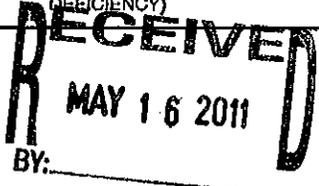


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/20/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185138</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/07/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>WESLEY MANOR NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5012 EAST MANSLICK RD LOUISVILLE, KY 40219</b>	
(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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	 <p><b>Corrective action to be accomplished for those residents found to be affected by the deficient practice:</b> We feel that this citation was written in error, as our analysis shows that all funds have been conveyed within 30 days of death of the resident. However, we have written a new policy on conveyance of those funds. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice:</b> All residents are equally affected by this deficient condition. <b>Measures put into place or systematic changes made to ensure that the deficient practice will not recur:</b> We are evaluating those accounts on a monthly basis to ensure that we are complying with our policy of payment. <b>How the facility monitors its performance to ensure that solutions are sustained:</b> The Chief Financial Officer will monitor those accounts on a monthly basis to ensure prompt payment. <b>Person responsible for compliance:</b> Chief Financial Officer.</p>	5/22/11
F 160 SS=B	<p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to convey resident funds to the individual administering the residents' estate within thirty (30) days of residents' death for two (2) of five (5) unsampled residents.</p> <p>The findings include:</p> <p>Closed record review of two (2) of five (5) unsampled residents revealed a death date of 12/16/10 and 12/28/10. A review of resident accounts revealed closing dates of 03/09/11 and 02/15/11, respectively.</p> <p>An interview with the Accounts Receivable Representative (ARR) on 04/07/11 at 4 PM revealed she knew accounts were to be closed no later than thirty (30) days following the death of a resident. Further interview with ARR revealed she was not able to determine why the accounts</p>	F 160		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Randy Rozanson* TITLE: Administrator/President (X6) DATE: 5-13-11

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

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F 160  F 252 SS=E	Continued From page 1 were not closed within thirty (30) days. 483.15(h)(1) <b>SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</b>  The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, clean, and homelike environment as evidenced by the lack of maintenance performed on the wall edge guards and lower kick rails in the hallways and resident areas.  The findings include:  Observation on 04/05/11 at 9:55 AM, revealed the top of nineteen (19) of twenty-two (22) plastic wall edge guards were loose from the wall and door jams. Observation revealed the wall edge guards were loose from the wall at the floor level and observation revealed the loose wall edge guards had sharp edges exposed.  Observation on 04/05/11 at 10:30 AM, revealed in the hallway between rooms N9-N7, the lower kick rail endcap was missing, exposing the bare metal end.  Interview with the maintenance assistant, on 04/07/11 at 11:10 AM, revealed the wall edge guards should be removed when they become	F 160  F 252	<b><u>Corrective action to be accomplished for those residents found to be affected by the deficient practice:</u></b> All plastic guards have been removed from the walls and door jams, and the affected areas have been prepared and painted. <b><u>How the facility will identify other residents having the potential to be affected by the same deficient practice:</u></b> All residents are equally affected by this deficient condition. <b><u>Measures put into place or systematic changes made to ensure that the deficient practice will not recur:</u></b> Plastic protective covers are no longer be used in the facility. The painted doors jams are re-painted as wear occurs on the door jams. <b><u>How the facility monitors its performance to ensure that solutions are sustained:</u></b> The Director of Maintenance performs routine inspections of the entire facility on a monthly basis to ensure that the facility is safe and clean. Door jams are repainted as necessary <b><u>Person responsible for compliance:</u></b> Director of Maintenance.	5/22/11

