% audit of equipment inspections.	F 253			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined the facility failed to follow physician orders for one (1) resident (#15) of the twenty-three (23) sampled residents. Resident #23's medication Lopressor was withheld and did not receive Lopressor as	F 309	F-309 I. Resident #15's physician orders have been reviewed and is receiving medications as ordered by the physician. II. Residents' physician orders have been reviewed and are receiving medications as ordered by the physician. III. Licensed nurses have been re-educated on following physician orders and on pharmacy re-order procedures. IV. The Director of Nursing, Staff Development Coordinator and/or Designee will complete random audits of physician orders, medication administration records with medication passes weekly for 4 weeks, monthly for 2 months, then quarterly for 2 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed. V. Completion Date	6/28/2010	



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F 309	<p>Continued From page 4 ordered by the physician.</p> <p>The findings include:</p> <p>Observations of the medication pass on 06/09/10 at 8:30am revealed Resident #15's Lopressor was withheld and Namenda was not available on the cart.</p> <p>Review of the physician orders for Resident #15 revealed Namenda 10 mg was to be given twice a day at 8:00am and 8:00pm for Alzheimer's Disease. In addition, the resident was to receive Lopressor 12.5 mg (1/2 tab) twice daily for Hypertension. The medication was to be held for a systolic blood pressure below 100 and a heart rate below 55. In addition, review of the medication administration record (MAR) revealed the evening dose of Namenda had been initialed as given.</p> <p>Interview with the nursing staff responsible for the medication pass on 06/09/10 at 8:30am revealed the Namenda was not available on the cart. In addition, the nursing staff was not sure why the medication was not available and stated that the pharmacy would have to be contacted.</p> <p>Interview with the North Unit Manager (UM) on 06/10/10 at 8:35am revealed she would have to check to see if the medication had been received from pharmacy and reported the medication would be sent today. The facility was unable to produce evidence the medication had been reordered prior to 06/10/10 or that the physician had been notified of the missed dose of medication. The UM could not explain how the medication was given on the evening shift if the medication was not available.</p>	F 309			

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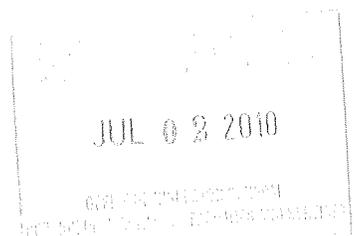
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F 309	Continued From page 5 Interview with the North Unit Registered Nurse (RN#2) on 06/10/10 at 8:20am revealed the Namenda for Resident #15 was not in the drawer for the morning medication pass. RN#2 related that the medication cart was searched and the Namenda was not available and that the pharmacy would have to be notified. Interview with the North Unit Registered Nurse (RN#1) on 06/10/10 at 2:20pm revealed the Lopressor for Resident #15 was held because the systolic blood pressure was 100 and did not realize the orders were to hold the medication if the blood pressure was less than 100. The Lopressor should have been given as the blood pressure was 100/56 and the pulse was 55. In addition, the nurse reported the Namenda was not received before leaving the shift and the nurse did not follow up with the pharmacy when the medication did not come in before leaving.	F 309			
F 371 SS=E	483.35(i) 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, record review and interview it was determined the facility failed to	F 371	F-371 I. The refrigerators on the North Unit and South Unit have been cleaned. Resident specific food items are labeled and dated when opened. II. Refrigerators have been checked and cleaned where needed. Specific food items are labeled and dated when opened. III. Re-education has been provided for nursing and dietary staff on sanitation requirements for cleaning the refrigerators, labeling and dating food items where appropriate. IV. The Director of Nursing, Dietary Supervisor and/or Designee will complete random sanitation audits of the refrigerators weekly for 4 weeks, then monthly for 3 months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed. V. Completion Date	6/28/2010	

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F 371	<p>Continued From page 6</p> <p>ensure the resident's food refrigerators, in the medication rooms, on the North and South Units were clean and free of expired foods and that opened foods were dated. The findings include:</p> <p>Observations of the resident's refrigerator on the North Unit, on 06/09/10 at 9:40am, revealed one can of Red Bull and two Mountain Dew bottles in a bag with no name or identifying information. In addition, a bottle of Thousand Island Dressing and a bottle of Mustard that had been opened were not dated. The freezer section of the refrigerator contained an opened red popsicle with no date or name and a one quart container of cottage cheese with a resident's name and an expiration date of 05/30/10 with no date when opened. The bottom drawer of the refrigerator was saturated with a dried red substance covering half of the drawer.</p> <p>Observation of the South Unit refrigerator used for residents' food items, on 06/09/10 at 10:15am revealed two containers of milk that were opened with no date or name.</p> <p>Interview with the North Unit Manager on 06/09/10 at 9:40am revealed the contents of the bag containing the Red Bull and Mountain Dew drinks belonged to staff.</p> <p>Interview with the South Unit Manager on 06/09/10 at 10:15am revealed the unit managers were responsible for the refrigerators however, the Dietary Department was responsible for cleaning and removing the expired foods from the refrigerators. The Unit Manager related that the containers of milk should not have been placed back into the refrigerator once they were opened.</p>	F 371			



