

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

PRINTED: 05/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/10/2012
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217	
(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		
F 225 SS=D	<p>A standard health survey was conducted from 05/08/12 through 05/10/12 and a Life Safety Code survey was conducted on 05/09/12 with deficiencies cited at the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>	F 225	<p>F225 The Human Resources Manager (HR Manager) is responsible to maintain all of the records for current and past employees. In order to assure quality care for our residents, it is important that all information is in order that is needed and required to assure that no abuse takes place. The information required may be found in our written Abuse Policy for the Home. See Attachments.</p> <p>A review of the personnel records for Employee #1 indicated that no Nurse Aide Registry check was done at any time for that employee. All nurse aide checks were done at the time of the survey. A more current copy of the background check was done at this time.</p> <p>Employee #4 is a resident of Indiana. She was hired on March 12, 2012, but the Nurse Aide Registry check was not made in Indiana at that time. A Nurse Aide Registry check in the State of Indiana was made on May 10, 2012. The HR Manager verified that the</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *S. Maurice Courtney* TITLE: *Administrator* (X6) DATE: *06-15-12*

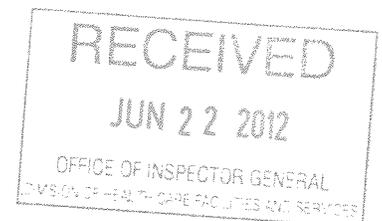
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

RECEIVED
If continuation sheet Page 1 of 18
JUN 22 2012
OFFICE OF INSPECTOR GENERAL
CENTERS FOR MEDICARE & MEDICAID SERVICES

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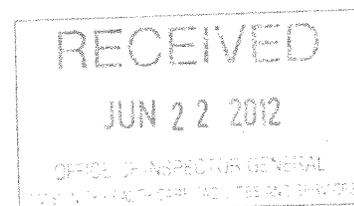
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F 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure employees were not found guilty of abusing, neglecting, or mistreating residents prior to employment for two (2) of ten (10) sampled employees. The facility hired Employee #1 on 05/13/11, however, the nurse aide abuse registry was not checked until 05/09/12. The facility hired Employee #4 on 03/12/12, however, the nurse aide abuse registry was not checked until 05/10/12.</p> <p>The findings include:</p> <p>Review of the facility's Abuse Policy, dated 5/2006, revealed all potential employees shall be screened for a history of reported abuse, neglect, or mistreatment of residents. All employees of the facility are subject to the requirements of this policy.</p> <p>Interview with the Human Resources Director, on 05/10/12 at 2:00 PM, revealed she was</p>	F 225	<p>Kentucky Nurse Aide Registry was checked prior to interview and hire since the employee is certified in Kentucky.</p> <p>It was not clear to the HR Manager that states' registries other than where the employee is certified/licensed needed to be checked. The HR Manager has since received clarification on the requirements. A Nurse Aide Registry screening will be done for all states of residence and work history prior to employing any future new hire per the recommendation of this State Survey.</p> <p>The HR Manager will report directly to the Mother Superior or the Administrator in the event that an applicant does not have a clean report. Any questions regarding that report will be directed to the applicant for the purpose of clarification. If the applicant does not meet acceptable standards per direction of the Administrator and Mother Superior, the HR Manager will inform the applicant and the hiring supervisor that their employment offer has been rescinded.</p> <p>The Sisters who staff the home are not paid employees and are assigned to the Home by their Superior, so are therefore not hired by the Home's Human Resources Department. The HR Department has no access to the Sisters' private files. As each new Sister joins the staff of the Home, Mother Superior will share with the Human Resources</p>	



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F 225	Continued From page 2 responsible to ensure all applicants had nurse aide abuse registry checks prior to employment. She stated she often checked the Indiana abuse registry as some employees lived there. Review of the personnel record for Employee #1, revealed the facility hired the employee on 05/13/11. The employee had histories of working in California, Colorado and Illinois. The facility provided documentation of state nurse aide abuse registry checks for these states; however, they were not completed until 05/09/12. Review of the personnel record for Employee #4, revealed the facility hired the employee on 03/12/12. The employee lived in Indiana, however, documentation of a nurse aide abuse registry check in Indiana was not completed until 05/10/12. Interview with the Human Resources Director, on 05/10/12 at 2:00 PM, revealed she thought an abuse registry check on Employee #4 for Kentucky, completed on 03/12/12, would be sufficient since the Indiana check was missed. Interview with the Administrator, on 05/09/12 at 3:00 PM, revealed the facility policy did require nurse aide abuse registry checks on potential employees. She agreed that the nurse aide abuse registry checks were not completed as required.	F 225	Manager that all requirements and qualifications dictated by policy or law have been met. Immediately upon request, personnel files and records for the Sisters will be given to authorized persons. Please see the attached addendum to the Home's Abuse Policy regarding the treatment of Sisters' files. At each quarterly Quality Assurance Meeting, the Administrator will require the HR Manager to randomly pull two files from the previous quarter's new hires to verify compliance in that they include all the appropriate Nurse Aide Registry and background checks. The next Quality Assurance Meeting is July 18, 2012. See Attachments F226 The Human Resources Manager (HR Manager) is responsible to maintain all of the records for current and past employees. In order to assure quality care for our residents, it is important that all information is in order that is needed and required to assure that no abuse takes place. The information required may be found in our written Abuse Policy for the Home. See Attachments. A review of the personnel records for Employee #1 indicated that no Nurse Aide Registry check was done at any	6/8/12
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		



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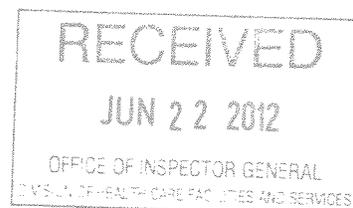
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F 226	<p>Continued From page 3</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to implement their facility Abuse policy, to check potential employees for a history of abuse prior to employment, for two (2) of ten (10) sampled employees. The facility hired Employee #1 on 05/13/11, however, the nurse aide abuse registry was not checked, per policy, until 05/09/12. The facility hired Employee #4 on 03/12/12, however, the nurse aide abuse registry was not checked, per policy, until 05/10/12.</p> <p>The findings include:</p> <p>Review of the facility's Abuse Policy, dated 5/2006, revealed all potential employees shall be screened for a history of reported abuse, neglect, or mistreatment of residents. All employees of the facility are subject to the requirements of this policy.</p> <p>Interview with the Human Resources Director, on 05/10/12 at 2:00 PM, revealed she was responsible to ensure all applicants had nurse aide abuse registry checks prior to employment per facility policy.</p>	F 226	<p>time for that employee. All nurse aide checks were done at the time of the survey. A more current copy of the background check was done at this time.</p> <p>Employee #4 is a resident of Indiana. She was hired on March 12, 2012, but the Nurse Aide Registry check was not made in Indiana at that time. A Nurse Aide Registry check in the State of Indiana was made on May 10, 2012. The HR Manager verified that the Kentucky Nurse Aide Registry was checked prior to interview and hire since the employee is certified in Kentucky.</p> <p>It was not clear to the HR Manager that states' registries other than where the employee is certified/licensed needed to be checked. The HR Manager has since received clarification on the requirements. A Nurse Aide Registry screening will be done for all states of residence and work history prior to employing any future new hire per the recommendation of this State Survey.</p> <p>The HR Manager will report directly to the Mother Superior or the Administrator in the event that an applicant does not have a clean report. Any questions regarding that report will be directed to the applicant for the purpose of clarification. If the applicant does not meet acceptable standards per direction of the Administrator and Mother Superior, the HR Manager will inform the applicant</p>	
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F 226	Continued From page 4 Review of the personnel record for Employee #1, revealed the facility hired the employee on 05/13/11. The employee had histories of working in California, Colorado and Illinois. The facility provided documentation of state nurse aide abuse registry checks for these states; however, they were not completed until 05/09/12. Review of the personnel record for Employee #4, revealed the facility hired the employee on 03/12/12. The employee lived in Indiana, however, documentation of a nurse aide abuse registry check in Indiana was not completed until 05/10/12. Interview with the Human Resources Director, on 05/10/12 at 2:00 PM, revealed she did not follow the facility policy to obtain a nurse aide abuse registry check, prior to employment, on Employee #4 in Indiana where the employee resided. Interview with the Administrator, on 05/09/12 at 3:00 PM, revealed the facility policy did require nurse aide abuse registry checks on potential employees. She agreed that the nurse aide abuse registry checks were not completed per facility policy.	F 226	and the hiring supervisor that their employment offer has been rescinded. The Sisters who staff the home are not paid employees and are assigned to the Home by their Superior, so are therefore not hired by the Home's Human Resources Department. The HR Department has no access to the Sisters' private files. As each new Sister joins the staff of the Home, Mother Superior will share with the Human Resources Manager that all requirements and qualifications dictated by policy or law have been met. Immediately upon request, personnel files and records for the Sisters will be given to authorized persons. Please see the attached addendum to the Home's Abuse Policy regarding the treatment of Sisters' files. At each quarterly Quality Assurance Meeting, the Administrator will require the HR Manager to randomly pull two files from the previous quarter's new hires to verify compliance in that they include all the appropriate Nurse Aide Registry and background checks. The next Quality Assurance Meeting is July 18, 2012. See Attachments	6/8/12
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's	F 272	F272 Requirement not met for identifying progress/lack of progress towards goals	



ABUSE

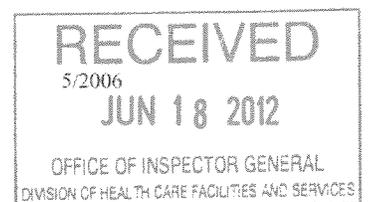
PROHIBITION, REPORTING AND INVESTIGATION OF RESIDENT ABUSE, NEGLECT AND MISTREATMENT

3. Residents, staff and families will be provided information on how and to whom they should report concerns, incidents and grievances. It is important for all such reporters of possible abuse to understand that reporting the possibility of abuse will not bring about any retribution against the individual or the Resident. The Facility will provide feedback to the reporter in a timely manner.

