

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

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2010
NAME OF PROVIDER OR SUPPLIER JAMES S TAYLOR MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 W MAGAZINE STREET LOUISVILLE, KY 40203	
(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 Amended CMS 2567L issued to facility on 08/30/10. A Nursing Home Initiative standard health survey was conducted 08/10/10 beginning at 7:00 AM through 08/12/10. Deficiencies were cited with the highest scope and severity of an "E". A Life Safety Code survey was conducted on 08/12/10. An abbreviated survey investigating KY00015146 was initiated on 08/10/10 and concluded on 08/12/10. The incident was found to be Substantiated, with no regulatory violations cited.	F 000	The grievance for Residents #9, #18, #19, and #20 related to call lights not being answered, cell phones being used by employees (talking and texting), not being notified in advance of appointments, and not being assisted out of bed in time to go on a smoke break have been addressed.	
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to notify residents of the status of their grievances and the progress the facility had made in resolving those grievances for four (4) of eight (8) residents attending the group interview (Residents #9, #18, #19, and #20). Residents with lost property, food complaints, and long waits for staff assistance were not notified of how the facility resolved their grievances. The findings include: Review of the facility policy for Grievances,	F 166	All residents have the potential to be affected. Resident #9 was interviewed on 8/31/10 by the Social Worker and voiced no complaints. Resident #18 was interviewed on 8/31/10 by the Social Worker and voiced no complaints. Resident #19- A search was conducted by the facility upon receiving the grievance of the missing DVD the facility was unable to locate the missing DVD. Resident #19 requested that he be given \$20.00 for the missing DVD. \$20.00 was placed in resident #19's account by the facility. Resident #20 is now discharged from the facility. Resident was discharged from the facility on 8/24/10.	09/11/10

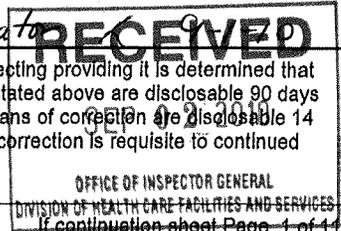
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Stephanie L. Mathis

Administrator

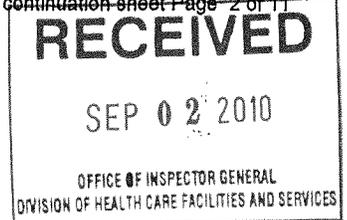


Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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 166	<p>Continued From page 1</p> <p>undated, revealed the facility would address grievances timely.</p> <p>Review of the facility Resident Council Minutes dated 07/15/10 revealed residents complained of call lights not being answered in a timely manner. The minutes indicated staff would come to the room and turn the call light off and tell residents they would be back to assist them; however, the staff would not return.</p> <p>Interviews with Residents #9, #18, #19, and #20 on 08/10/10 at 2:30pm, revealed the residents had waited as long as forty-five minutes to have staff address their needs after they rang the call light. They stated the staff would also come to the room and turn the call light off and promise to return but would not return. They stated this issue was discussed at the last resident council meeting and they had received no response from anyone. In addition, they stated on occasions, meal service was late getting started, due to nurse aides talking and texting on cell phones, allowing food trays to sit while residents waited for their food. The residents indicated that appointments outside the facility were scheduled and residents were not notified of the appointment until the ambulance came to pick them up. In addition, residents were not assisted to get out of bed in time to go on a smoke break. They stated these issues were reported to management staff at the facility; however, the problems continued and the residents were not informed as to what the facility was doing to resolve the issues.</p> <p>Interview with Resident #19 at 2:30pm on 08/10/10 revealed the resident had reported the loss of some DVDs; however, the resident was</p>	F 166	<p>The Interim Director of Nursing conducted in-services with staff on 4/11/10, 5/20/10, 6/14/10, 6/30/10, 8/17/10 and 8/18/10 regarding answering call lights in a timely manner and not using cell phones. All employees are given a copy of the cell phone policy upon hire which states cell phones are not allowed in resident areas.</p> <p>A new procedure has been implemented to verify residents are notified in advance of appointments. This was implemented on 9/1/10. The Ward Clerk will give residents an appointment card at least one day in advance when possible. A copy of this will be placed in the medical record in the Social Services section. The Ward Clerk was in-serviced on this 8/31/10 by the Social Worker. This will be monitored by the Social Worker Monday-Friday for 2 weeks beginning 9/1/10, then 3 times a week for 2 weeks, and then once per week. This results of this audit will be brought to the QA Committee at the weekly QA meeting.</p> <p>An in-service was held with staff on 8/12/10 by the Nursing Supervisor on assisting residents out of bed in time for them to go on a smoke break. The time of the resident smoke breaks is posted at the Nurses' Station.</p>	



