

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

PRINTED: 03/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185466	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/14/2013
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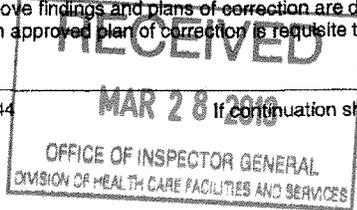
NAME OF PROVIDER OR SUPPLIER WESTPORT PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 4247 WESTPORT ROAD LOUISVILLE, KY 40207
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F 000	INITIAL COMMENTS A Health recertification survey was conducted from 03/12/13 through 03/14/13 and a Life Safety Code survey was conducted on 03/13/13. Deficiencies were cited with 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.	F 000	The submission of this Plan of Correction does not indicate an admission by Westport Health Care Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Westport Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities for title 18/19 programs. To this end, this plan of correction shall serve as the credible allegation of compliance with all the state and federal requirements governing the management of this facility. It is thus submitted as a matter of status only.	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined the facility failed to complete a quarterly Resident Assessment Inventory (RAI) within the time frame allotted by federal guidelines for one (1) of fifteen (15) sampled residents, Resident #1. The Findings Include: Review of the Centers for Medicare and Medicaid Services (CMS's) Resident Assessment Inventory (RAI) 3.0 Manual (Dated October 2011), revealed the quarterly (non-comprehensive) assessment was to be completed no later than ninety-two (92) days from the Assessment Reference Date (ARD) of a previous assessment of any type. Review of the clinical record revealed the facility admitted Resident #1 on 09/01/2012 with	F 276	F-276 1. The quarterly assessment for Resident #1 was completed on 3/13/13. No adverse effects for resident as a result of non completion of the assessment. 2. Campus Support- Resident Assessment person reviewed MDS Master Schedule and MDS Due Report on 3/13/13 to determine OBRA assessments out of compliance. All non-compliant assessments will be current by 4/21/13. 3. Education for Interdisciplinary Team will be held on 3/25 and 3/27/13 with emphasis on OBRA required assessments and completion dates, implementation of Master MDS schedule to monitor OBRA Assessments and how to generate MDS Date report from MDS Software.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Stephanie...</i>	TITLE <i>Executive Dir.</i>	(X6) DATE <i>3/28/13</i>
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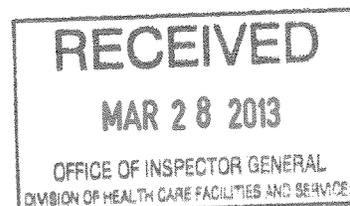
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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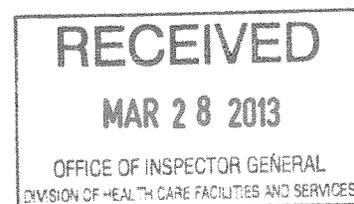
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F 276	Continued From page 1 diagnoses of Ischemic Bowel Obstruction, Paralytic Ileus, Gastroenteritis and Colitis, Chronic Diastolic Congestive Heart Failure, Atrial Fibrillation, Hypothyroidism, Hypercholesterolemia, Severe Pulmonary Hypertension, and Barrett's Esophagus. Resident #1's clinical record contained the admission (comprehensive) assessment dated 09/08/12, and the quarterly assessment dated 11/19/12, but the facility had not completed the quarterly Minimum Data Set (MDS) assessment due 03/05/13, nine (9) days late. Interview, on 03/14/13 at 1:30 PM, with the facility's RAI/MDS Coordinator revealed Resident #1's quarterly assessment should have been completed no later than 03/05/13. The RAI/MDS Coordinator stated she was responsible for completion of the scheduled assessment, and a regional support staff person was responsible for completion of the residents' assessments in the event she had to be absent from work. Interview, on 03/14/13 at 3:05 PM, with the Director of Health Services (DHS) revealed the facility needed additional staff to assist with the MDS assessment process to ensure timely completion of the scheduled assessments.	F 276	F276 continued 4. Ongoing compliance will be maintained by MDS Coordinator who will generate MDS Due Report monthly and by running MDS Date Report bi-weekly. With the use of the campus Monthly MDS Calendar and CMS Validation reports, audits will be conducted to insure timely completion of OBRA Assessments. Audits will be completed by DHS/ADHS/MDS as follows: 3 OBRA assessments weekly x 3 months, then 6 assessments monthly x 2 months, then scheduled assessments monthly until substantial compliance is achieved. Audits will be reviewed in Monthly QA meetings and will continue until substantial compliance is reached for 3 consecutive months. Compliance will also be reviewed quarterly as part of campus clinical review by Home Office.	4/21/2013
F 371 SS=F	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	F 371	F371 POC on next page	