IDENTIFICATION AND REPORTING OF SUSPECTED ABUSE, NEGLECT AND MISTREATMENT

1. All of the following are examples of possible abuse, neglect or mistreatment and must be reported immediately to the Unit supervisor and charge nurse, regardless of the staff member's department or job responsibility. This list is not exhaustive. Staff should report any incident believed to be abuse, neglect or mistreatment of a Resident. Staff need **not** be 100 percent sure abuse has occurred before reporting it.
 - a. Any observation of a staff member, Resident, family member or other individual hitting, striking or otherwise injuring a Resident;
 - b. Any significant unexplained bruise, cut or other wound;
 - c. Verbal abuse, including rude, disrespectful or threatening language;
 - d. Any comment by a Resident that suggests possible abuse or mistreatment;
 - e. Missing Resident property, either reported to a staff member or directly observed;
 - f. Residents left unattended, uncared for, or otherwise at risk for injury or harm;
 - g. Involuntary seclusion of a Resident;
 - h. Untreated bedsores;
 - i. Evidence of malnutrition or dehydration; and
 - j. Any otherwise unexplained or unusual occurrence that results in injury to a Resident, or danger to a Resident's health or safety.

**NO RESIDENT, REGARDLESS OF AGE, ABILITY TO
COMPREHEND, DISABILITY, OR COMOTOSE STATUS IS
IMMUNE FROM ABUSE, NEGLECT AND MISTREATMENT. ALL
RESIDENTS MUST BE PROTECTED FROM ABUSE, NEGLECT
AND MISTREATMENT.**



Addendum Abuse Policy

Page -2-

EMPLOYEE SCREENING AND STAFF TRAINING : NOTIFICATION OF RESIDENTS AND FAMILIES, ETC.....

1. All potential employees shall be screened for a history of reported abuse, neglect or mistreatment of Residents. Information shall be obtained from previous employers, when available and State licensing agencies and registries. The Facility will not employ individuals who:
 - a. Have been found guilty of abusing, neglecting or mistreating Residents by a court of law: or
 - b. Have had a finding entered into the State nurse aid registry concerning abuse, neglect or mistreatment of Residents.

Addition:

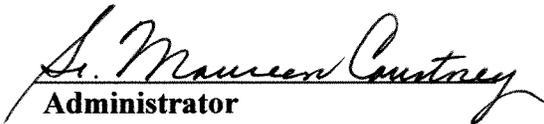
All Little Sisters of the Poor who are considered staff persons *will* have the same screening. However, the records should not be kept the Human Resources Offices.

The required information for every Little Sister of the Poor who is part of the Staff will be the same as those required by law for any salaried personnel. This includes and is not limited to: 1) Background Checks: 2) State Nurse Aide registry concerning abuse for each of the States the Little Sister has served in: 3) Appropriate medical background.

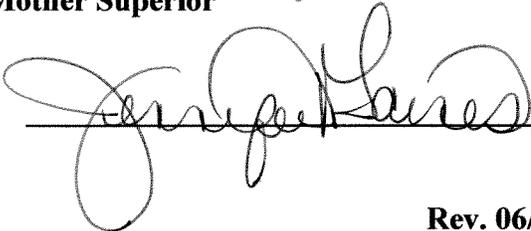
The Mother Superior/Administrator is responsible to assure the Human Resources Manager of the status of each Little Sister. Their personal records will be kept in the Convent Office and available promptly for any State Agency or need.



Mother Superior

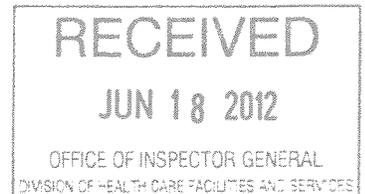


Administrator



Human Resources Manager

Rev. 06/04/2012



NOTICE NOTICE NOTICE NOTICE NOTICE
June 12, 2012

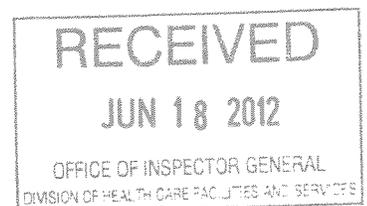
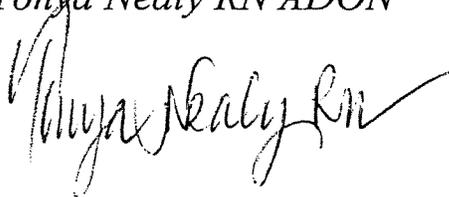
CERTIFIED NURSING ASSISTANTS & CMT'S

Please make yourselves familiar with the white binder that is now on each nursing unit. The binder is identified with the units name and CAREPLANS along the spine.

Inside the binder you will find a care plan and a set of goals for each one of our residents. Review the goals carefully. Throughout your shift you are to implement care that will allow the resident to achieve these goals. If you believe a goal needs to be changed or believe a new or different goal would be beneficial please bring it to Jane Finney, the MDS Coordinator or Jeanette Stephens RN, the Director of Nurses or to Tonya Nealy RN, the Assistant Director of Nurses.

Jane Finney RN will be reviewing this 1 on 1 with each one of you and plans are to have each session completed by June 30, 2012.

Tonya Nealy RN ADON



CH-LSP Louisville - NUR
CAA Worksheet

Date: Jun 11, 2012
Time: 09:57:32 ET
User: Jane Finney

Resident Name: EMINGTON, IRENE (951004)
Description: Nursing home: comprehensive asmt
Location of Doc: CAA WS dated 12/19/2011
Status: Accepted
CP Decision: Y
ARD: 12/09/2011
Triggered: Yes

- Dressing:**
- Locates/selects/obtains clothes
 - Not applicable
 - Maintenance to prevent decline
 - Treatment to achieve highest practical self-sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in)
 - Grasps/puts on upper/lower body
 - Not applicable
 - Maintenance to prevent decline
 - Treatment to achieve highest practical self-sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in)
 - Manages snaps, zippers, etc.
 - Not applicable
 - Maintenance to prevent decline
 - Treatment to achieve highest practical self-sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in)
 - Puts on in correct order
 - Not applicable
 - Maintenance to prevent decline
 - Treatment to achieve highest practical self-sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in)
 - Grasps, removes each item
 - Not applicable
 - Maintenance to prevent decline
 - Treatment to achieve highest practical self-sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in)
 - Replaces clothes properly
 - Not applicable
 - Maintenance to prevent decline
 - Treatment to achieve highest practical self-sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in)
 - Other

Ms. Emington can dress herself with the extensive assist of one.

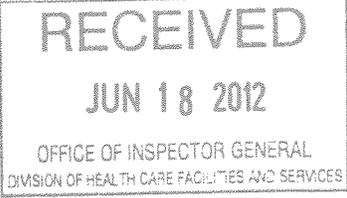
CH-LSP Louisville - NUR
CAA Worksheet

Date: Jun 11, 2012
Time: 09:57:32 ET
User: Jane Finney

Resident Name: EMINGTON, IRENE (951004)
Description: Nursing home: comprehensive asmt
Location of Doc: CAA WS dated 12/19/2011
Status: Accepted
CP Decision: Y
ARD: 12/09/2011
Triggered: Yes

- Bathing:**
- Goes to tub/shower
 - Not applicable
 - Maintenance to prevent decline
 - Treatment to achieve highest practical self-sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in)
 - Turns on water/adjusts temperature
 - Not applicable
 - Maintenance to prevent decline
 - Treatment to achieve highest practical self-sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in)
 - Lathers body (except back)
 - Not applicable
 - Maintenance to prevent decline
 - Treatment to achieve highest practical self-sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in)
 - Rinses body
 - Not applicable
 - Maintenance to prevent decline
 - Treatment to achieve highest practical self-sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in)
 - Dries with towel
 - Not applicable
 - Maintenance to prevent decline
 - Treatment to achieve highest practical self-sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in)
 - Other

Ms. Emington can bathe herself with the extensive assist of one.