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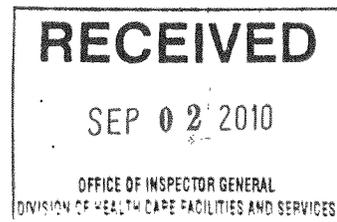
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F 166	<p>Continued From page 2 not aware of what the facility did to recover these items.</p> <p>Review of the facility Grievance Log revealed there were no entries since 06/08/10. There was no evidence presented by the facility to show the complaints regarding late meal service, nurse aides talking on cell phones while working, or call lights not being answered timely had been addressed or resolved. There was no evidence provided by the facility to show what action was taken to locate the missing DVDs.</p> <p>Interview with the Activity Director on 08/11/10 at 8:45am, revealed she was currently responsible for managing the resident council and typing the minutes. She stated she wrote out the complaints received during the July 2010 resident council meeting and delivered the complaints to the department heads. She stated she was not given any information after that; however, the department managers were to address the complaints and talk to the residents. She stated she would give residents information at the next council meeting if she heard anything. She revealed the Social Services Coordinator was currently out ill and she was trying to help do her job.</p> <p>Interview with the Director of Nursing on 08/12/10 at 5:00pm, revealed she had provided the nurse aides with in-services regarding answering call lights and the nurse supervisor was to monitor and ensure call lights were answered. She stated she was not aware of any recent problems with call lights. She stated there were adequate staff to meet the residents' needs.</p> <p>Interview with the Administrator on 08/12/10 at</p>	F 166	<p>A mandatory in-service will be conducted, by the Interim Director of Nursing, Social Worker and or Administrator by 9/3/10 on answering call lights, cell phones not being used in resident areas, and assisting residents out of bed in time to go on a smoke break. Any staff that has not attended this in-service will not be allowed to work after 9/7/10 until doing so.</p> <p>The Interim Director of Nursing and Social Worker conducted an in-service on 8/23/10 on the grievance process. The grievances are brought to the morning meeting Monday-Friday by the Social Worker and discussed. The Social Worker checks the grievance book located at the Nurses Station Monday-Friday and is responsible for resolving the grievances and reporting back to the resident in a timely manner.</p> <p>100% of residents were interviewed by 8/30/10 by the Social Worker to see if they had any grievances. All grievances were addressed by the Social Worker on 8/30/10 and the Social Worker reported back to the resident the resolution of the grievance. These results were discussed at the monthly QA meeting by the QA committee on 9/1/10.</p>	
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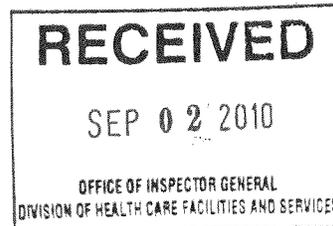
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F 166	Continued From page 3 4:50pm, revealed complaints were responded to as soon as possible; however, she was unable to provide any information regarding grievances as the log stopped on 06/08/10.	F 166	The Social Worker will continue to interview 5 residents per week to see if they have any grievances. This will be ongoing and the results of these interviews will be discussed with the QA Committee at the weekly QA meeting.	
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to make the survey results available for examination in a place readily accessible to residents and failed to post a notice of their availability. The findings include: Observations of the survey book upon entrance and exit from the facility on 08/10/10 at 12:45pm and 1:45pm, on 08/11/10 at 7:40am and at 5:50pm, and on 08/12/10 at 7:40am and at 2:00pm revealed the survey book was located in the front lobby. The residents remained behind locked doors, which required a keypad code or the assistance of a staff member to enter the lobby.	F 167	The social worker will report the grievances including the tracking and trending of these grievances to the QA committee at the weekly and monthly meeting beginning 9/1/10. A resident council meeting will be held by 9/10/10 in addition to the monthly meeting to inform residents of the progress of the call lights not be answered in a timely manner. The Interim Director of Nursing will attend this resident council meeting and explain the process and answer any questions the residents may have. No specific residents were cited. All residents have the potential to be affected. The Administrator placed the survey binder in the activity room that is accessible to all residents on 8/12/10. A notice was posted of the survey results availability in the activity room on 8/12/10 by the Administrator. The Administrator conducted an in-service for the Activity Director regarding requirements for the	09/11/10