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F 252	Continued From page 2 damaged or loose. He further stated he was unaware there were so many that were pulling away from the wall.	F 252		5/22/11
F 332 SS=E	<b>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</b>  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure a medication error rate of less than five (5) percent was maintained. Observation of the Medication Pass on 04/05/11 and 04/06/11 revealed five (5) errors were made of forty-two (42) opportunities, resulting in an 11.9 percent medication error rate. The errors involved four (4) unsampled residents.  The findings include:  1. Review of the Clinical Record for Unsampled Resident A revealed a Physician's Order for Librium, five (5) milligrams (mg), to be given every morning. Observation of the Medication Pass on 04/05/11 at 9:40 AM revealed the drug was not available on the medication cart. Interview with Licensed Practical Nurse (LPN) #4 at the time of the observation revealed the facility had run out of the medication and the nurse had sent a request to the Pharmacy for the drug to be delivered. Continued interview revealed a medication refill order should be sent five (5) days before the supply was depleted. She further stated she had ordered the medication "a while	F 332	<b><u>Corrective action to be accomplished for those residents found to be affected by the deficient practice:</u></b> There was no identified reaction or side-effects related to the medication errors experience by unsampled residents A-D. Resident A's medication was found on the cart, LPN #4 was not aware that Librium was maintained and locked in the controlled box. Nurse #4 was educated to look in all places for medications. <b><u>How the facility will identify other residents having the potential to be affected by the same deficient practice:</u></b> All residents are equally affected by this deficient condition. <b><u>Measures put into place or systematic changes made to ensure that the deficient practice will not recur:</u></b> All full-time and part-time nurses/CMT's shall be required to watch a <u>Med Pass Error and Prevention Video</u> (sign off sheet attached) and complete the quiz (attached) by May 11, 2011. PRN or pool nurses shall not be permitted to schedule days to work after May 11, 2011 until this requirement is met. A new policy was developed <u>Medication Administration</u> (attached) and shall be reviewed with all full-time and part-time nurses/CMT's. PRN or pool nurses shall not be permitted to schedule days to work after May 11, 2011 until this requirement is met. A new policy was	

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F 332	<p>Continued From page 3 back". Interview with the Nurse Manager on 04/06/11 at 9:10 AM revealed a six-pack of the medication had been delivered on 04/04/11 and should have been placed on the medication cart. She could not explain why the dose was missed.</p> <p>2. Observation of the Medication Pass on 04/05/11 at 9:50 AM revealed the morning medications for Unsampled Resident B included Guaifenesin 100 mg. (Guaifenesin is given to help thin respiratory secretions.) Registered Nurse #10 administered all of the resident's medications, including the Guaifenesin, prior to administering a nebulizer (breathing) treatment. Review of the Physicians' Orders revealed the Guaifenesin was to be administered after the nebulizer treatment. Subsequent observation of the medication pass on 04/07/11 at 10:00 AM revealed LPN #7 administered the Guaifenesin, with the other oral medications, prior to the nebulizer treatment. Interview with LPN #7 at that time revealed she did not realize the Guaifenesin should have been given after the nebulizer treatment. Review of the Medication Administration Record (MAR) with the nurse confirmed the error.</p> <p>3. Review of the Medication Pass for Unsampled Resident C on 04/06/11 at 10:30 AM revealed LPN #9 administered two (2) drops of Restasis to each eye. Continued observation revealed LPN #9 administered Flonase, one spray to each nostril. Review of the Physicians' Orders revealed Resident C was to receive one (1) drop of Restasis to each eye twice daily. Continued review revealed an order for Flonase, two (2) sprays to each nostril twice daily. Interview with LPN #9 on 04/06/11 at 11:00 AM confirmed she had made two (2) errors of administration. The</p>	F 332	<p>developed <u>Medication Administration</u> (attached) and shall be reviewed with all full-time and part-time nurses/CMT's. PRN or pool nurses shall not be permitted to schedule days to work after May 11, 2011 until this requirement is met. A new policy was developed <u>Ophthalmic Administration</u> (attached) and shall be reviewed with all full-time and part-time nurses/CMT's. PRN or pool nurses shall not be permitted to schedule days to work after May 11, 2011 until this requirement is met. Upon hire, during orientation nurses/CMT shall be required to review the <u>Med Pass Error and Prevention Video</u> and complete the quiz. They will also be required to review the Nursing guidelines manual to review all nursing policies.</p> <p><b><u>How the facility monitors its performance to ensure that solutions are sustained:</u></b> All nurses/CMT's are audited on medication administration using the <u>Medication Administration Audit</u> tool (attached) initially and then annually by the Assistant Director of Nursing or Vice President of Nursing and Client Services. Upon hire and during orientation nurses/CMT's shall be audited on medication administration using the <u>Medication Administration Audit</u> tool. The Administrative Assistant shall review (see attached audit) all Health Care Center nurse/CMT evaluations and orientation check-off information for completion. The report shall be sent to the ADON for review quarterly. The findings will be reported to the Quality Assessment and Assurance Committee for their review and recommendations, if any.</p>	