Item Changes

Description	Resolved Date	Revision Date	Revision By
Ms. Sondergeld has peripheral vascular disease. Has a left above the knee amputation. Return from hospital w/ right leg above the knee amputation. 32 staples. Some oozing of fluid lateral side of stump.	6/6/2012	6/6/2012	Jane Finney
Ms. Sondergeld has peripheral vascular disease. Has a left above the knee amputation. Return from hospital w/ right leg above the knee amputation. 32 staples. Some oozing of fluid lateral side of stump.		4/6/2012	Tonya Nealy
Ms. Sondergeld has peripheral vascular disease. Has a left above the knee amputation.		3/7/2011	Jane Finney
Ms. Sondergeld has peripheral vascular disease. Has a left above the knee amputation.		5/17/2010	Jane Finney
Ms. Sondergeld has peripheral vascular disease. Has a left above the knee amputation.		1/19/2010	Jane Finney

Original Care Plan Item

Description	Created Date	Created By
Ms. Sondergeld has peripheral vascular disease. Has a left above the knee amputation.	9/11/2009	Jane Finney

Progress Notes

Last 6 months



Effective Date	Type	Note
No Progress Notes Found.		

Item Changes

Description	Resolved Date	Revision Date	Revision By
Ms. Sondergeld requires active range of motion to arms.		5/14/2012	Jane Finney

Original Care Plan Item

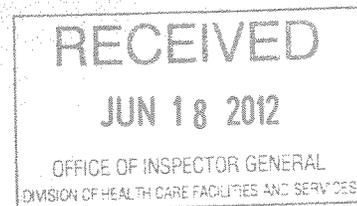
Description	Created Date	Created By
Ms. Sondergeld requires active range of motion to arms and leg.	1/2/2012	Jane Finney

Progress Notes

Last 6 months



Effective Date	Type	Note
No Progress Notes Found.		



Addendum Abuse Policy

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EMPLOYEE SCREENING AND STAFF TRAINING : NOTIFICATION OF RESIDENTS AND FAMILIES, ETC.....

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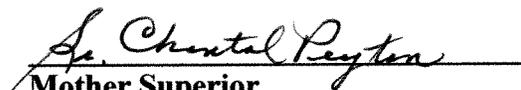
- a. Have been found guilty of abusing, neglecting or mistreating Residents by a court of law: or
- b. Have had a finding entered into any State nurse aid registry concerning abuse, neglect or mistreatment of Residents.

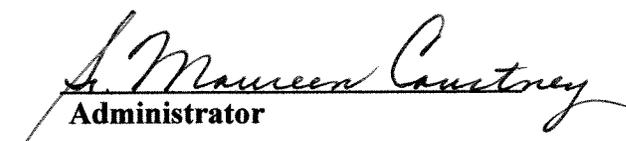
Addition:

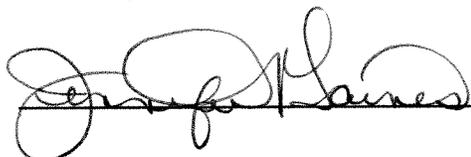
All Little Sisters of the Poor who are considered staff persons will have the same screening. However, the records should not be kept the Human Resources Offices.

The required information for every Little Sister of the Poor who is part of the Staff will be the same as those required by law for any salaried personnel. This includes and is not limited to: 1) Background Checks: 2) State Nurse Aide registry concerning abuse in each of the States the Little Sister has served in: 3) Appropriate medical background.

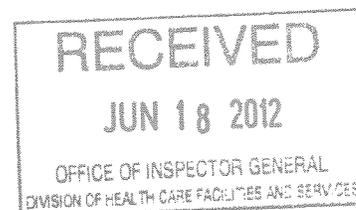
The Mother Superior/Administrator is responsible to assure the Human Resources Manager of the status of each Little Sister. Their personal records will be kept in the Convent Office and available promptly for any State Agency or need.


Mother Superior


Administrator


Human Resources Manager

Rev. 06/04/2012



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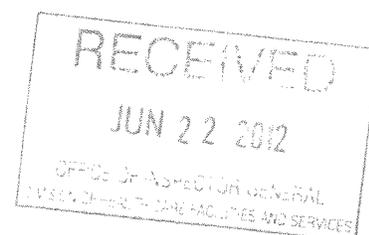
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/10/2012
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217	
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F 272	Continued From page 5 functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review	F 272	utilizing the care area of the MDS. Certified Nursing Aide was not aware of set goals. Assessment information was not included in the summary of the ADL care area. Goals, progress or lack of progress will be addressed with each routine care plan review-quarterly and annually Goals will be revised, removed, marked as met, or as ongoing according to assessment by the MDS Coordinator. This assessment will consist of, but not be limited to; assessment of the resident, interview of resident's staff care givers (all shifts), nurses, CMT's, therapy or restorative to implement a current and individualized set of ADL goals. The ADL area of the MDS will also include the current functional level for the resident and the planned goal. Review of the care plan is not limited to routine quarterly or annual. As goals are seen to be changing, the care plan will be adjusted accordingly. The MDS Coordinator will include her source of information for the resident's goal in the summary of the ADL care area to reflect the interview and assessment process and the progress or lack of progress for that goal.. Resident # 4 care plan was updated on May 14, 2012 by the MDS Coordinator. Both nursing units now have a binder with hard copies of the care plan and a separate copy of goals listed for each resident. The Residents individual	



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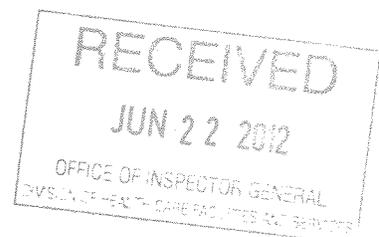
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F 272	<p>Continued From page 6</p> <p>and review of the facility's policy on assessment of residents, it was determined the facility failed to complete a comprehensive assessment, Minimum Data Set (MDS), which reflected a resident's functional capacity for one (1) of twelve (12) sampled residents, Resident #4. The facility failed to identify Resident #4's progress/lack of progress with functionality utilizing the care area for Activities of Daily Living (ADL) triggered by the MDS as requiring further assessment to ensure the resident reached the highest possible functional level.</p> <p>The findings include:</p> <p>Review of the facility's policy for Minimum Data Set (MDS) Nursing Assessment, dated 5/2006, revealed the purpose was to comprehensively assess each resident's ability to perform activities of daily living (ADL). A Registered Nurse (RN) would initiate the MDS and prepare a summary to be placed in the clinical record.</p> <p>Observation of Resident #4, on 05/08/12 at 11:25 AM, revealed the resident utilized a walker to ambulate around the facility and had an unsteady gait.</p> <p>Review of the clinical record for Resident #4, revealed the facility admitted the resident with diagnoses of Alzheimer's Disease and Osteoarthritis. Review of the care plan, initiated on 09/09/11, revealed the resident required extensive assistance of one person to dress</p>	F 272	<p>Kardex will reflect Care Plan goals related to activities of daily living. Completion date set for June 15, 2012.</p> <p>Remaining care plans were reviewed by the MDS Coordinator with completion by June 7, 2012.</p> <p>In order to prevent this from happening again, the DON will conduct a daily meeting, Monday through Friday at 10:00 AM. Present at these meetings will be the Director of Nursing, Dietary Manager, Social Worker, Activity Director, MDS Coordinator and ADON. New orders will be reviewed and any changes noted. Each discipline will bring to the table any issue they see with a resident/resident goal. Each discipline will have 24 hours to update the plan of care and will be reminded at the next daily meeting. The overall care plan will be reviewed by Dietary, Social Service, Activities, MDS Coordinator and Nursing with each MDS assessment. Meetings were initiated on May 14, 2012.</p> <p>Implementation of direct care giver input to address current and future goals of residents. This will be accomplished by having the direct care giver attend the care plan meetings. If the caregiver cannot attend, they will come to the next days 10:00 AM meeting. If this is not possible due to a shift issue, the caregiver will give an update to the disciplines goal in question. A list of</p>		



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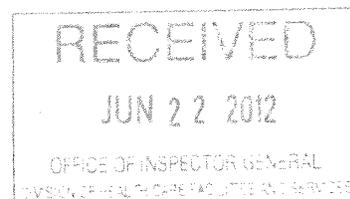
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F 272	<p>Continued From page 7.</p> <p>related to the resident's Alzheimer's Disease. The resident's goal, initiated on 09/09/11, was management of all zippers and snaps with verbal cues from staff. The facility completed an annual MDS assessment on the resident, on 12/09/11, which indicated the resident required extensive assistance of one person to dress. Review of the triggered care area for ADLs, revealed no documentation regarding the resident's progress or lack of progress with accomplishment of these goals. The ADL care area did specify the resident would maintain the current level of function, however, there was no documentation to specify the level at which the resident functioned.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 05/10/12 at 9:45 AM, revealed Resident #4 did not have clothing with zippers or snaps and had very few shirts with buttons. She stated the resident had pull-over tops and could manage these tops independently. She said the resident required assistance of one (1) person to put on slacks and could change adult briefs independently. She stated all the resident's slacks had elastic in the waist. She stated she was not aware of the resident's goal to manage zippers and snaps and since the resident's clothing items were zipper and snap free, she had not taught the resident how to manage them.</p> <p>Interview with the MDS Coordinator, on 05/10/12 at 9:55 AM, revealed she reviewed Resident #4's care plan every three (3) months and as needed. She stated the goal for the resident was management of zippers and snaps on clothing and that the resident was doing pretty good with</p>	F 272	<p>current goals for each resident is now kept in a binder at each nurse's station for the care giver staff to review. The Certified Nursing Assistants will be made aware of the binder by a notification being placed at each KIOSK on both nursing units. The notification will alert the staff of the changes being made. It will instruct the staff to review the care plan and goals. It will also identify how the staff can recognize the binder. It is white, with the units name and CAREPLANS on the spine. The staff will be instructed to make themselves familiar with the goals and the care plan and that throughout their care shift are to implement care that will allow the resident to achieve these goals. If the Certified Nursing Assistant believes a goal needs to be changed or believes a new or different goal could be added they will bring it to the MDS coordinator, the DON or the ADON. After the notification has been posted a 1 on 1 with the Certified Nurse Aide will be conducted by the MDS Coordinator to allow for questions. In order to assure complete compliance of this deficiency, it will be presented at the next Quality Assurance Meeting on July 18th. The members of the committee will be made more aware of its importance. The Director of Nursing, Jeanette Stephens will inform each of the staff members of the outcome of this meeting and the follow</p>	