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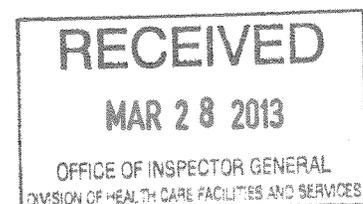
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F 371	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to ensure open foods were sealed, labeled, and/or dated in one (1) of one (1) freezer and one (1) of one (1) refrigerator. The facility failed to ensure kitchen appliances were clean for two (2) of two (2) appliances (stove and deep fryer). The facility failed to ensure the cleaning schedule was followed and documented. In addition, the facility failed to ensure the kitchen staff wore beard covers for three male staff members.</p> <p>The findings include:</p> <p>Review of the kitchen Sanitation and Safety Policy, dated 2009 revealed: hair restraints shall be used by kitchen staff; and leftovers must be labeled and dated</p> <p>Tour of the kitchen, on 03/12/13 at 8:20 AM, revealed, a container of peaches and a container of sour cream not dated when opened. There were two (2) partial bottles of tomato juice dated 01/16/13, and 4 salads without dates in the free standing two door refrigerator. The walk-in refrigerator had a pan of sliced ham which was uncovered/ no date. In the freezer there were chicken fingers, not dated. There was a scoop lying in the flour of the flour bin. The KitchenAid mixer had a white substance on the metal bowl. The convection oven had a brown/black substance on the floor of the oven.</p>	F 371	<p>F-371</p> <p>1. All food items in the free standing refrigerator and walk in refrigerator not labeled or dated were disposed of immediately. This included the container of peaches and sour cream and two bottles of tomato juice and pan of ham. Items in the freezer were labeled and dated and wrapped. 2. On 3/12/13 no residents showed any signs of food related illness, therefore no residents were affected. On 3/12/13 staff were informed to cover all exposed hair. DFS observed dietary staff to determine if appropriate beard covers were in place. The stove and deep fryer were cleaned and the oil in the deep fryer was changed.</p> <p>All kitchen equipment was cleaned and new cleaning checklist were posted. Male staff put on beard covers who had facial hair present.</p> <p>3. Director of Food Service inserviced staff on 3/25/2013 regarding sanitation and food storage policies, cleaning tasks and checklists that are to be followed daily and weekly, Labeling and dating of all food with "Date Opened" and "Use by Date". Cleaning of all equipment including a new schedule of changing the oil in the fryer on Friday night and Wednesday and anytime that it is used to cook seafood. The inservice covered the need for males to wear beard covers if any facial hair present.</p>



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F 371	Continued From page 3 Continued observation, at this time, revealed a brown/white coating on the back splash behind the grill. The grease in the fryer was dark and had sediment floating in the grease. Currently, the fryer oil is changed on Thursdays and the kitchen serves fried fish on Fridays' In addition, there were three (3) male kitchen staff with facial hair and were not wearing beard covers. Review of the cooks and aides cleaning schedule revealed there were no cleaning chores documented as completed for cooks since 02/14/13 and for aides since 02/17/13. Interview with the Director of Food Services, on 03/13/13 at 1:30 PM, revealed he was in the process of creating a new cleaning schedule. Because the old schedule had no checks for assigned tasks, he was unable to validate the old schedule had been followed. He stated he was not aware non-food items were not discarded after seven days. He stated the male staff with facial hair should wear beard covers. He stated he was unaware of the importance of changing the fryer oil after fish had been cooked in the oil.	F 371	F-371 continued Director and Assistant Directors of Food Service will be responsible to monitor cleaning schedules and all labeling and dating policies are followed. 4. Sanitation audits will be completed once a month for six months and will be maintained and reviewed in monthly QAA meeting. Director of Food Service and Assistant food Service Dir. will check for foods being dated as part of daily rounding in the kitchen. These items will also be reviewed in monthly QAA as well as during visits by Dietary Support and Dietician.	4/21/2013	