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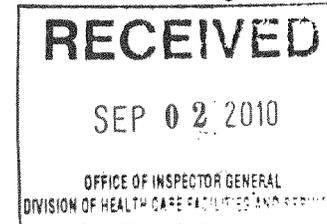
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F 167	Continued From page 4 Interviews during the Quality of Life group interview on 08/10/10 at 2:30pm revealed eight (8) residents were present and all eight (8) stated they were not sure of where the survey results were located in the building. Interview with the Administrator on 08/12/10 at 4:18pm revealed the survey results were in the lobby where the family and residents could review the results. She reported the residents could look at the book anytime they would like. She reported they would have to ask for the doors to be unlocked for them to go to the lobby, or ask for the book to be brought to them. She reported the residents were not given the code for the keypad for the purposes of safety and security. She reported she has had to replace the last survey results in the book on many occasions. She reported the book has always been in the lobby, and had never thought of the book as not accessible to the residents behind the locked doors.	F 167	survey results being available for examination in a place readily accessible to residents. This in-service was conducted on 8/30/10. A meeting was held with the residents on 8/31/10 to inform them that a survey binder was located in the activity room. 24 residents attend the meeting. The Activity Director will monitor the survey book in the activity room to ensure its availability to the residents. This will be checked daily Monday-Friday for 2 weeks beginning August 30, 2010 and then weekly for 4 weeks by the Activity Director. The results will be reported to the QA Committee at the weekly meeting.	
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide physician ordered mechanical soft diets to three (3) of twenty-two (22) sampled residents (Resident #11, #21 and #22). In addition, in the group interview, residents stated they were served whole fried bacon that they could not	F 365	All residents have the potential to be affected. Resident # 11 and Resident #21 received a Doctors order for a whole piece of crisp bacon on 8/11/10. Resident # 11 and Resident #21 received a clarification Doctors order for a whole piece of bacon on 8/25/10. On 8/25/ 10 the Dietary Manager placed on Resident #11 and Resident #21 tray card that these residents could have a whole piece of bacon.	9-1-10



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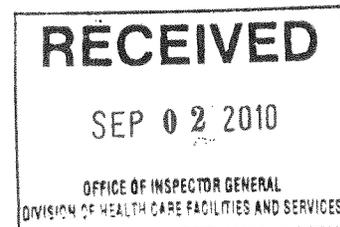
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F 365	<p>Continued From page 5 chew.</p> <p>The findings include:</p> <p>The facility's policy on Management of Nutritional care, dated 2005, required the facility to follow the recommendations of the dietician.</p> <p>Observation of the Dietary Aide (DA) serving breakfast on 08/11/10 at 8:00am, revealed he was serving breakfast without referring to the therapeutic menu and was serving whole bacon to residents.</p> <p>Review of the therapeutic menu revealed a mechanical soft diet required ground bacon.</p> <p>Observation of the breakfast meal on 08/11/10 at 9:00am, revealed three (3) residents not eating the whole bacon strips served. Each resident was on a mechanical soft diet as indicated by the diet cards on the tables.</p> <p>Interview with Resident #11 on 08/11/10 at 9:00am, revealed the resident did like bacon; however, was unable to chew the bacon due to missing teeth and the bacon was too tough. The resident stated he/she had reported this to the facility many times.</p> <p>Interview with Resident #21 on 08/11/10 at 9:10am, revealed the resident left the whole bacon uneaten. The resident stated the bacon was too tough to chew and the resident had missing teeth.</p> <p>Observation of Resident #22 on 08/11/10 at 9:15am, revealed the resident did not eat the</p>	F 365	<p>Resident # 22 began receiving chopped bacon on August 17, 2010.</p> <p>The Dietary Manager in-serviced 100% of Dietary Employees on 8/16/10 on diet order terminology. In this in-service it was specifically discussed that all meats including bacon must be chopped or ground for mechanically altered therapeutic residents.</p> <p>All therapeutic diets will be monitored daily for 2 weeks by the Shift Supervisor or Dietary Manager for 2 weeks, and then weekly thereafter. The results of this audit will be brought to the QA Committee by the Dietary Manager at the weekly QA meeting.</p>	
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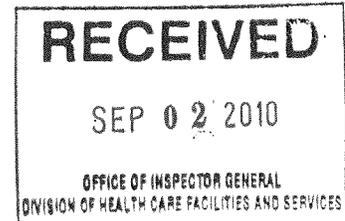
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F 365	Continued From page 6 whole bacon served with breakfast. It was observed the resident was missing teeth. Interview with the resident group on 08/10/10 at 2:30pm, revealed some residents lacked teeth with which to chew bacon at the breakfast meal. Interview with the Food Service Manager (FSM) and the Dietary Aide (DA), on 08/11/10 at 8:35am, revealed the DA knew what was on the therapeutic menu and had no need to refer to the menu during service. The FSM agreed with this statement. Interview with the DA and FSM 08/11/10 at 9:30am, revealed ground bacon should have been served to residents on mechanical soft diets as instructed by the therapeutic menu.	F 365	An in-service was conducted on 8/16/10 by the Dietary Manager to 100% of the Dietary Employees on personal hygiene. During this in-service the Dietary Manager emphasized wearing mustache and beard covers for those dietary employees with facial hair. This will be monitored daily for 2 weeks beginning 9/1/10 and weekly thereafter by the Dietary Manager or Shift Supervisor. The Dietary Manager will report this to the QA Committee at the weekly QA meeting. The Dietary Manager ordered new coffee pots on 8/31/10. A broom and mop hanger was ordered 8/31/10 by the Administrative Assistant. The stove hood will be painted by 9/7/10 by the Maintenance Director and his full-time assistant. The compartment sink will be repaired by 9/10/10 by the Maintenance Director and his full-time assistant. The coffee container is cleaned by the Dietary Aide after each meal. This is inspected daily by the Dietary Manager or Shift Supervisor. This was added to the daily cleaning schedule on 9/1/10 by the Dietary Manager. The hole in the wall next to the dishwasher will be repaired by 9/10/10 by the Maintenance Director and his full-time assistant. The large holes around the faucets in the mop area will be repaired by 9/10/10 by the Maintenance	
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, interview, and record review, it was determined the facility failed to store, prepare, distribute, and deliver food under sanitary conditions. The kitchen needed repairs and bearded male employees were observed cooking and serving food without covering facial	F 371		9-11-10



