

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

PRINTED: 10/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/07/2010
NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219		
(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 survey and abbreviated surveys KY14705, KY14753, and KY15160 were conducted 10/05/10 through 10/07/10, and a Life Safety Code Survey was conducted on 10/06/10. Deficiencies were cited, with the highest scope and severity of an "F" with the facility having the opportunity to correct deficiencies before remedies would be recommended for imposition.</p> <p>KY14705, KY14753, and KY15160 were found to be substantiated.</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</p>	F 225	<p>The submission of this Plan of Correction does not indicate an admission by Franciscan Health Care Center that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Franciscan Health Care Center. This facility recognized 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 state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE  
*x Remy Adkins - PLS* *x ED* *x 10/29/10*

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.

OCT 29 2010

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

PRINTED: 10/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/07/2010
NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219	
(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 225	<p>Continued From page 1 prevent further potential abuse while the investigation is in progress.</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 policy, it was determined the facility failed to thoroughly investigate and report an injury of unknown source for one (1) resident (#13) of twenty-five (25) sampled residents. The specific cause of injury to Resident #13's leg was not observed by facility staff nor did the resident know how the injury occurred. The facility failed to report the injury in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The findings include:</p> <p>Review of the facility's Abuse and Neglect Procedural Guidelines revealed that injuries of unknown source mean an injury that occurs when the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. The source of the injury is not observed by any person or the source of the injury could not be explained by the resident AND</li> <li>2. The injury is suspicious in nature because of the extent of the injury or the location of the injury.</li> </ol>	F 225	<ol style="list-style-type: none"> <li>1. Resident #13 no longer resides in the facility.</li> <li>2. Resident incidents reviewed from previous 30 days to insure no others affected by the cited deficiency. None were.</li> <li>3. Facility staff inserviced by ED/DHS/designee related to abuse policy with emphasis on thorough investigation and reporting of injuries of unknown origin.</li> <li>4. Ongoing monitoring will be accomplished daily through Morning CQI meeting when all incidents and change in condition are discussed. Monthly QA meetings will also include review. Inservices on abuse are included in general orientation for new employees and annually as required. Reportables will also be monitored by Home Office Support staff during visits. Noncompliance will be addressed with appropriate disciplinary measures.</li> </ol>	11/20/10

OCT 23 2010

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

PRINTED: 10/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/07/2010
NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219		
(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 225	<p>Continued From page 2</p> <p>3. Reporting 24 hour initial reporting to applicable state agencies.</p> <p>4. A written report of the investigation outcome, including resident response and /or condition, final conclusion and actions taken to prevent reoccurrence, will be submitted to the applicable State Agencies within five days.</p> <p>Record review revealed Resident #13 was admitted to the facility on 04/02/10 with diagnoses that included: a history of falls, joint pain, dementia and congestive heart failure, (CHF). Record review of the Skilled Nursing Assessment and Data Collection dated 04/02/10 thru 04/10/10 revealed the facility assessed Resident #13 as alert, oriented x2, some difficulty in new situations and his/her skin was warm; dry and no skin impairment.</p> <p>Review of Nurse's Notes dated 04/10/10 for 8:30pm entry revealed the resident was found sitting at bedside with a right leg laceration/tear and was bleeding. The physician was notified, and the resident was transported via EMS to a local hospital for treatment and evaluation.</p> <p>An interview with Certified Nursing Assistant (CNA) #2, on 10/07/10 at 11:45am, revealed on 04/10/10 she was asked by CNA #10 to assist with transferring Resident #13 from the wheelchair to the bed. CNA #2 stated she questioned CNA #10 whether Resident #13 should be transferred by a lift and the CNA stated the resident could be a two (2) person assist. CNA #2 further stated that after she and CNA #10 transferred Resident #13, they noted the bottom of her pants leg was wet and the CNAs thought Resident #13 had urinated. CNA #2 stated they examined Resident #13 closer and noticed that</p>	F 225			