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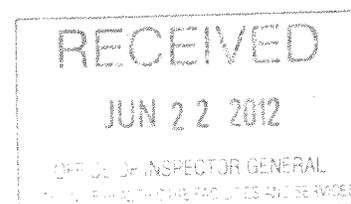
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F 272	Continued From page 8 the goal. She stated various sources were used to determine the resident's needs: the nursing notes; CNA documentation; general talks with the resident; and reports. She indicated she did not include this information in the summary of the ADL care area. She revealed she was not aware the resident's clothing did not include zippers or snaps and so the goal was not helpful in maintaining the resident's highest functional level.	F 272	up plans which were submitted on our Plan of Correction. See attachment.	6/23/12
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279	F279 Requirement not met for Resident # 2 because the facility failed to revise the resident's comprehensive care plan to reflect an above the right knee amputation. Resident # 2 was readmitted on 04/04/2012 with a right above the knee amputation. The comprehensive care plan was revised/updated to reflect this change by the ADON on 04/06/2012. At this time all Focus areas were reviewed and changes were made. However, under Focus.... Resident #2..... requires active range of motion to arms and leg, the ADON failed to cancel leg from the Focus and to cancel out... knee extension exercise from the interventions. The care plan was updated again on May 14, 2012 to reflect Resident # 2's status as a double above the knee amputee. The MDS Coordinator has reviewed all comprehensive plans of care for resident updates. Completion date was June 7, 2012. In order to prevent this from happening again, the DON will conduct a daily meeting, Monday through Friday at 10:00 AM. Present at these meetings will be the	



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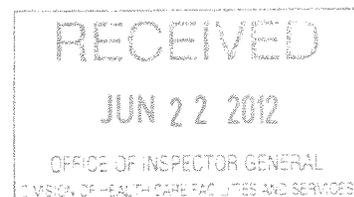
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F 279	<p>Continued From page 9</p> <p>highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy for care planning, it was determined the facility failed to develop a comprehensive care plan to address one (1) of twelve (12) sampled residents' (Resident #4) needs based on the Minimum Data Set (MDS) assessment. Resident #4's MDS triggered Activities of Daily Living, specifically dressing. The facility failed to develop a care plan, for Resident #4, to address the resident's individualized needs.</p> <p>The findings include:</p> <p>Review of the facility's Care Plan Policy, dated 5/2006, revealed the purpose of the care plan was to develop quantifiable objectives for the highest level of functioning the resident may be able to attain. The comprehensive care plan includes measureable objectives and time tables to meet the resident's nursing needs as identified in the MDS.</p>	F 279	<p>Director of Nursing, Dietary Manager, Social Worker, Activity Director, MDS Coordinator and ADON. New orders will be reviewed and any changes noted. Each discipline will bring to the table any issue they see with a resident/resident goal. Each discipline will have 24 hours to update the plan of care and will be reminded at the next daily meeting. The overall care plan will be reviewed by Dietary, Social Service, Activities, MDS Coordinator and Nursing with each MDS assessment. Meetings were initiated on May 14, 2012</p> <p>The Resident and/or Resident family member will continue to be part of the care plan process and be invited to participate in the quarterly care conferences. Both will be encouraged to voice any concerns at any time and may request a care conference be held.</p> <p>Staff nurses will be individually re-educated in the updating and revising of the electronic care plans. This will be done by the MDS Coordinator and will be completed by June 15, 2012.</p> <p>F279 Requirement not met for an Individualized Care Plan related to Resident #4</p> <p>Maintain management of zippers and snaps with verbal cues from staff</p>	



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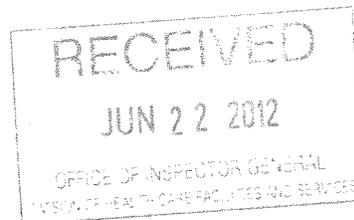
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F 279	<p>Continued From page 10</p> <p>Review of the clinical record for Resident #4, revealed the facility admitted the resident with diagnoses of Alzheimer's Disease and Osteoarthritis. The facility completed an annual MDS assessment, on 12/09/11, and indicated the resident required extensive assistance of one staff for dressing. Review of the care plan, initiated on 09/09/11, revealed the resident required extensive assistance of one person to dress related to the resident's Alzheimer's Disease. The goal was for the resident to management of all zippers and snaps with verbal cues from staff.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 05/10/12 at 9:45 AM, revealed she had provide care for the resident for a long time. Resident #4 did not have clothing with zippers or snaps and had very few shirts with buttons. She stated the resident had pull-over tops and could manage these tops independently.</p> <p>Interview with the MDS Coordinator, on 05/10/12 at 9:55 AM, revealed she wrote a care plan problem for Resident #4 related to dressing. She stated the resident's goal was management of zippers and snaps on clothing, however, she was not aware the resident had no clothing with zippers or snaps. She revealed the care plan for dressing was not appropriate to maintain the resident's highest functional level.</p> <p>Interview with the Director of Nursing, on 05/10/12 at 11:15 AM, revealed her expectations were that the residents were assessed accurately</p>	F 279	<p>because staff reported no garments with zippers or snaps.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 05/10/12 at 9:45 AM indicated to the Survey Team that she had cared for Resident #4 for a long time and that she did not have any clothing with zippers or snaps and had very few shirts with buttons.</p> <p>Inspection of Resident # 4 clothing on June 11, 2012 by the ADON (with resident's permission) revealed 21 individual articles of clothing that had buttons or zippers and 1 that had a type of front snap. Some articles of clothing had both buttons and zippers. Resident #4 states she does not wear these clothes on a daily basis, mostly on Sundays and for special occasions. She states she is able to button some of the buttons but not all of them.</p> <p>The care plan goal for Resident # 4 was to maintain, to prevent further decline in the management of snaps, zippers, etc. This care plan goal is pulled directly from the CAA Worksheet and was/is appropriate for this resident but the Certified Nursing Assistant was unaware of this goal.</p> <p>In order to prevent further issues of this type a list of current goals for each resident is now kept in a binder at each nurse's station. This is for the Certified</p>		



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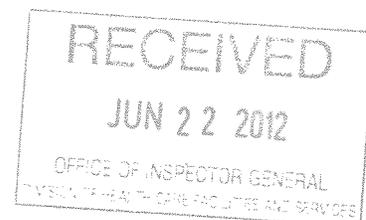
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F 279	Continued From page 11 and problems/goals/interventions were developed to resolve residents' problems. She stated Resident #4's care plan for dressing was not appropriate.	F 279	Nurse Aide to review. Also in this binder is a complete care plan on each individual resident.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility's policy, it was determined the facility failed to revise the comprehensive care plan, based on the Minimum Data Set (MDS) assessment, for one (1) of twelve (12) sampled residents (Resident #2). The facility failed to revised Resident #2's comprehensive care plan	F 280	Implementation of direct care giver input to address current and future goals of residents. This will be accomplished by having the direct care giver attend the care plan meetings. If the caregiver cannot attend, they will come to the next days 10:00 AM meeting. If this is not possible due to a shift issue, the caregiver will give an update to the disciplines goal in question. A list of current goals for each resident is now kept in a binder at each nurse's station for the care giver staff to review. The Certified Nursing Assistants will be made aware of the binder by a notification being placed at each KIOSK on both nursing units. The notification will alert the staff of the changes being made. It will instruct the staff to review the care plan and goals. It will also identify how the staff can recognize the binder. It is white, with the units name and CAREPLANS on the spine. The staff will be instructed to make themselves familiar with the goals and the care plan and that throughout their care shift are to implement care that will allow the resident to achieve these goals. If the Certified Nursing Assistant believes a goal needs to be changed or believes a new or different goal could be added they will bring it to the MDS coordinator, the		