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F 332	Continued From page 4 nurse stated she was nervous and got mixed up.  4. Review of the Clinical Record revealed Unsampld Resident D was to receive two (2) drops of Artificial Tears to each eye four (4) times daily. Observation of the Medication Pass on 04/06/11 at 4:20 PM revealed Artificial Tears eye drops were not available for Unsampld Resident D. Interview with RN #3 at that time revealed she did not know why the eye drops were not available. Observation of the medication cart with LPN #8 on 04/07/11 at 10:10 AM revealed a new bottle of Artificial Tears with an unbroken seal was in the resident's drawer. Review of the MAR revealed two (2) doses were missed on 04/06/11, in the afternoon and at bedtime. LPN #8 stated Resident D received only two (2) applications of the eye drops on 04/06/11, instead of four (4) applications as ordered.	F 332	Members of QAAC include: The Medical Director, 2 members of the board (Resident Care Policies Committee), Administrator, Vice President of Nursing and Client Services, Assistant Director of Nursing (Chairman of the Committee) Director of Social Services, Director of Activities, Consultant Pharmacist, Staff Development Coordinator, Director of RAI.	
F 371 SS=E	<b>483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</b>  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure food was prepared, distributed, and served under sanitary conditions. This was	F 371	<b><u>Corrective action to be accomplished for those residents found to be affected by the deficient practice:</u></b> All dietary staff have been inserviced regarding proper hand-washing techniques, proper use of gloves, and proper use of hair nets/restraints. The facility polices and procedures regarding hand-washing, gloves, and hair nets/restraints have been reviewed and revised to emphasize proper techniques and procedures. Copies of the revised polices and procedures are attached to this POC.	5/22/11

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F 371	<p>Continued From page 5</p> <p>evidenced by the facility failure to utilize proper hand sanitation and appropriate hair coverings.</p> <p>The findings include:</p> <p>Review of the facility's "Hand Washing Policy", dated 02/10, revealed hands needed to be washed before work, after using the rest room, after smoking, eating and prior to leaving work. Further review of the policy revealed employees should wash their hands before and after a task is completed, even if gloves are worn.</p> <p>Review of the facility's "Employee Sanitary Practices", dated 05/08, revealed all employees are to wear hair nets or restraints and to follow the facility's hand washing policy.</p> <p>Observation of dietary staff in the serving kitchen on 04/04/11 at 5:40 PM revealed Dietary Aide #5 touched his face twice then continued to plate food two (2) times without washing his hands. Further observation revealed Dietary Aide #5 removed utensils from the drawer, opened the refrigerator for supplies and brought up trays of soup bowls, all while wearing the same gloves he was using to plate residents' food. Continued observation revealed he was reminded by a fellow staff member to change gloves. He was observed to change gloves without washing hands prior to donning new gloves. Observation at 6:05 PM revealed Dietary Aide #5 opened the refrigerator using the same gloves he used to plate residents' food, then went back to plating food for residents without washing his hands or changing gloves. Further observation revealed Dietary Aide #4 did not wash his hands between numerous glove changes while he acted as a</p>	F 371	<p><u>How the facility will identify other residents having the potential to be affected by the same deficient practice:</u></p> <p>All residents in the facility have the same potential to be affected, as they all eat the facility's food.</p> <p><u>Measures put into place or systematic changes made to ensure that the deficient practice will not recur:</u></p> <p>All staff have been inserviced regarding sanitation, hand-washing, glove use, and hair nets/restraints. The facility conducts weekly audits by the dietary manager or representative to ensure compliance. The dietary manager also conducts daily visual audits for compliance.</p> <p><u>How the facility monitors its performance to ensure that solutions are sustained:</u></p> <p>The facility monitors its performance via weekly audits of the sanitation process as well as daily observations. Any deficient practice is addressed immediately by the dietary manager through re-education of the affected staff person(s). Periodic reports regarding the facility's compliance are made to the Quality Assurance Committee.</p> <p><u>Person responsible for compliance:</u> Dietary Manager</p>	