OCT 29 2010

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

PRINTED: 10/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/07/2010
NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219		
(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 225	<p>Continued From page 3</p> <p>his/her lower leg was bleeding. CNA #2 stated she immediately reported the incident to Licensed Practical Nurse (LPN) #6. CNA#2 concluded the interview by stating she did not know how the injury happened.</p> <p>Phone interview, on 10/07/10 at 1:00pm with LPN #6, revealed she was called into Resident #13's room by CNA #2 due to bleeding of Resident #13's lower leg. LPN #6 stated upon entering the room, Resident #13 was in bed with a gash to his/her lower leg. LPN #6 further stated she proceeded to kerlix wrap Resident #13's lower leg, notified the doctor, EMS and the Resident's responsible party regarding the injury. LPN #6 stated she was unaware of how the injury happened to Resident #13.</p> <p>Attempted phone contact with CNA #10 on 10/07/10 at 1:45pm, revealed a recording that the number or code was incorrect. No interview could be obtained.</p> <p>An interview, on 10/07/10 at 5:15pm with the Assistant Director of Nursing (ADON), revealed that CNA #2 notified her by phone regarding the injury to Resident #13. The ADON stated that she did not come in to the facility to investigate because she was not on call. The ADON stated that she did not notify the On Call Supervisor but did notify the Director of Nursing (DON) regarding the injury to the resident. The ADON stated she assumed the injury to Resident #13 occurred during the transfer from the wheelchair to the bed. The ADON also stated that based on facility policy, no staff observed how the injury occurred, and the resident was unable to explain how the injury occurred, therefore, this would be considered an injury of unknown source.</p>	F 225		

OCT 29 2010

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

PRINTED: 10/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/07/2010
NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219		
(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 225	Continued From page 4  An interview, on 10/07/10 at 3:50pm with the DON revealed she was notified of the injury to Resident #13 on 04/10/10 by the ADON. The DON further revealed the investigation was not started until 04/12/10. The DON stated she assumed the injury occurred when Resident #13 was transferred from the wheelchair. The DON further revealed that no staff member observed how the injury occurred and that Resident #13 was unable to explain how the injury occurred; therefore, based on facility policy, this would be considered an injury of unknown source.	F 225		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked,	F 431		

OCT 29 2010

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

PRINTED: 10/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/07/2010
NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219	
(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 431	<p>Continued From page 5</p> <p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to maintain medication room refrigerators at proper temperature levels for two (2) medication refrigerators, and failed to maintain medications in properly labeled containers in four (4) medication carts.</p> <p>The findings include:</p> <p>Record review of the Medication Storage Policy for the facility found that medications requiring refrigeration are stored at temperatures between thirty-six (36) degrees and forty-six (46) degrees. The Temperature is monitored each night by the Charge Nurse on third shift. The Medication Storage Policy also states medications managed in the thirty (30) day card system are stored in containers that meet legal requirements.</p> <p>Record review of the Downtown Unit medication refrigerator temperature check log on 10/07/10 at 9:15am revealed no checks were documented on 10/01/10, 10/03/10, 09/13/10, and 08/05/10, and there were recorded temperatures greater than forty-six (46) degrees on 08/21/10, 08/24/10, and</p>	F 431	<ol style="list-style-type: none"> <li>1. No residents were affected by cited deficiency.</li> <li>2. All medication room refrigerators were checked at the time of the survey to insure that temperatures were at appropriate levels (36-46) F. Medication carts were assessed to insure that adequate storage space for containers was available.</li> <li>3. Nurses and CMTs will be inserviced by November 19th, 2010 related to Refrigerator Temperatures and Storage of Drugs and Biologicals. Carts will be checked daily by Charge Nurses to insure carts do not become too full to hold required containers. Additional Medication carts will be obtained if needed to maintain compliance.</li> <li>4. Ongoing monitoring will occur through daily observation of documented Refrigerator temps by ADHS. DHS will complete random audits of temperatures weekly. Consultant Pharmacist will check Medication Carts during weekly visits.</li> </ol>	11/20/10