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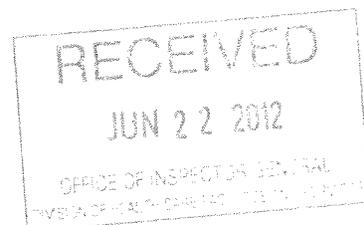
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F 280	<p>Continued From page 12 after an above the knee amputation triggered a change in the resident's needs.</p> <p>The findings include:</p> <p>Review of the facility's Care Plan Policy, dated May/2006, revealed the care plan will meet the residents medical, nursing, mental and psychosocial needs.</p> <p>Review of the Minimum Data Set (MDS) Care Plan Plan Policy, section five (5) dated 05/2006, revealed at least every ninety (90) days and as needed, the nurse, the social worker, the dietary staff, other staff and Resident and/or family would update the comprehensive care plan.</p> <p>Review of the clinical record for Resident #2, revealed the resident was readmitted by the facility on 04/04/12 after an Above the Knee Amputation on the right leg. This changed Resident #2's status to a double above the knee amputee. A significant change MDS assessment was completed by the facility on 04/12/12, however, review of the care plan revealed it had not been updated to reflect the resident's amputation. An intervention for active range of motion (ROM) exercises for the right leg was still on the care plan on 05/09/12.</p> <p>Interview, on 5/10/12, at 2:00 PM, with the MDS Coordinator revealed the multidisciplinary staff updated care plans, but the Assistant Director of Nurses (ADON) and the MDS Coordinator were</p>	F 280	<p>DON or the ADON. After the notification has been posted a 1 on 1 with the Certified Nurse Aide will be conducted by the MDS Coordinator to allow for questions. In addition, the deficiency will be presented for review at the next Quality Assurance Meeting on July 18th. Each member of the Committee will be made more aware of the importance of this citation and the follow up plan which was presented on the Plan of Correction. See Attachments.</p> <p>F280 Requirement not met for Right to Participate Planning Care-Revise Care Plan Resident # 2.</p> <p>The MDS Coordinator advised Resident # 4 of upcoming Care Conference on April 19, 2012. Resident # 2 was asked about any concerns she had. This was documented in the resident's permanent record, in the nurse's notes by the MDS Coordinator.</p> <p>Resident # 2's daughter who is POA/Guarantor was notified of the upcoming care conference via mail, as is usual for this facility. This includes date and time.</p> <p>Resident # 2 was then notified again by the MDS Coordinator with an appointment slip 24 hours prior to the</p>	<p>6-12-12 5/25/12- <i>per Nancy Reynolds</i> by PO 6-28-12</p>



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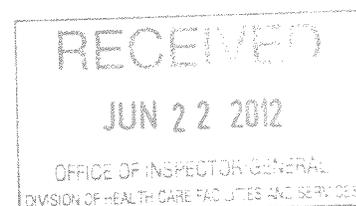
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/10/2012
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217		
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F 280	Continued From page 13 ultimately responsible for ensuring residents' care plans were current.	F 280	conference. The slip included the date of May 1, 2012 and the time of 9:30AM		
F 371 SS=F	Interview with the MDS Coordinator, on 05/10/12 at 2:00 PM, revealed she and the ADON received daily reports from the night shift nurses on the status of residents, and new physician orders were reviewed for changes in residents' care. The MDS Coordinator also stated, Resident #2's care plan should have been updated to reflect his/her status as a double above the knee amputee. 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 review of the dietary cleaning schedule, it was determined the facility failed to follow a daily cleaning schedule to ensure the warming ovens, gas grill, and stove burners were cleaned. The findings include: Review of the facility's policy for Dietary Sanitation and Maintenance, not dated, revealed	F 371	The Resident and/or Resident family member will continue to be part of the care plan process and be invited to participate in the quarterly care conferences. Both will be encouraged to voice any concerns at any time and may request a care conference be held. The care plan for Resident #2 was updated on 04/06/2012 to reflect a right above the knee amputation. A range of motion intervention in another Focus area was not removed to reflect this change. The care plan was updated/revised again on May 14, 2012 by the MDS Coordinator to reflect a status change for Resident#2 as a double above the knee amputation. In order to prevent this from happening again, the DON will conduct a daily meeting, Monday through Friday at 10:00 AM. Present at these meetings will be the Director of Nursing, Dietary Manager, Social Worker, Activity Director, MDS Coordinator and ADON. New orders will be reviewed and any changes noted. Each discipline will bring to the table any issue they see with a resident/resident goal. Each discipline will have 24 hours to update the plan of care and will be reminded at the next daily meeting. The overall care plan will be reviewed by Dietary, Social Service, Activities, MDS		



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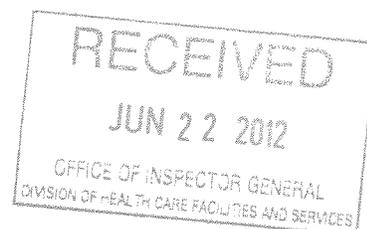
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F 371	<p>Continued From page 14</p> <p>it was the duty of the Food Service Supervisor to maintain the kitchen in a clean and sanitary condition at all times.</p> <p>Review of the Cleaning Checkoff List for A.M. and P.M. Cooks, revealed the stove top and grill were to be cleaned after each use. The ovens were not listed to be cleaned on the check off cleaning list.</p> <p>Review of the dietary cleaning list which identified all kitchen equipment, revealed none of the equipment had an initial or a signature of an employee completing the cleaning from January 2012 until May 2012.</p> <p>Observations during the initial kitchen tour, on 05/08/12 at 8:20 AM, revealed the two (2) stacked ovens with two (2) doors contained a flat pan on the bottom shelf covered with a black substance. A brown liquid was pooled on the ledge on which the oven doors closed. The gas grill had a crusted black substance on the grill. The stove burners had a crusted black substance on the burners and around the edges of the cooktop.</p> <p>Observations, on 05/10/12 at 8:20 AM, revealed the pans with the black crusted substance had been removed from the ovens. There was a brown greasy substance on the door ledge. The gas grill and stove top burners, had a black crusted substance covering the surface.</p> <p>Interview with the Dietary Manager, on 05/10/12 at 8:20 AM, revealed the dietary staff were scheduled to clean the ovens and grill each evening, The dietary manager stated she could see grease on the ledge for the closure of the</p>	F 371	<p>Coordinator and Nursing with each MDS assessment. Meetings were initiated on May 14, 2012. In addition, the deficiency will be presented for review at the next Quality Assurance Meeting on July 18th. Each member of the Committee will be made more aware of the importance of this citation and the follow up plan which was presented on the Plan of Correction.</p> <p>F371 In order to correct this violation the following measures have been taken.</p> <p>The Dietary Supervisor was given a detailed education session by her supervisor, Sister Grace, CDM, FSPP regarding requirements of cleaning schedules and the monitoring of them. A copy of this session is included in this plan of correction material.</p> <p>The policy and procedures for the cleaning of char-broiler, range top, standard and convection oven have been revised with a copy included in this plan of correction material.</p> <p>A new comprehensive cleaning schedule has been drawn up by Sister Grace, CDM, FSPP which includes all kitchen equipment, person responsible for cleaning and how often it is to be cleaned. By using such a detailed cleaning schedule we are able to</p>	5/25/12	



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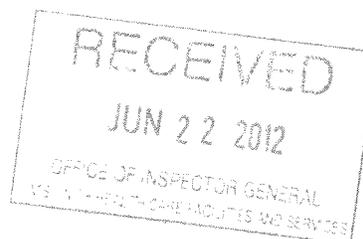
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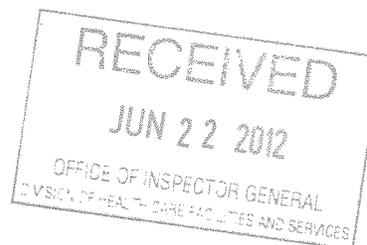
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F 371	Continued From page 15 oven doors. In addition, the dietary manager stated the black substance on the grill and cook top could be removed.	F 371	determine that all equipment is being cleaned. An in-service was given by Debra Anderson, Dietary Supervisor on June 6 to dietary staff on the revised Policy and Procedures for cleaning of standard and convection ovens, grills, range and char-broiler and the importance of signing off on cleaning schedule. An introduction to the new cleaning schedule also took place. A copy of this in-service is included in this plan of correction material		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and		To ensure the violation will not recur, the dietary supervisor, Debra Anderson, or Sister Grace will be responsible to check the cleaning schedule on a daily basis to ensure the tasks are being accomplished and that they are signed off. She or Sister Grace will also be responsible to check the equipment daily to ensure it is kept clean and in perfect working condition. The dietary supervisor will monitor the effectiveness of these measures taken and report the effectiveness of this Plan of correction to the Quality Assurance Committee at the next meeting.	6/12/12	