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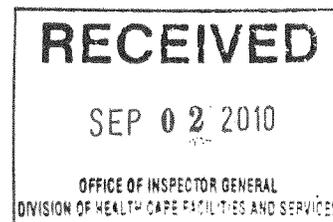
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F 371	<p>Continued From page 7 hair.</p> <p>The findings include:</p> <p>Review of the facility policy Environmental Sanitation, dated 2010, revealed dietary employees were to wear a hair restraint that effectively covers head and/or facial hair in food preparation areas to prevent contamination of food.</p> <p>Observation of lunch on 08/11/2010 at 8:30am revealed two (2) male employees with facial hair dished food for residents without a covering over the facial hair.</p> <p>Interview with the Dietary Aide (DA) on 08/11/10 at 9:30am, revealed he should have covered facial hair while preparing and serving food to prevent hair from falling into the residents' food.</p> <p>Interview with the Food Service Manager on 08/11/10 at 9:40am, revealed facial hair should be covered when preparing and serving food.</p> <p>The facility did not provide a policy on kitchen sanitation.</p> <p>Observation of the kitchen on 08/12/10 at 2:30pm, revealed the caulk around the three (3) compartment sink was in poor condition, cracked, and pulling away from the wall. The paint around the edges of the stove hood was flaking and peeling off. The coffee container had ground in brown particles. The glass coffee pots had brown stains inside the pots. There was a hole in the wall next to the dishwasher and large holes around both faucets in the mop area. Brooms and mops were stored on the floor. The ice machine</p>	F 371	<p>Director and his full-time assistant. The lime deposits on the outside of the ice machine is cleaned on a weekly basis by a Dietary Aide or Dietary Cook. The ice machine is inspected Monday-Friday by the Dietary Manager and is presently on the weekly cleaning schedule. The caulk around the hand sink will be repaired by 9/10/10 by the Maintenance Director and his full-time assistant.</p> <p>The Maintenance Director will report the status of the items requiring Maintenance repairs in the kitchen to the QA Committee at the weekly QA meeting beginning 9/7/10.</p> <p>The Dietary cleaning schedule is monitored by the Dietary Manager Monday-Friday. The cleaning schedule is reported to the QA Committee by the Dietary Manager at the weekly QA meeting beginning 9/7/10.</p>	
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NAME OF PROVIDER OR SUPPLIER JAMES S TAYLOR MEMORIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 W MAGAZINE STREET LOUISVILLE, KY 40203
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 371	Continued From page 8 had deposits of lime on the outside. The caulk around the hand sink was cracked and pulling away from the wall. Interview with the Food Service Manager on 08/12/10 at 2:30pm, revealed a cleaning schedule was not posted and he told employees what tasks he wanted them to complete that day. He stated the employees did complete these tasks. He stated he had informed maintenance of the needed repair work in the kitchen; however, he did not remember when this occurred. He stated he had not followed up with maintenance when the repairs did not occur.	F 371		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure bags of trash were stored in a closed dumpster. The dumpster was found to be full and bags of trash were on the ground around and near the dumpster. The findings include: Observation of the facility parking lot at the rear entrance to the building on 08/10/10 at 7:00am revealed the dumpster was full and ten (10) clear trash bags were on the ground around the dumpster. Four (4) more bags of trash were observed near the dumpster. The trash bags contained food and adult briefs as well as paper	F 372	No specific residents were cited. All residents have the potential to be affected. The facility has waste management services set up with a local vendor. The garbage is scheduled to be picked up three days per week. The garbage is scheduled to be picked up by the local waste management company on Monday, Wednesday, and Friday. The waste management services resumed on 8/11/10 and the garbage was disposed properly. The local waste management company bill was paid on 8/9/10. The Maintenance Director was in-service on ensuring the dispose of garbage and refuse properly. This in-service was conducted by the Administrator on 8/31/10.	9-1-10