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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: 2010, 2012</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet and dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 03/13/13. Westport Place Health Campus was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty two (62) beds with a census of fifty one (51) 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		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>[Signature]</i>	(X6) DATE <i>3/28/13</i>
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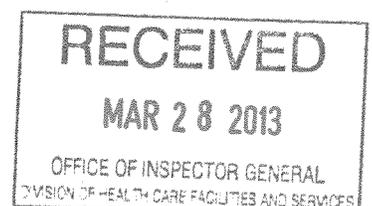
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RECEIVED
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If continuation sheet Page 1 of 19
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH CARE FACILITIES AND SERVICES

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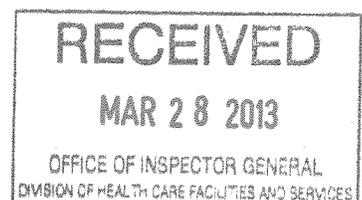
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K 000	Continued From page 1	K 000		
K 029 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</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 two (2) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for sixty two (62) beds with a census of fifty one (51) on the day of the survey. The facility failed to provide self-closing devices for doors protecting hazardous areas.</p> <p>The findings include:</p> <p>Observation, on 03/13/13 between 9:30 AM and 2:30 PM, with the Director of Plant Operations revealed rooms required being self-closing or containing a hazardous amount of combustibles did not have self-closing device to keep the door closed. The rooms identified as hazardous requiring a self-closing device were the Kitchen Bathroom, Janitor Closet in the Kitchen, a closet</p>	K 029	<p>K-029</p> <p>No residents affected by cited deficiency. All doors to hazardous areas were checked by DPO on day of survey, no other problems found.</p> <p>Director of Plant Operations installed self closing devices on kitchen bathroom door, Janitor Closet in the kitchen, a closet located in the Director of Resident Programs office, Medical Records Office , and Clean Linen Room door to the laundry.</p> <p>Work was completed on 03/21/2013.</p> <p>DPO to make monthly inspections of all hazardous areas protected by the automatic self closing devices and that they are working properly to ensure that the deficient practice does not recur. DPO will report findings at monthly QAA and Safety meeting to ensure our solution is sustained and compliance is maintained.</p>	4/21/13



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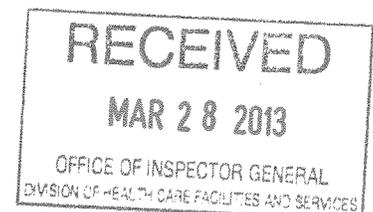
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K 029	<p>Continued From page 2</p> <p>located in the Director of Resident Programs, Medical Records Office, and the Clean Linen Room door to the Laundry.</p> <p>Interview, on 03/13/13 between 9:30 AM and 2:30 PM, with the Director of Plant Operations revealed he was not aware the doors to these rooms were required to be self-closing.</p> <p>Interview, on 03/13/13 at 3:00 PM, with the Executive Director revealed she was aware of the requirements for doors protecting hazardous areas.</p> <p>8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions</p>	K 029		



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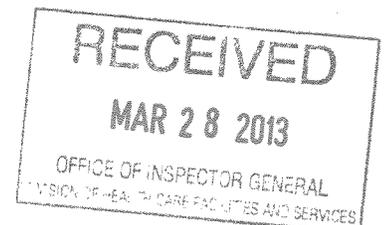
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K 029	<p>Continued From page 3</p> <p>and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. <p>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.</p> <p>18.3.2 Protection from Hazards. 18.3.2.1* Hazardous Areas. Any hazardous area shall be protected in accordance with Section 8.4. The areas described in Table 18.3.2.1 shall be protected as indicated.</p> <p>Table 18.3.2.1 Hazardous Area Protection</p> <p>Hazardous Area Description Separation/Protection Boiler and fuel-fired heater rooms 1 hour Central/bulk laundries larger than 100 ft² (9.3</p>	K 029			