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F 371	Continued From page 7 Interview with the Dietary Manager on 06/10/10 at 10:24am revealed the Dietary Department cleans the refrigerators on the nursing units weekly and defrosts the refrigerators monthly. The milk is not to be opened and left in the refrigerator without a date and labels. The Manager related that dietary staff receive random assignments for cleaning the refrigerators however, there is not system in place to ensure the cleaning assignments are done. Interview with the Director of Nursing on 06/10/10 at 11:50am revealed it is her responsibility to ensure all expired items are removed from use and she depends on the unit managers to share in that responsibility. However, she related that there was no system in place to monitor for compliance. Review of the facility's policy and procedure for proper use and sanitation of Nursing Station Refrigerators revealed: 1) All items stored in the Nursing refrigeration is for Resident use only. 2) Nursing Station refrigerators will be cleaned daily on as needed basis and thoroughly emptied and washed down minimum of weekly. 3) Dietary Manager will assign designated personnel for weekly cleaning.	F 371			
F 431 SS=D	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.	F 431	F-431 I. Temperature logs for the medication refrigerators have been reviewed for accuracy and are being completed. Facility procedures have been updated to reflect the pharmacy recommendations for medications temperature range of 35-46 degrees F.		

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F 431	Continued From page 8 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined the facility failed to ensure the South Unit medication refrigerator was monitored consistently and assessed by maintenance to determine if functioning properly, when temperatures were documented above 41 degrees. The findings include: Observation of the medication refrigerator on the	F 431	II. Refrigerator temperature logs have been reviewed and meet current recommendations. III. Education has been provided to the licensed professionals of requirement for medication refrigerator temperatures and to notify Maintenance when needed for temperatures not in acceptable ranges. IV. The Director of Nursing, Staff Development Coordinator and/or Designee will complete random audits of the medication refrigerator temperatures weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed. V. Completion Date	6/28/2010

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F 431	<p>Continued From page 9</p> <p>South Unit, on 06/09/10 at 10:07am, revealed temperature logs posted on the front of the refrigerator. The medication refrigerator also contained temperature sensitive medications including insulin.</p> <p>Record review of the temperature logs for the month of March 2010 indicated the acceptable temperature range was 35 - 46 degrees which was in conflict with the facility's policy and procedure that required temperatures not to exceed 41 degrees. Review of the April 2010 log revealed April 2, 2010 was blank where no temperature had been documented and June 2010 revealed no temperatures had been documented for 06/02, 06/03, 06/04, 06/05 and 06/06. In addition, the temperature logs indicated the refrigerator was consistently above 41 degrees for 31 days in March, 29 days in April, 31 days in May and 4 days in June.</p> <p>Interview with the Unit Manager on 06/09/10 at 10:15am revealed the night shift staff are to check the refrigerator temperatures and document them on the log sheets. In addition, they are to report out of ranges to maintenance. The temperatures could not be verified as maintained in the acceptable parameters since they were not documented.</p> <p>Interview with the Maintenance Director on 06/10/10 at 4:25pm revealed there is a maintenance log on each unit to identify any concerns that require his attention. The nursing staff have not reported any concerns with the temperatures or the function of the medication refrigerator.</p> <p>Review of the facility's policy and procedure for</p>	F 431		

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F 431	Continued From page 10 proper use and sanitation of Nursing Station Refrigeration revealed: 1) temperatures will be recorded daily by designated Dietary or Nursing Personnel; 2) Temperatures that exceed 41 degrees will require Maintenance Personnel to attend refrigeration for continued use.	F 431			
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure laboratory supplies were not expired. Observations revealed five (5) lab specimen collection tubes and four (4) blood culture tubes had expired as late as 07/2006. The findings include: Observation of the North Unit medication room on 06/09/10 at 9:40am revealed three (3) yellow top Vacutainer Lot #9104007 with an expiration date of 04/2010, one (1) yellow top Vacutainer Lot #8109829 with an expiration date of 04/2009 and one (1) purple top Vacutainer Lot #5067221 with an expiration date of 07/2006. In addition, observation of the South Unit medication room on 06/09/10 at 10:15am revealed two (2) bottles of Bact/Alert SN Anaerobic blood cultures Lot #1022963 had expired on 03/31/10 and two (2) bottles of Bact/Alert FA Aerobic blood cultures Lot #1022908 with an expiration date of 03/31/10. Interview with the South Unit Manager on	F 502	F-502 I. Laboratory supplies have been checked and have current expiration dates. II. The lab company has been contacted and service/supplies are available to meet resident needs. III. Re-education has been provided to nursing supervisors on monitoring laboratory supplies for expiration dates. IV. The Director of Nursing, Staff Development Coordinator and/or Designee will complete random audits of the laboratory supplies monthly for 3 months, then quarterly for 3 quarters. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed. V. Completion Date	6/28/2010	