001 2 9 2010

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

PRINTED: 10/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/07/2010
NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219		
(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 431	<p>Continued From page 6</p> <p>08/26/10 with no documentation of further action.</p> <p>Record review of the Belle Town medication refrigerator temperature check log on 10/07/10 at 9:00am revealed no checks were documented on 10/02/10 and 09/20/10, and temperatures of less than thirty-six (36) degrees on 10/05/10, 10/04/10, 10/02/10, and 10/01/10 with no documentation of further action.</p> <p>Observation of the Belle Town medication cart #1 on 10/07/10 at 9:00am revealed seven (7) loose medications were in the bottom of the medication drawer under labeled blister cards, verified by Licensed Practical Nurse (LPN) #3.</p> <p>Observation of the Transitional Care Unit (TCU) medication cart #1 on 10/07/10 at 9:15am revealed eight (8) loose medications in the bottom of the medication drawer under labeled blister cards, verified by LPN #4.</p> <p>Observation of the TCU medication cart #2 on 10/07/10 at 10:15am revealed one (1) tablet loose in the bottom of the medication drawer under labeled blister cards, verified by LPN #5.</p> <p>Observation of the Belle Town medication cart #2 on 10/07/10 at 10:20am revealed eighteen (18) tablets were loose in the bottom of the medication drawer under labeled blister cards, verified by LPN #2.</p> <p>Interview with LPN #4, on 10/07/10 at 9:15am, revealed it could be possible for the nurse to "miss" the medication cup when the medication falls into the medication drawer. She stated it is possible that the medication falling into the drawer might not be noticed by the nurse, which</p>	F 431			

OCT 23 2010

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

PRINTED: 10/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/07/2010
NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219		
(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 431	<p>Continued From page 7 could result in a missed dose for the resident.</p> <p>Interview with LPN #2, on 10/07/10 at 10:20am, revealed that Belle Town unit has only two (2) medication carts, and used to maintain three (3) carts. She stated that the blister packs become too packed into the drawer and it becomes difficult to see or find a medication which falls into the drawer, and the third cart would help to alleviate the crowded drawers. She also stated, "Pharmacy has got on us before about finding loose meds in the drawers."</p> <p>Interview with the Director of Engineering Services, on 10/07/10 at 1:30pm, revealed that a work order is completed requesting service when a medication refrigerator is not maintaining adequate cooling. He said that recently Belle Town nursing unit replaced a refrigerator which was not working properly, but he was uncertain of the replacement date.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 10/07/10 at 2:00pm, revealed the ADON checks the temperature logs for accuracy and documentation periodically, but no log is maintained to document the review.</p> <p>Interview with the Director of Nursing (DON) and a Division Clinical Support staff member on 10/07/10 at 2:50pm found that when the refrigerator temperature is not within acceptable parameters, the nurse should adjust the temperature and recheck in thirty (30) minutes, then document the corrected temperature on the log. The DON said the ADON should check the medication refrigerator logs daily for compliance with policy and that Maintenance is consulted if the refrigerator is not working properly. The DON</p>	F 431			

OCT 28 2010

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

PRINTED: 10/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/07/2010
NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219		
(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 431	Continued From page 8 said she checks the logs for compliance at least monthly. The DON stated loose medications have been found in the drawers beneath the blister packs in the past, and stated this has been "resolved" with Pharmacy. The DON stated she was surprised that loose medications were found on all four (4) medication carts that totaled thirty-four (34) medications. Both the DON and Division Clinical Support staff member agreed this was a significant finding which would require corrective action.	F 431		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide resident emergency call systems in three (3) bathrooms available and accessible to residents. Two (2) bathrooms were located on the 400 hall and one (1) bathroom was located on the 300 hall.  The findings include:  Observation on 10/05/10 at 2:20pm of the two (2) hallway bathrooms on the 400 hallway revealed neither had an emergency call system in place. Each of the bathrooms could be accessed by residents.  Observations on 10/06/10 at 11:00am of the one (1) hallway bathroom on the 300 hallway revealed	F 463	1. No residents were affected by this deficient practice. 2. All residents that are independent with toileting and use these public bathrooms have the potential to be affected by the deficient practice. 3. Both hallway bathrooms on the 400 Hallway will have an emergency call system installed. The hallway bathroom on the 300 hall will be used for visitors only. The door will be locked at all times. The Key will be hung up on the wall, at the Nurses station, not in Reach of the residents. 4. Director of Plant Operations (DPO)/designee will ensure that the new call systems in the two Bathrooms will remain functional and that the other door stays locked with the key Hung up at the nurses station.	11/20/10