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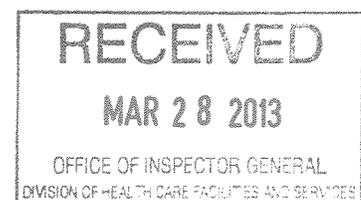
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K 029	Continued From page 4 m2)1 hour Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard See 18.3.6.3.4 Laboratories that use hazardous materials that would be classified as a severe hazard in accordance with NFPA 99, Standard for Health Care Facilities 1 hour Paint shops employing hazardous substances and materials in quantities less than those that would be classified as a severe hazard 1 hour Physical plant maintenance shops 1 hour Soiled linen rooms 1 hour Storage rooms larger than 50 ft2 (4.6 m2) but not exceeding 100 ft2 (9.3 m2) storing combustible material See 18.3.6.3.4 Storage rooms larger than 100 ft2 (9.3 m2) storing combustible material 1 hour Trash collection rooms 1 hour	K 029		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiencies had the potential to affect seven (7) of seven (7) smoke compartments, residents,	K 038	K-038 POC on next page	



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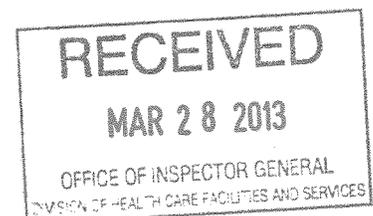
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	<p>Continued From page 5</p> <p>staff and visitors. The facility is certified for sixty two (62) beds with a census of fifty one (51) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 03/13/13 between 9:30 AM and 2:30 PM, with the Director of Plant Operations revealed the delayed egress doors located throughout the facility were equipped with delayed egress doors; however, the signage did not have a contrasting background making the signage easily visible.</p> <p>Interview, on 03/13/13 between 9:30 AM and 2:30 PM, with the Director of Plant Operations revealed he was not aware the delayed egress signage was required to be on a contrasting background.</p> <p>Interview, on 03/13/13 at 3:00 PM, with the Executive Director revealed she was not aware the delayed egress signage was required to be on a contrasting background.</p> <p>Reference:</p> <p>NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic</p>	K 038	<p>K-038</p> <p>No residents affected by cited deficiency. Director of Plant Operations ordered delayed egress door signs that are on a contrasting background, red lettering on white background in 1 inch high lettering. The new signs were ordered 3/19/2013 and are expected to arrive at campus in two weeks and DPO will install on all facility doors that have delayed egress by 4/12/2013. DPO will install new egress signs on all 13 doors with delayed egress by 4/12/2013. DPO will complete monthly inspection of all delayed egress doors to ensure that deficient practice does not recur. DPO will report findings to QAA and Safety monthly to ensure that our solution is sustained and compliance is maintained.</p>	4/21/13



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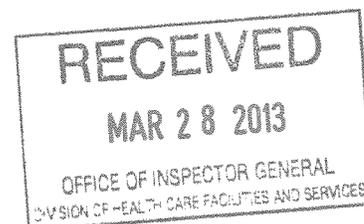
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K 038	Continued From page 6 fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual	K 038			



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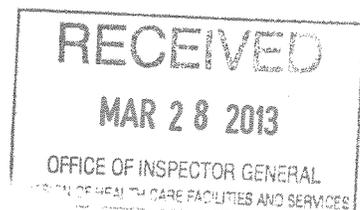
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K 038	<p>Continued From page 7 means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.</p> <p>7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit.</p>	K 038		



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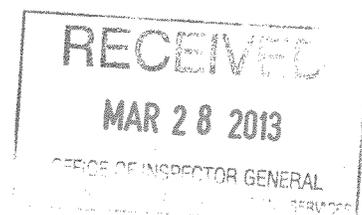
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K 038	Continued From page 8 Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.	K 038		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed with continuous illumination also served by the emergency lighting system in accordance with section 7.10. 18.2.10.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for sixty two (62) beds with a census of fifty one (51) on the day of the survey. The facility failed to ensure exits were clearly recognizable with proper exit signage. The findings include:	K 047	K-047 No residents affected by the cited deficiency. DPO contacted Beula Electric to install the lighted exit signs above the kitchen exit doors to make the path of egress clearly recognizable. This work was completed on 3/20/2013. DPO will complete Life Safety tours monthly and will ensure that the exit lighting in all areas of the building are in place and functioning properly to ensure this deficient practice does not recur. DPO will report monthly to QAA and Safety his findings to ensure that our solutions are sustained and compliance is maintained.	4/21/13