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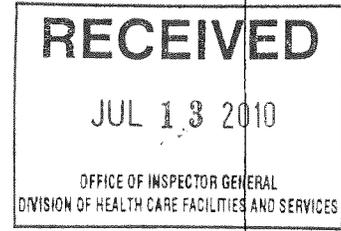
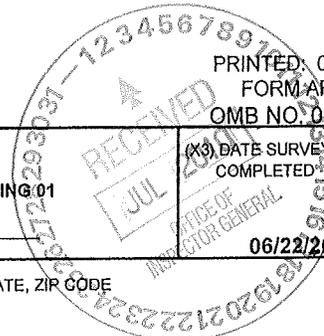
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2010
NAME OF PROVIDER OR SUPPLIER GEORGETOWN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 900 GAGEL AVENUE LOUISVILLE, KY 40216		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 502	<p>Continued From page 11</p> <p>06/09/10 at 10:15am revealed she was responsible to ensure all expired supplies are removed from the supply room. However, there is no system in place to ensure supplies are checked and removed when necessary.</p> <p>Interview with the Director of Nursing on 06/10/10 at 11:50am revealed she was ultimately responsible to ensure all items that had expired are removed from available use by staff. However, she had no system in place to ensure this was accomplished.</p> <p>The facility could not produce any policy and procedure on checking and removing expired stock from use.</p>	F 502			

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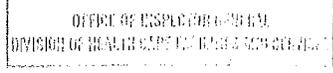
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2010
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 06/22/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency identified at a F.	K 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. The plan of correction constitutes our credible allegation of compliance.	
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 conducted on 06/22/10, it was determined the facility failed to ensure that electrical wiring and standards met NFPA requirements. The findings include: Observation during the Life Safety Code tour conducted on 06/22/10 at 10:00 AM, with the Maintenance Director, revealed the facility had an annunciator alarm for the emergency generator; however, the alarm was located in the laundry room and could not be readily heard by staff on all shifts.	K 144	K-144 I. The annunciator alarm for the emergency generator has been relocated to the north nurses' station on 7/7/2010. II. The annunciator alarm will visually and audibly notify staff. III. The annunciator alarm is located in an area that is audible and visual by staff. IV. The Maintenance Director will monitor the annunciator alarm system monthly for 2 quarters. Results will be reviewed at the Quality Assurance meeting for revisions as needed. V. Completion Date	7/7/2010



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Raymond Bell TITLE: Administrator (X6) DATE: 7/2/2010

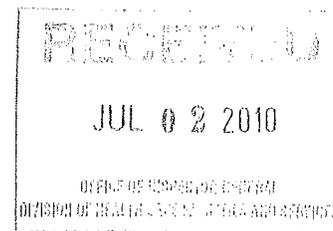
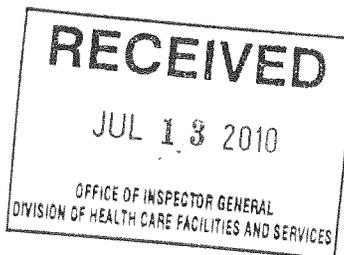
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 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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NAME OF PROVIDER OR SUPPLIER GEORGETOWN MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 900 GAGEL AVENUE LOUISVILLE, KY 40216		
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K 144	<p>Continued From page 1</p> <p>An interview with the Maintenance Director revealed the annunciator alarm will be moved next to the alarm panel at the nurse's station where it can be heard at all times by staff.</p> <p>Reference to:</p> <p>NFPA 99, 1999 Edition</p> <p>3-4.1.1.15 Alarm Annunciator. A remote annunciator, storage battery-powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12). The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follow:</p> <p>(a) Individual visual signals shall indicate the following:</p> <ol style="list-style-type: none"> 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel- when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This</p>	K 144		



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K 144	<p>Continued From page 2</p> <p>derangement</p> <p>signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. {110:3-5.5.2}</p> <p>Reference: NFPA 110 1999 edition</p> <p>5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.</p> <p>Reference: NFPA 101 2000 edition</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment.</p> <p>A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.</p> <p>Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.</p>	K 144		