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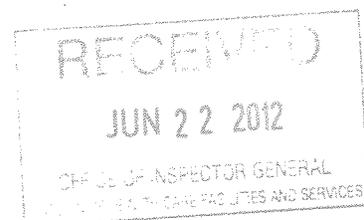
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F 371	Continued From page 15 oven doors. In addition, the dietary manager stated the black substance on the grill and cook top could be removed.	F 371	cleaning schedule we are able to determine that all equipment is being cleaned. An in-service was given by Debra Anderson, Dietary Supervisor on June 6, 2012 to dietary staff on the revised Policy and Procedures for cleaning of standard and convection ovens, grills, range and char-broiler and the importance of signing off on cleaning schedule. An introduction to the new cleaning schedule also took place. A copy of this in-service is included in this plan of correction material		
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F 441	<p>Continued From page 16 transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to review and update their Infection Control Policies in accordance with the Centers for Disease Control (CDC) guidelines related to Universal Precautions and failed to provide evidence the Medical Director's approved the policy and procedure manual.</p> <p>The findings include:</p> <p>Review of the facility's Infection Control Manual, dated for 2003 revealed there was no documentation in the manual to indicate the policies had been reviewed or updated since 2003. Continued review of the manua revealed the table of contents in the Infection Control Manual did not include a policy to meet the CDC gidelines for Universal Precautions. In addition, there was no evidence the Medical Director reviewed and approved the manual.</p> <p>Interview with the Director of Nursing (DON), on 05/10/12 at 2:00 PM, revealed she was aware there was no policy review sheet in the Infection Control Manual. She stated she was aware of the CDC recommendations for use of Universal/Standard Precautions for all residents. She stated the staff utilized Universal/Standard Precautions; however, thought because this</p>	F 441	<p>F441 Universal Precautions Policy was added to infection control manual on May 11, 2012. Review and changes as necessary to Policy and Procedures have been initiated in accordance with CDC Guidelines to the Infection Control Manual.</p> <p>The Medical Director, Dr. Robert Hammer, was notified that requirements were not met.</p> <p>Universal Precautions Policy was reviewed and met the CDC guidelines and was signed by the Medical Director on May 31, 2012.</p> <p>Universal Precautions was added to the Table of Contents pages 129-130-131 in the Infection Control Manual.</p> <p>A Universal Policy and Procedure Review Sheet was current and signed and was in the LSP Facility Policy and Procedure Manual, which included Universal Precautions and was thought to be sufficient. A Review and Signature sheet has now been added to the Infection Control Manual, signed on June 6, 2012.</p> <p>The Infection Control Manual has been reviewed by Dr. Robert Hammer, the facility Medical Director on June 6, 2012, and signed. Jeanette Stephens RN DON has also reviewed and signed. Policies</p>



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F 441	Continued From page 17 policy was in the manual staff should be aware of it. Interview with the Administrator, on 05/10/12 at 3:00 PM, revealed she was unaware the Infection Manual did not have evidence the policies and procedures were reviewed and approved, and was not aware the manual did not reflect current DCD guidelines related to Universal Precautions.	F 441	and procedures will be updated to meet current and changing guidelines in accordance with the CDC. At the Quality Assurance meetings any changes or updates in CDC guidelines will be reviewed with all facility disciplines as well as with the Medical Director, the facility Administrator and the facility pharmacy consultant. An annual review with signatures will be done every June. The next quarterly QA meeting is due July, 2012. The current LSP Administrator will review and sign the Infection Control/Universal Precaution Policy and Procedure. The facility Administrator will be present at quarterly Quality Assurance meetings. The facility maintains infection records by utilizing an in house Monthly Infection Report that tracks the type of infection and of treatment. The facility also utilizes infection reports generated through our pharmacy service and through our lab provider. This information is then shared at the quarterly Quality Assurance meetings.	6/7/12	



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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: 1990</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type II (222)</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 05/09/12. Little Sisters of the Poor was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for thirty five (35) beds with a census of thirty three (33) 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	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;"> <p>RECEIVED</p> <p>JUN 22 2012</p> <p>OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE LICENSING AND SERVICES</p> </div>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X. A. Maureen Courtney</i>	TITLE <i>X. Administrator X 06-15-12</i>	(X6) DATE
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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 other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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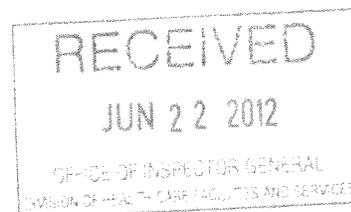
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K 000	Continued From page 1 Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	The cross corridor doors by the Chapel at the entrance to the Medical Hall did not seal when tested on the day of the survey, May 9, 2012.	
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for thirty five (35) beds with a census of thirty three (33) on the day of the survey. The findings include: Observation, on 05/09/12 at 1:36 PM, with the Maintenance Director revealed the cross-corridor doors located in the Medical Hall by the Chapel did not seal when tested, leaving a gap larger than ¾ of an inch at the top.	K 027	All of the Maintenance Staff were instructed to correct this deficiency and to call the proper persons on May 10 th , 2012 to place these important doors in total compliance. Contacts were made by the Administrator to Wehr Contractors. Since the company which installed them was no longer available Claude "Skip" Berry recommended that we contact a local person to begin the total inspection. The inspection of the cited doors revealed that the top parts of the door were "warped" and no longer closing properly. Bill Graves, the Project Manager from Schiller Hardware ordered new doors to meet the NFPA standards and replaced these doors on May 31, 2012. During the installation of these doors the Residents will be accompanied by staff members in order to arrive safely at their destinations (Activities, Chapel, Dining rooms, Service Areas or Medical areas.) (Continued)	



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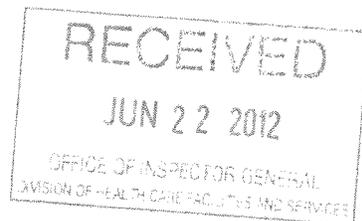
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NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR	STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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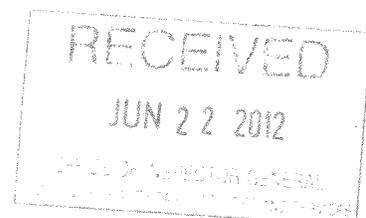
K 027	<p>Continued From page 2</p> <p>Interview, on 05/09/12 at 1:36 PM, with the Maintenance Director revealed they were unaware the doors did not seal properly.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>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 three (3) smoke compartments, residents, staff</p>	K 027	<p>(continued from previous page)</p> <p>The Maintenance Director will supervise this replacement and work directly with Schiller hardware to assure that all of the doors in the facility meet the requirements. At the initial inspection by Schiller Hardware no other immediate needs were determined. An inspection list will be kept in the maintenance office of each of the doors in the facility and its location. This list will include: 1) the location of the door; 2) date of inspection; 3) action to be completed; 4) person/s responsible for the work.</p> <p>Attached are copies from Schiller hardware for the proposed work. Also is the purchase order for the work from the facility.</p> <p>The Life Safety Corrections for the facility were discussed at the Safety Meeting, June 11th, 2012. All Life Safety citations will be presented to the Quality Assurance Meeting which meets quarterly each year. The next meeting is scheduled on July 18, 2012.</p> <p>See Attachments</p>	6/8/12
K 029 SS=D		K 029		



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K 029	<p>Continued From page 3</p> <p>and visitors. The facility is licensed for thirty five (35) beds with a census of thirty three (33) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/09/12 at 12:54 PM, with the Maintenance Director revealed the storage room in Office A had an abundance of hazardous material (paper records) stored in the room. The room was rated with a substantial door, but the door did not have a self-closing device.</p> <p>Interview, on 05/09/12 at 12:54 PM, with the Maintenance Director revealed they were not aware the door was required to be self closing.</p> <p>Reference:</p> <p>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 and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <p>(1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft²</p>	K 029	<p>In Office "A" a self closing device was placed on the door of the storage area on May 11, 2012. In addition, this storage area is completely inside of Office "A" The area contains paper, computer supplies and articles used for development.</p> <p>Residents are usually not in this restricted area. The Development Assistant uses this office and the supplies for her work. No Residents are usually involved in this office. The office is kept locked at all times when the staff person is not using it.</p> <p>All areas in the facility are checked to determine if there are proper closures for hazardous materials.</p> <p>The personnel in the area where this correction was made will contact the Administrator and/or the Maintenance Director. This counsel was re-enforced on May 12, 2012.</p> <p>(Continued)</p>	



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K 029 Continued From page 4
(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.
NFPA 101 LIFE SAFETY CODE STANDARD

K 029 (Continued from previous page.)
The Maintenance Director and his assistants were given a new issue of the NFPA Edition of the Life Safety Code. Reference to 19.3.2.1 was reviewed on May 12, 2012 in order that all personnel, including the Maintenance Director could understand the need to install fire rated doors in areas hazardous materials are stored. A sign will be placed on the door in Storage Room "A": **For Authorized Persons Only.**

This citation will be reviewed at the next Safety Meeting, June 11, 2012 and at the Annual Quality Assurance Meeting on July 18, 2012, and quarterly quality meetings each year.

K 045 SS=D
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

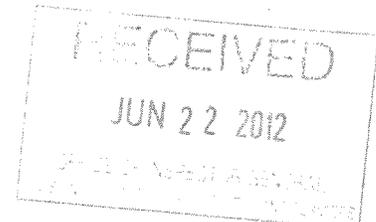
This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for thirty five (35) beds with a census of thirty three (33) on the day of the survey.

K 045
At the time of the Life Safety Survey, May 9, 2012, it was observed that the exterior exit was only equipped with a single bulb. This bulb illuminates the egress path to the public way from the exit.

The Maintenance Department made a thorough check of all exits and egresses from the main building.