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

PRINTED: 10/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/07/2010
NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219		
(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 463	Continued From page 9 the bathroom did not have an emergency call system in place. The bathroom could be accessed by residents.	F 463			
F 465 SS=D	<p>Tour with maintenance staff #4 on 10/07/10 at 2:30pm revealed the bathrooms were intended for visitors and staff. Staff responded that a resident could also use those bathrooms.</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a safe, functional, and sanitary environment for residents as evidenced by rooms 218 and 319 with stains on the ceilings, the wheelchairs of residents in rooms 216-1 and 216-2 were torn and cracked, and resident room 213 had a hole in the bathroom wall with drywall exposed.</p> <p>The findings include: Observations on 10/06/10 at 10:30am revealed in rooms 218 and 319 a plate size area, in the ceiling, parallel to the room entrance door, had a yellowish green color with dark brown and black edges. Observations on 10/07/10 at 11:20am in room 216 revealed both residents' wheelchair arms had torn handles with pieces of covering missing.</p>	F-465	<p>1. No residents were affected by this deficient practice.</p> <p>2. All rooms and wheelchairs were observed by Plant Operations and Environmental Staff. No other residents were affected by this deficient practice. The ceiling in rooms 218 and 319 were cleaned and painted. The wheelchairs in the room were fixed. The bathroom wall in 213 was patched and painted where the gash was.</p> <p>3. DPO/designee will monitor monthly the ceilings for any discoloring. DPO will monitor monthly for any gashes (holes) in the bathroom walls. The DPO will check wheelchairs monthly for any missing wheelchair arms or torn handles. He will correct any findings.</p> <p>4. DPO will report in QAA monthly Any findings and corrective action taken.</p>	11/20/10	

OCT 29 2010

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

PRINTED: 10/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/07/2010
NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219	
(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 465	Continued From page 10  Observations on 10/07/10 at 2:40pm of resident bathroom 213 revealed a gash in the wall above the toilet paper holder with drywall exposed.  Interview with maintenance staff #4 on 10/07/10 at 2:45pm revealed there were no work orders for the repair of the ceilings in rooms 218 and 219, nor repair of the wheelchair arms in room 216, or the repair of the drywall in bathroom 213.	F 465		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on Interview and record review it was determined the facility failed to maintain clinical records on one (1) of twenty-five (25) sampled residents in accordance with accepted professional standards and practices that are complete and accurately documented as evidenced by a telephone order that was not dated for Resident #5.	F 514	1. The order for Resident 5 had been transcribed and implemented, so no adverse effect on resident. 2. Telephone orders for September were reviewed for all residents to insure that no other residents were affected. Any deficient practice identified was corrected. 3. Licensed staff will be inserviced by Nurse Managers by November 19th, 2010 related to writing Telephone orders with emphasis on dating orders. 4. Medical Records and DHS/Designee will review telephone orders daily to insure thorough completion. Quality Assurance Committee will require corrective action plan for any pattern of noncompliance. Staff will be disciplined for noncompliance.	11/20/10

OCT 29 2010

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

PRINTED: 10/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/07/2010
NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219	
(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 514	<p>Continued From page 11</p> <p>The findings include:</p> <p>Policy review of "Guidelines for Telephone Orders" number 2 revealed "The entry shall contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information."</p> <p>Record review on 10/06/10 revealed a telephone order for "Dulcolax Suppository times one followed with 30cc MOM only if no results. Repeat times one the following day." This order was not dated by the nurse taking the order or by the nurse processing the order.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 10/06/10 at 10:55am revealed that all orders written should be dated both by the date received and the date the orders taken off and processed. The ADON acknowledged that the order on Resident #5 was not properly dated and the possible consequence would be the possibility of giving a one time only order of medication a second time.</p>	F 514		