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K 047	Continued From page 9 Observation, on 03/13/13 at 1:18 PM, with the Director of Plant Operations revealed the exit doors located in the Kitchen did not have an exit sign above the door making the path of egress clearly recognizable. Interview, on 03/13/13 at 1:18 PM, with the Director of Plant Operations revealed he was not aware the exits did not have proper signage. Interview, on 03/13/13 at 3:00 PM, with the Executive Director revealed she was not aware the exits did not have proper signage. Reference: NFPA 101 (2000 edition) 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.	K 056	POC on next page	



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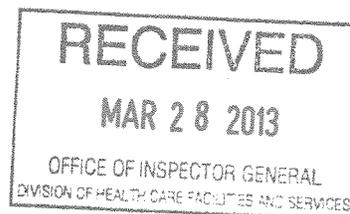
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K 056	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, installed in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for sixty two (62) beds with a census of fifty one (51) on the day of the survey. The facility failed to ensure sprinkler heads installed in a compartment were of the same temperature response type. The findings include: Observations, on 03/13/13 between 9:30 AM and 2:30 PM, with the Director of Plant Operations revealed mixed response sprinkler heads located in the Kitchen. Interview, on 03/13/13 between 9:30 AM and 2:30 PM, with the Director of Plant Operations revealed he was not aware of the requirement for sprinkler heads being of the same response rating in a compartment. Interview, on 03/13/13 at 3:00 PM, with the Executive Director revealed she was not aware of the installation requirements for sprinklers.	K 056	K-056 No residents affected by cited deficiency. Director of Plant Operations checked all sprinkler heads on 3/15/2013 and no others were out of compliance. Director of Plant Operations has contacted Kelly Fire Sprinkler Protection Company to schedule them to change all the quick response sprinkler heads to the same temperature response type heads within the same compartment of the kitchen. Kelly Fire and Sprinkler Protection is now scheduled to make these changes on 4/04/2013. DPO will check all sprinkler heads each month to ensure that all the sprinkler heads installed in the same compartment are the same temperature response type sprinkler heads. DPO will report these findings in QAA and safety meetings monthly to ensure that our solutions are sustained and compliance maintained.	4/21/13



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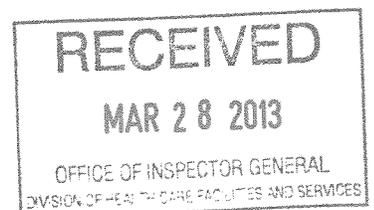
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K 056	Continued From page 11 Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the 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 056		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	K-144 POC on next page	



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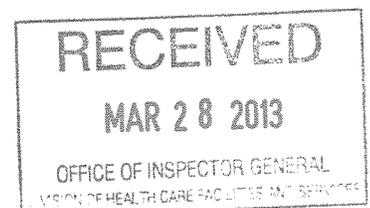
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K 144	Continued From page 12 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff, and visitors. The facility is certified for sixty two (62) beds with a census of fifty one (51) on the day of the survey. The findings include: Observation, on 03/13/13 at 10:19 AM, with the Director of Plant Operations revealed the facility did not document the time it took for the generator to transfer power in the event of a power interruption. Interview, on 03/13/13 at 10:19 AM, with the Director of Plant Operations revealed he was not aware the transfer time was to be documented. Interview, on 03/13/13 at 3:00 PM, with the Executive Director revealed she was not aware the transfer time was to be documented. Reference: NFPA 99 (1999 Edition). 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered,	K 144	K-144 No residents affected by cited deficiency. Director of Plant Operations has updated the Generator Log Sheet to include the transfer time. He will document the transfer time during the monthly load test. If transfer is longer than 10 seconds then the service contractor will be called for needed repairs to the transfer switch. DPO made the correction to the Generator Log Sheet on 3/14/2013 and conducted monthly load test on 3/14/2013 and documented the transfer time as 8 seconds. DPO will complete his monthly generator load test and document the transfer time on the log sheet to ensure the deficient practice does not recur. DPO will report the findings monthly at the QAA and Safety meeting to ensure that our solution is sustained and compliance is maintained.	4/21/13



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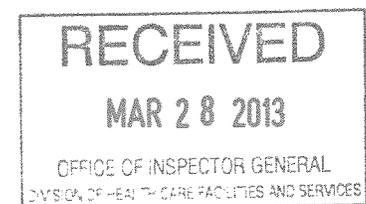
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K 144	<p>Continued From page 13</p> <p>shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.)</p> <p>The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>a. Individual visual signals shall indicate the following:</p> <ol style="list-style-type: none"> 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning <p>b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-3.1 The Level 1 or Level 2 EPS equipment location shall be</p>	K 144		