The staff, including the Maintenance Director, was in-serviced on NFPA

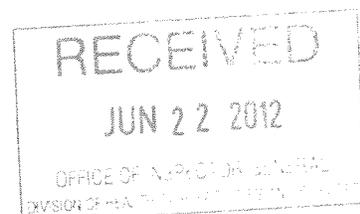
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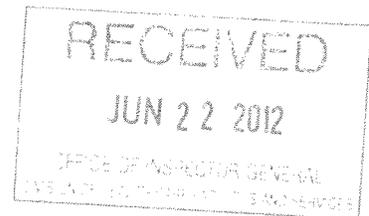
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K 045	Continued From page 5 The findings include: Observation, on 05/09/12 at 2:23 PM, with the Maintenance Director revealed the exterior exit at the John Hagan Porch was equipped with a single bulb for illuminating egress path to the public way from the exit. Interview, on 05/09/12 at 2:23 PM, revealed the Maintenance Director was unaware the lighting fixtures serving the exterior exits must include more than one bulb. Exit lighting must be arranged so the failure of a single bulb will not leave the exit in complete darkness. Reference: NFPA 101 (2000 edition) 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 ft-candle (2 lux) in any designated area.	K 045	7.8.1.4 referring to the necessity to have a second bulb in case of the failure of one. Leaving an area in total darkness for any period of time can seriously jeopardize those using this exit area. This is especially important for the more infirm residents who frequent this porch. Staff members were also alerted to inform 1) the charge nurse; 2) the maintenance department; 3) the Sister supervisor / administrator immediately when this light is not working properly. Meiner's Electric Company made the additional installation of June 1, 2012. The company will rely on the surveillance of the maintenance staff to assure this work. Copies of the bill and purchase orders are attached. This citation was reviewed at the Safety Meeting on June 11, 2012. It will also be presented to the Quality Assurance Committee at the next scheduled meeting on July 18, 2012.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 050	Photos of completed work are attached for reference.	6/12/12



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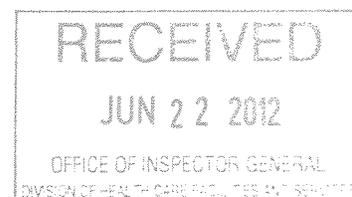
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K 050	Continued From page 6 This STANDARD is not met as evidenced by: Based on interview and Fire Drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff, and visitors. The facility is licensed for thirty five (35) beds with a census of thirty three (33) on the day of the survey. The findings include: Fire Drill record review, on 05/09/12 at 12:06 PM, with the Maintenance Director revealed the fire drills were not being conducted quarterly and at unexpected times under varied conditions. First shift fire drills were conducted routinely between 8:15 AM and 9:15 AM, Second shift fire drills were being conducted routinely between 4:00 PM and 5:10 PM, and Third shift fire drills were being conducted routinely between 5:00 AM and 6:06 AM. Interview, on 05/09/12 at 12:06 AM, with the Maintenance Director revealed he was unaware the fire drills were not being conducted as required on all shifts. This is a repeat deficiency from 2011. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied	K 050	The NFPA 101 Life Safety Code Standard clearly states that Fire Drills are to be conducted at unexpected times. On the day of the survey, May 9, 2012 the facility was cited for non-compliance with this regulation. This is a repeated deficiency. Sr. Chantal Peyton, the Mother Superior; Sr. Maureen Courtney, Administrator; the Director of Nursing; Assistant Director of Nursing; and Jennifer Gaines, the Human Resources Manager met with Charles Amback, the Engineer, on May, 15, 2012 to discuss this deficiency. In order to assure that this deficiency is corrected the following steps were stressed: <ul style="list-style-type: none"> • Inform the Mother Superior and the Administrator of the tentative times and dates of the next scheduled drills: • Drills must be rotated and scheduled during the three shifts. • Shift times are: Days: 7:00 – 3:30 Afternoons: 3:00 – 11:30 and Nights: 11:00 – 7:30 • There should be no "overlap" drills for two shifts. When an Alarm sounds during this time for either a fire or false alarm only <i>one shift can be counted for this alarm</i>: 		



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		K050	<ul style="list-style-type: none"> Report to the Administrator any difficulties with the times of "silent drills" (acceptable during the night shift): The Signed Attendance Sheets will be reviewed by the Administrator within 24 hours of the drill: The Maintenance Engineer is responsible to coordinate with the In-Service Director and Human Resources Manager for the dates and times of the Mandatory Fire In-Service each year. Those In-Services will not count as a "drill". <p>A memo of this meeting was drafted by Ms. Gaines, Human Resource Manager, in regard to the plans for correcting this citation. Minutes of the meeting are attached to this response.</p> <p>The Administrative Staff realize the importance of this regulation and have stressed the need of compliance immediately. This deficiency was presented to the Life Safety committee which met on June 11, 2012. It will be reviewed at the Quality Assurance Meeting on July 18, 2012.</p> <p>The Quality Assurance Committee will be informed at each quarterly meeting of the compliance of this regulation. See Attachment.</p>	6/12/12	



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K 050 Continued From page 7 conditions on all shifts.

K 051 SS=D NFPA 101 LIFE SAFETY CODE STANDARD

A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6

K 050

K 051

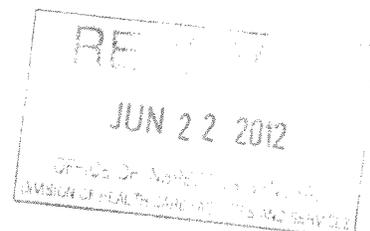
An observation on May 9, 2012 revealed that an exit door in the Arts and Crafts Room did not have a manual fire pull station with five feet of the exit door.

Since there is already one fire pull station in the room, one is needed to be installed within the required footage of the exit doors. The residents do not use this space on a regular basis. However, some senior volunteers do use it for activities.

The Maintenance Director and the key staff were instructed on the instructions cited in the NFPA 72 (1999 Edition) as to the importance of more alarms being placed in a conspicuous unobstructed and accessible area. This fire alarm box must be securely mounted and visible to those using this area. Volunteers who use this space were made aware of the importance and necessity of this pull station.

This STANDARD is not met as evidenced by:
Based on observation and interview it was determined the facility failed to ensure the building fire alarm system was installed as required by NFPA standards. The deficient practice has the potential to affect one (1) of three

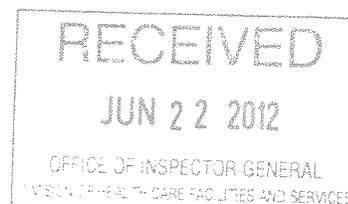
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K 051	<p>Continued From page 8</p> <p>(3) smoke compartments, residents, staff, and visitors. The facility is licensed for thirty five (35) beds with a census of thirty three (33) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/09/12 at 1:24 PM, with the Maintenance Director revealed an exit door in the Crafts Room did not have a manual fire pull station located within five (5) feet of the exit door.</p> <p>Interview, on 05/09/12 at 1:24 PM, with the Maintenance Director revealed he was not aware a pull station for the fire alarm was to be located within five (5) feet of each exit door.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>5.12 Manually Actuated Alarm-Initiating Devices.</p> <p>5.12.1 Manual fire alarm boxes shall be used only for fire alarm-initiating purposes.</p> <p>5.12.2 Combination manual fire alarm boxes and guard ' s signaling stations shall be permitted.</p> <p>5.12.3 Each manual fire alarm box shall be securely mounted.</p> <p>5.12.4 The operable part of each manual fire alarm box shall be not less than 1.1 m (3½ ft) and not more than 1.37 m (4½ ft) above floor level.</p> <p>5.12.5* Manual fire alarm boxes shall be located throughout the protected area so that they are conspicuous, unobstructed, and accessible.</p> <p>5.12.6 Manual fire alarm boxes shall be located within 1.5 m (5 ft) of the exit doorway opening at each exit on each floor.</p> <p>5.12.7 Manual fire alarm boxes shall be mounted</p>	K 051	<p>(continued from previous page)</p> <p>A pull station was installed on May 31, 2012 by Simplex Electric Company closer to the exit door. Simplex will be responsible for the upkeep of this alarm and any which are in the facility at this time.</p> <p>The Maintenance Director and his staff will be totally responsible to report to Administration on the status of this correction.</p> <p>This citation was presented at the Safety Meeting, June 11th and will be reviewed at subsequent meetings. It will also be presented to the Quality Assurance Committee at their quarterly meeting, July 18, 2012</p> <p>Photos of this completed work are attached for reference.</p> <p>6/12/12</p>



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K 051 Continued From page 9
on both sides of grouped openings over 12.2 m (40 ft) in width, and within 1.5 m (5 ft) of each side of the opening.
5.12.8* Additional manual fire alarm boxes shall be provided so that the travel distance to the nearest fire alarm box will not be in excess of 61 m (200 ft) measured horizontally on the same floor.

K 062 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E
Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained as required. The deficiency had the potential to affect two (2) of three (3) smoke compartments, residents, staff, and visitors. The facility is licensed for thirty five (35) beds with a census of thirty three (33) on the day of the survey.

The findings include:
Observation, on 05/09/12 between 1:00 PM and 2:40 PM, with the Maintenance Director revealed paint on the sprinkler heads located in storage room #8, also in the shower room across from room #1222.