OCT 29 2010

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

PRINTED: 10/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  10/06/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3626 FERN VALLEY ROAD LOUISVILLE, KY 40219
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	INITIAL COMMENTS	K 000		
K 027 SS=E	<p>A Life Safety Code survey was initiated and concluded on October 6, 2010. The facility was found not to meet the minimum requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire/smoke corridor doors were functioning properly to resist passage of smoke, according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 10/06/10 at 12:00pm with the Maintenance Staff, revealed the fire/smoke corridor doors on the Derby Wing would not close properly when tested. Further observation at 12:30pm on the Downtown Wing revealed the fire/smoke corridor doors had a gap of more than 1/8 inch when closed.</p>	K 027	<p>1. No residents were affected by this deficient practice.</p> <p>2. All residents could have been affected by this deficient practice. The fire/smoke corridor doors on Derby were fixed and the doors now close properly. The fire/smoke doors on the Downtown wing were fixed and now does not have more than a gap of 1/8 inch when closed.</p> <p>3. The Director of Plant Operations (DPO) will check all fire/smoke doors Monthly for any doors that do not close properly or any that have more than a 1/8 inch gap when closed. He will fix these doors if any are found.</p> <p>4. The DPO will report his findings in QAA monthly and any corrective action taken.</p>	11/20/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Renaud Adkins - RB TITLE: ED (X6) DATE: 10/29/10

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.

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

PRINTED: 10/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  10/06/2010
NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219	
(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 027	Continued From page 1 Interview with the Maintenance Director on 10/06/10 at 12:00pm, indicated that he was not aware the fire/smoke corridor doors would not close properly on the Derby Wing. He also was not aware that the fire/smoke corridor doors on the Downtown Wing had a gap of more than 1/8 inch when closed.  Reference: NFPA 101 (2000 Edition) 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.  Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18 mm) for wood doors.	K 027		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	1. No residents were affected by this deficient practice. 2. All residents could have been affected by this deficient practice. The green canopy was taken down. The second canopy was sprinkled. 3. There are no other canopies in the campus. 4. DPO will ensure any new canopies will be equipped with sprinklers.	11/20/10

OCT 29 2010

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

PRINTED: 10/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  10/06/2010
NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219	
(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 056	Continued From page 2  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, according to NFPA standards.  The findings include:  Observation on 10/06/10 at 12:05pm, with the Maintenance Staff, revealed two (2) canopies with combustibile construction. The first canopy was a green canopy located over the Derby Wing exit and the second canopy was located over the Derby and Bell Wing exit.  Interview with the Maintenance Director on 10/06/10 at 12:15pm, revealed he was not aware that the canopies needed sprinklers.  Reference NFPA 13/1999 (Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft. (1.2m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustibile construction.	K 056		
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4	K 073		

OCT 29 2010

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

PRINTED: 10/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  10/06/2010
NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219	
(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 073	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview during the survey on 10/06/10, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards.</p> <p>The findings include:</p> <p>Observation during the tour of the building on 10/06/2010 from 10:45am through 12:30pm, with the Maintenance Staff, revealed fifteen (15) resident rooms with hanging decorations on the doors that were not flame retardant. The resident rooms were numbered 204, 208, 301, 303, 306, 307, 310, 312, 313, 315, 316, 317, 323, 324, and 330.</p> <p>Interview with Maintenance Staff on 10/06/10 at 10:45am, revealed they were unaware of the requirement that the decorations had to be treated for flame retardant.</p> <p>NFPA Standard NFPA 101.2000 Edition 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.</p>	K 073	<p>1. No residents were affected by this deficient practice.</p> <p>2. All residents could have been affected by this deficient practice. It was discussed with affected residents that we could not have these decorations without being flame retardant and they were removed.</p> <p>3. DPO/designee will ensure that any resident rooms with hanging decorations on the doors will be sprayed with a Flame retardant.</p> <p>4. DPO will monitor monthly for any decorations hanging on the doors. He will ensure that they are sprayed with a flame retardant and logged. He will report findings in QAA monthly.</p>	11/20/10

OCT 20 2010