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F 371	<p>Continued From page 6</p> <p>"runner" for kitchen staff. Continued observation at 6:15 PM revealed Dietary Aide #4 bagged sandwiches for tray line, removed items from refrigerator for tray line then returned to handling sandwiches without washing hands or changing gloves.</p> <p>Observation on 04/04/11 at 6:05 PM revealed the bouffant hair covering for the Dietary Manager did not completely cover her hair, leaving bangs and long side curls unrestrained. Further observation on 04/04/11 at 6:15 PM revealed Dietary Aide #5 had hair touching the nape of his neck with just a ball cap to cover his hair.</p> <p>Interview with Dietary Aide #5 04/04/11 at 6:30 PM revealed he had been inserviced about hand washing before and after food service but that's all he remembers. He further stated that hair needed to be covered.</p> <p>Interview with Dietary Aide #4 on 04/05/11 at 1:55 PM revealed he should wash hands before and after food handling. Further interview revealed he should have taken his gloves off before opening the refrigerator doors to get pureed foods, then should have washed his hands before donning new gloves to continue meal service. Dietary Aide #4 further stated that hair needed to be completely covered.</p> <p>Interview with Dietary Aides #2 and #3 on 04/06/11 at 11:15 AM revealed hands needed to be washed before and after using gloves, and hands needed to be washed after touching anything, such as refrigerator handles or the telephone. Further interview revealed hair needed to be completely covered with either a hair net or bouffant hat.</p>	F 371		

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F 371	Continued From page 7  Interview with the Dietary Supervisor on 04/06/11 at 11:20 AM revealed hands needed to be washed after completing one task before going to another task and after removing gloves. Further interview revealed that men with long hair should either wear a hair net or tuck their hair under a ball cap.  Interview with the Dietary Manager on 04/06/11 at 4:00 PM revealed hands should be washed upon entering the kitchen, before donning or after removing gloves, or if your person is touched. She further stated that gloves need to be removed before opening the refrigerator, and hands washed before donning gloves. Further interview revealed gloves are primarily used for food handling. She further stated that complete hair coverage is mandatory for all dietary staff by use of either a hair net, bouffant cap or ball cap. She further stated that if the ball cap does not completely cover the hair, then a hair net must be worn under the cap.	F 371		
F 441 SS=D	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  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	F 441	<b><u>Corrective action to be accomplished for those residents found to be affected by the deficient practice:</u></b> The nurse involved with this deficient practice has been instructed as to the proper handling of medications, i.e., medications are not to be touched with a bare hand, but only using a gloved hand or with the appropriate instrument and according to nursing protocol. The resident was determined to be asymptomatic to infection following the deficient practice, and all residents' conditions are reviewed weekly.	5/11/11

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F 441	<p>Continued From page 8</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure adequate infection control practices were maintained during medication administration. The nurse handled Pills belonging to Unsampled Resident C with her bare hands prior to administration.</p> <p>The findings include:  Observation of the Medication Pass on 04/06/11 at 10:30 AM revealed Licensed Practical Nurse (LPN) #9 placed her finger in a cup containing</p>	F 441	<p><b><u>Measures put into place or systematic changes made to ensure that the deficient practice will not recur:</u></b></p> <p>All residents have the potential to be affected by this deficient practice. New policies and in-services with nurses/CMT's have been identified and put into place to ensure that infection control practices are maintained during medication administration. A new policy was developed <u>Medication Administration</u> (attached) and shall be reviewed with all full-time and part-time nurses/CMT's. PRN or pool nurses shall not be permitted to schedule days to work after May 11, 2011 until this requirement is met. All nurses/CMT's upon hires shall review this policy during orientation.</p> <p><b><u>How the facility monitors its performance to ensure that solutions are sustained:</u></b> All nurses/CMT's shall be audited on med administration using the <u>Medication Administration Audit</u> tool (attached) initially and then annually by the Assistant Director of Nursing or Vice President of Nursing and Client Services. Upon hire and during orientation nurses/CMT's shall be audited on med administration using the <u>Medication Administration Audit</u> tool. The Administrative Assistant shall review (see attached audit) all</p>	