Interview, on 03/22/12 at 10:54 AM, with the Maintenance Director revealed he was not aware

K 051
K 062
On the day of the survey, May 9, 2012 the sprinkler system and its condition and its records were reviewed. Observations included some of the following:

- 1) A more current inspection by the Brown Sprinkler Company was completed on May 14th, 2012.
- 2) The sprinklers designated in the room across from Room 1222 were removed and replaced by the assistant engineer, J. Spears on May 17, 2012.
- 3) Storage that was observed in Room #8 of the Dietary Department was removed on May 10, 2012. The Dietary Manager, Debra Anderson and the Sister Supervisor, Sr. Grace will monitor this area daily. On of the Assistant Engineers will check this weekly.

(continued)

JUN 22 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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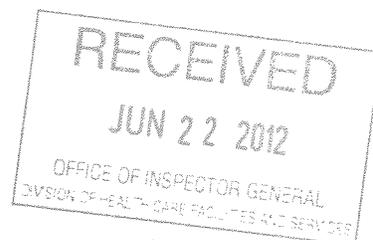
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NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR	STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217
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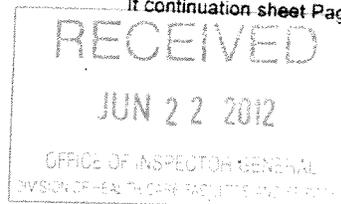
K 062	<p>Continued From page 10 the sprinklers in the attic were blocked by insulation.</p> <p>Observation, on 05/09/12 at 1:49 PM, with the Maintenance Director revealed storage within 18 inches of a sprinkler head located in the Dietary Managers Office Storage Closet.</p> <p>Interview, on 05/09/12 at 1:49 PM, with the Maintenance Director revealed he was aware items could not be stored within 18 inches of a sprinkler head, but not sure who placed the items so close.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the</p>	K 062	<p>(continued from the previous page.)</p> <p>4) A steel cupboard was purchased on May 18, 2012 for the flammable containers and is kept locked. The cupboard is located in the lower level office area of the engineer. The key is only available to those personnel.</p> <p>5) The Dietary Manager, Maintenance Director and staff were made aware of this deficient practice. The Dietary Supervisor, Sr. Grace will oversee all of the stored items in that area.</p> <p>6) The Administrator purchased an updated version of the Life Safety Code for their reference. The Human Resources Manager and Business Managers will assure that the maintenance staff is well aware of NPFA 5. 12.6</p> <p>This citation was presented at the Safety Committee at the meeting, June 11, 2012. It will also be discussed at the quarterly Quality Assurance meeting which will meet on July 18, 2012.</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 062	Continued From page 11 density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 062	Reference in 062 regarding: 03/22/12 at 10:54 does not seem to apply to this facility. Please advise. Photos Attached	6/12/12	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076			



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K 076 Continued From page 12

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored in accordance with NFPA standards. This deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff, and visitors. The facility is licensed for thirty five (35) beds with a census of thirty three (33) on the day of the survey.

The findings include:

Observation, on 05/09/12 at 2:48 PM, with the Maintenance Director revealed one (1) E cylinder oxygen tank stored in a closet next to the Activities Office. The tank was not secured in a rack and the room did not have signage indicating oxygen was stored inside.

Interview, on 05/09/12 at 2:48 PM, with the Maintenance Director revealed they were not aware the oxygen tanks needed signage indicating they were in the room.

Reference: NFPA 99 (1999 edition)
8-3.1.11.2

Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3)
(A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible

K 076

On the day of the survey, May 9, 2012 an oxygen cylinder was found stored in the room next to the Activities Department.

The Activities Staff were not aware than this tank was left in that area.

The Oxygen cylinder left outside the door of the Activities office was secured and placed in the proper storage area immediately on May 9, 2012 at the time of survey.

The Director of Nurses, Ms. Stephens, the Activity Staff, Maria Bertrand, Mary Amback, and Rose Bareis were informed at that time along with the staff on subsequent shifts of the proper place to store all oxygen cylinders. The Maintenance Director was assured that the tanks stored in that area are clearly marked and in the proper places. Chains are placed on the full cylinders.

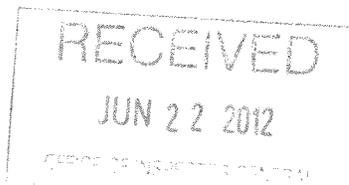
(Continued)



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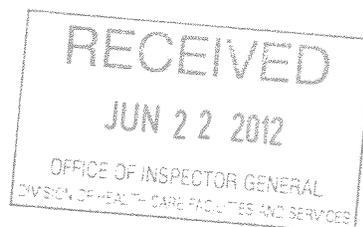
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K 076	Continued From page 13 construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 076	(Continued from previous page) The required signage is on the door. This sign was placed <i>in that area several years ago</i> . Photos of the room are attached. Precautionary signs which are readable from a distance are conspicuously displayed on each door or gate of the storage room. Further, all residents rooms containing oxygen or oxygen compressors have a sign on the entrance to the room. The members of the Safety Committee discussed this deficient practice at their meeting, June 11, 2012. Further, The Quality Assurance Committee will review these at their next scheduled meeting, July 18, 2012. Attachments: Copies of signs	6/12/12	
K 130 SS=D	This STANDARD is not met as evidenced by: Based on observation and interview, it was				



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K 130	Continued From page 14 determined the facility failed to ensure candles used in the facility were maintained under continuous supervision. The deficiency had the potential to affect one (1) of the three (3) smoke compartments, residents, staff, and visitors. The facility is licensed for thirty five (35) beds with a census of thirty three (33) on the day of the survey. The findings include: Observation, on 05/09/12 at 1:31 PM, with the Maintenance Director revealed a single candle burning in the Chapel that was unsupervised. Interview, on 05/09/12 1:31 PM, with the Maintenance Director revealed he thought the candle could be unsupervised due to religious reasons. Reference: CMS letter (S&C-07-07) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: 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	K 130	At the time of the survey, May 9, 2012 the following was cited: A Single Candle which burns on the altar next to the Tabernacle was unsupervised. It usually burns day and night. Since this candle is no longer permitted, the Candle will be replaced with an electric lamp. The facility will purchase an electric lamp 12 inches high and 6 inches wide with a six foot cord. This lamp can only be purchased with a UL approved electrical cord. Purchase is anticipated by June 15, 2012. Installation will follow during the week of June 18 th . This deficiency was presented at the Safety Committee meeting on June 11, 2012. The Maintenance Director and Administrator will discuss this further at the next scheduled Quality Assurance Meeting, July 18, 2012.	6/20/12
K 147 SS=D				



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K 147 Continued From page 15
affect one (1) of three (3) smoke compartments, residents, staff, and visitors. The facility is licensed for thirty five (35) beds with a census of thirty three (33) on the day of the survey.

The findings include:

Observations, on 05/09/12 between 12:00 PM and 1:30 PM, with the Maintenance Director revealed:

- 1) An extension cord was plugged into a power strip located in Office C.
- 2) Two (2) power strips were plugged into a multi plug adaptor located in Office D.
- 3) Storage in front of electrical panels located in the Chapel Storage Room.

Interview, on 05/09/12 between 12:00 PM and 1:30 PM, with the Maintenance Director revealed they were not aware of the storage in front of electrical panels, or the misuse of power strips, and extension cords.

This is a repeat deficiency from 2011.

Reference: NFPA 99 (1999 edition)
3-3.2.1.2 D

Minimum Number of Receptacles. The number of receptacles shall be determined by the

K 147

On the day of the annual survey, May 9, 2012 the following deficiencies were observed.

The Administrator, President and key staff persons met with the Engineer and all of the persons involved in regard to the requirements of NFPA 3-3.2.1.2D. Discussed was the importance of *not having any storage obstructing the electrical panels - in any area of the Home.* The following citations mandated immediate correction:

- 1) An extension cord plugged into a power strip in Office "C" was removed. The placement of this cord was the desire of the staff person in that office. The Maintenance Engineer will be totally responsible for the enforcement of this regulation. One of the members of that department will check at least weekly to assure that this regulation is kept.



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K 147	<p>Continued From page 16 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> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p>	K 147	<p>2) The existing "surge protector was removed and placed in the power strip which was placed in the receptacle in the wall. The Maintenance Engineer will be responsible for the enforcement of this regulation. One of the members of that department will check at least weekly to assure that this regulation is kept.</p> <p>3) Items in front of the Electrical Panel in the Chapel Storage Room were removed. The remaining cabinets are for the storage of music materials and of steel construction. A sign is posted as a reminder to all who have access to this room. This area, too, will be checked at least weekly by the Maintenance Department.</p> <p>Routine inspections all areas of the facility are made by the Maintenance Staff. Extreme importance is placed on the areas where multiple electrical equipment is used for the care of the Residents. Reminders are given to the staff on the importance of this regulation</p>	
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K 147		K 147	<p>(Continued from the previous page.)</p> <p>The Safety Committee met on June 11, 2012 and discussed this and each of the deficiencies of the Life Safety Code. In addition, they will be presented at the next Quality Assurance Meeting which meets on July 18, 2012.</p>	6/12/12
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