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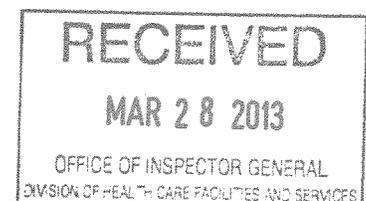
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K 144	<p>Continued From page 14 provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.</p> <p>Reference: NFPA 99 (1999 Edition)</p> <p>Actual NFPA Standard: NFPA 99, 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1.</p> <p>(b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b).</p> <p>Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p> <p>Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to</p>	K 144		



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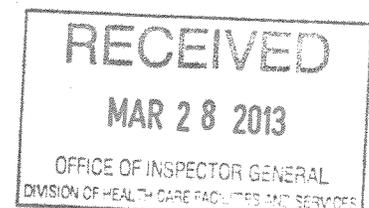
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K 144	Continued From page 15 be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. (b) Inspection and Testing. 1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. 2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads. 3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures. Actual Standard: NFPA 99, 3- 3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	K-147 Director of Plant Operations removed extension cords out of the following locations: 3 cords removed from resident room 513 1 cord removed from resident room 108 1 cord removed from resident room 511 1 cord removed from resident room 512 1 cord removed from Health Care Salon	



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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185466	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - WESTPORT PLACE HEALTH CAMPUS B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2013
NAME OF PROVIDER OR SUPPLIER WESTPORT PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 4247 WESTPORT ROAD LOUISVILLE, KY 40207	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	<p>Continued From page 16</p> <p>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 affect two (2) of seven (7) smoke compartments, residents, staff, and visitors. The facility is certified for sixty two (62) beds with a census of fifty one (51) on the day of the survey. The facility failed to maintain proper use of extension cords.</p> <p>The findings include:</p> <p>Observations, on 03/13/13 between 9:30 AM and 2:30 PM, with the Director of Plant Operations revealed:</p> <ol style="list-style-type: none"> 1) Three (3) extension cords in use located in room #513. 2) An extension cord located in room #108, 511, and 512. 3) An extension cord to a hair dryer located in the HC Salon. <p>Interview, on 03/13/13 between 9:30 AM and 2:30 PM, with the Director of Plant Operations revealed he was not aware of the misuse of extension cords.</p> <p>Interview, on 03/13/13 at 3:00 PM, with the Executive Director revealed she was aware of the requirements for extension cords; however, she was not aware of the misuse.</p> <p>Reference: NFPA 99 (1999 edition)</p>	K 147	<p>K-147 continued</p> <p>Director of Plant Operations completed second Life Safety Tour of entire campus on 3/14/2013 to check that no other extension cords were being used in the campus. None found during this inspection.</p> <p>Director of Plant Operations had Beula Electric Company install two GFCI receptacles in the Health Care Salon to eliminate the need for any extension cords. All residents residing on the 500 hall of the Assisted Living have signed the Admission Agreement prohibiting the use of extension cords. DPO spoke to the residents in room 513, 511, 512, and room 108 to explain the policy prohibiting the use of extension cords on 3/14/2013.</p> <p>Director of Plant Operations will complete monthly Life Safety Tour that includes all resident rooms in the Assisted Living as well as the Health Care Center. His tours will include checking for the use of extension cords to ensure that the deficient practice will not recur. DPO will report the findings monthly at QAA and Safety to ensure that our solution is sustained and that compliance is maintained.</p>	



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

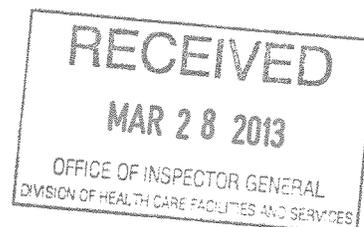
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K 147	<p>Continued From page 17 3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <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> <p>Reference: NFPA 70 (1999 edition)</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>370.28(c) Covers.</p> <p>All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.</p> <p>Reference: NFPA 101 (2000 Edition)</p>	K 147		4/21/13
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K 147	Continued From page 18 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147		4/21/13