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/07/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WESLEY MANOR NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5012 EAST MANSLICK RD LOUISVILLE, KY 40219</b>
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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)	(X6) COMPLETION DATE
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F 441	<p>Continued From page 9</p> <p>pills belonging to Unsampled Resident C. The nurse moved the pills about with her finger to identify them. Continued observation revealed the nurse poured the pills into the palm of her hand and back into the cup. Subsequently, the nurse administered the pills to the Resident.</p> <p>Interview with LPN #9 on 04/06/11 at 11:00 AM revealed she knew she shouldn't have touched the pills with bare hands.</p>	F 441	<p>Health Care Center nurse/CMT evaluations and orientation check-off information for completion. The report shall be sent to the ADON for review quarterly. The findings will be reported to the Quality Assessment and Assurance Committee for their review and recommendations, if any. Members of QAAC include: The Medical Director, 2 members of the board (Resident Care Policies Committee), Administrator, Vice President of Nursing and Client Services, Assistant Director of Nursing (Chairman of the Committee) Director of Social Services, Director of Activities, Consultant Pharmacist, Staff Development Coordinator, Director of RAI.</p> <p><b>Person responsible for compliance:</b> The VP of Nursing and Client Services.</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185136	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  04/05/2011
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NAME OF PROVIDER OR SUPPLIER  WESLEY MANOR NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5012 EAST MANSLICK RD LOUISVILLE, KY 40219
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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)	(X6) COMPLETION DATE
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K 000	INITIAL COMMENTS  A Life Safety Code survey was initiated and concluded on 4/5/2011. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".  Type Of Structure: 2000 Existing/TypeV-Protected with complete sprinkler system  Plan Approval Date: 4/19/1976	K 000		
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  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 deficiency has the potential to affect all residents, staff and visitors. The facility is licensed for (68) beds and	K 056	<b>RECEIVED</b> MAY 16 2011 BY: _____  <u>Corrective action to be accomplished for those residents found to be affected by the deficient practice:</u> The automatic sprinkler system has been extended to provide coverage to the two canopies on the east wing as well as the overhangs on the north, south, and east wing exits. <u>How the facility will identify other residents having the potential to be affected by the same deficient practice:</u> All residents are equally affected by this deficient condition. <u>Measures put into place or systematic changes made to ensure that the deficient practice will not recur:</u> The automatic sprinkler system is tested per manufacturer's recommendations and state regulation.	5/22/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Yermyl Boganson</i>	TITLE Administrator/President	(X8) DATE 5-13-11
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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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/05/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>WESLEY MANOR NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5012 EAST MANSLICK RD LOUISVILLE, KY 40219</b>		
(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 1 the census on the day of the survey was (66) residents.  The findings include:  Observation on 4/5/2011 at 11:30 AM with the V. P. Administration and Maintenance Director, revealed two canopies and three overhangs with no sprinklers. The two canopies are located at the front entrance on the East Wing of the building. The three overhangs are located on the East Wing exit, the South Wing exit and the North Wing exit. The two canopies and the three overhangs are all over four (4) feet in width.  Interview with the V. P. Administration and the Maintenance Director on 4/5/2011 at 11:30 AM, indicated that they were not aware of the requirement that the canopies and overhangs needed to be sprinkled.  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 combustible construction.	K 056	<b>How the facility monitors its performance to ensure that solutions are sustained:</b> Any problems found during routine inspections or maintenance will be corrected immediately. <b>Person responsible for compliance:</b> V.P. of Operations		
K 073 SS=E	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  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency has	K 073	<b>Corrective action to be accomplished for those residents found to be affected by the deficient practice:</b> A new policy has been written which addresses decorations in the facility. The policy states that all decorations must be of made non-combustible materials or must be treated with flame-retardant material to ensure that they are safe.	5/22/11	

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NAME OF PROVIDER OR SUPPLIER  <b>WESLEY MANOR NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5012 EAST MANSLICK RD LOUISVILLE, KY 40210</b>		
(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)	(X6) COMPLETION DATE	
K 073	<p>Continued From page 2</p> <p>the potential to affect all residents, staff, and visitors. The facility is licensed for (68) beds and the census on the day of the survey was (66) residents.</p> <p>The findings include:</p> <p>Observation on 4/5/2011 at 10:50 AM with the Maintenance Director, revealed hanging decorations on the resident rooms doors numbered S-5, S-6, and S-9 on the South Wing, and N-1, N-2, N-3, N-8, and N-12 on the North Wing.</p> <p>Interview with the Maintenance Director on 4/5/2011 at 10:50 AM, revealed the facility did not have a policy or system in place to ensure the decorations were treated with a flame retardant material.</p> <p>Reference: 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><u>How the facility will identify other residents having the potential to be affected by the same deficient practice:</u></p> <p>All residents are equally affected by this deficient condition.</p> <p><u>Measures put into place or systematic changes made to ensure that the deficient practice will not recur:</u></p> <p>Routine inspections are made to ensure that all decorative hangings are flame retardant. Also, employees have been inserviced regarding the new policy. If inappropriate materials are found to be in use for decorations, the decorations are to be removed immediately.</p> <p><u>How the facility monitors its performance to ensure that solutions are sustained:</u></p> <p>The Director of Maintenance or his designee will make monthly inspections of the facility to ensure that only flame-retardant decorations are used.</p> <p><u>Person responsible for compliance:</u> Director of Maintenance.</p>		