

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

PRINTED: 12/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2013
NAME OF PROVIDER OR SUPPLIER WESLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 5012 EAST MANSLICK RD 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 A standard health survey was conducted 12/17/13 through 12/19/13 and a Life Safety Code survey was conducted on 12/17/13 with deficiencies cited at the highest scope and severity at an "E". This was a Nursing Home Initiative survey with entry at 7:05 am.	F 000			
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH 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. This REQUIREMENT is not met as evidenced by: Based on interview, and review of the facility's policy and trust fund account documentation, it was determined the facility failed to convey funds from resident trust fund accounts in a timely manner upon the death of four (4) of five (5) unsampled residents (Unsampled Residents A, B, C, and D). The findings include: Review of the facility's policy titled refunds to Families of Deceased residents, effective April 2011, revealed any balances in the accounts of all deceased residents will be returned to the surviving family member within thirty (30) days of death of the resident.	F 160	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: All files of discharged residents will be reviewed on a monthly basis by the Chief Financial Officer to ensure that refunds are conveyed to the responsible party within 30 days of discharge or death. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All discharged/deceased residents have the potential to be affected by the same deficient practice. MEASURES TO BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The administrator will assess the facility data base on a weekly basis to determine which residents were discharged during the previous week. The administrator will question the resident funds administrator to ascertain when refunds were made and remind him/her that refunds must be made within 30 days of discharge/death. HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT	01/30/14	

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

TITLE

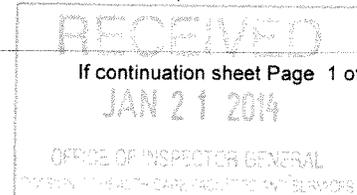
(X6) DATE

X *JERRY L. Hodganson*

X Administrator

X January 21, 2014

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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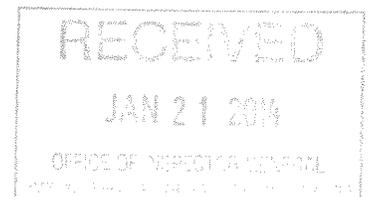
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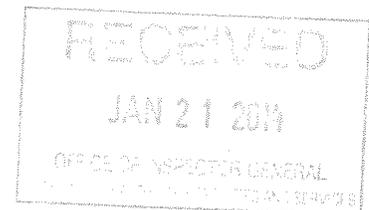
F 160	<p>Continued From page 1</p> <ol style="list-style-type: none"> Review of Unsampled Resident A's Trust Account revealed the resident had deceased on 08/08/13; however, the facility failed to convey funds to the responsible party until 12/05/13, 89 days late. Review of Unsampled Resident B's Trust Account, revealed the resident expired on 10/07/13; however, the funds were not dispensed until 12/04/13, or 27 days late. Review of Unsampled Resident C's Trust Account, revealed the resident expired on 08/27/13; however, the resident's trust account was not dispensed until 11/26/13, or 60 days late. Review of Unsampled Resident D's Trust Account, revealed the resident expired on 08/27/13; however, the trust account was not conveyed until 12/04/13, or 69 days late. <p>Interview with the Bookkeeper responsible for reconciling accounts, on 12/19/13 at 11:35 AM, revealed she knew resident trust fund accounts were to be closed within 30 days of a resident's death; however, stated that she had been out sick from 09/02/13 until 11/06/13.</p> <p>Interview with the Administrator, on 12/19/13 at 1:42 PM, revealed the Corporate Finance Officer (CFO) was responsible to oversee Resident Trust Accounts. He stated he was not aware accounts were not being closed within thirty (30) days after a resident's death. He stated he was knowledgeable that the bookkeeper was out sick, but didn't think to ask the CFO to ensure accounts were closed. He stated it just got missed. He stated he had not received any calls</p>	F 160	<p>SOLUTIONS ARE SUSTAINED: The administrator will track all discharges and dates of refund-conveyance on a weekly basis. The results of this tracking will be reported to the Quality Assurance Committee on a monthly basis. PERSON RESPONSIBLE FOR THE IMPLEMENTATION OF THE PLAN: Chief Financial Officer</p>	
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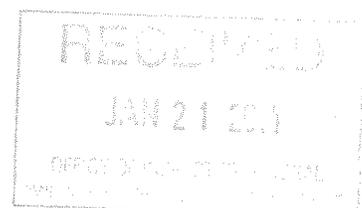
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F 160	Continued From page 2 or complaints about resident accounts not being closed within thirty (30) days.	F 160		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility records, it was determined the facility failed to maintain a safe and sanitary physical environment for two (2) of three (3) wings, North and South. The North wing had gouges in the wall in room N7-B. The South wing had gouges in the wall in room S2-B. The South wing doors and frames to resident rooms were scuffed and had scraped paint for twelve (12) of twelve (12) resident rooms. Additionally, the South wing hallway had bead board that was broken and pulled away from the wall. The findings include: The facility did not provide a policy for maintenance and upkeep of the physical environment. Observation, on 12/19/13 at 11:04 AM and 11:10 AM, of the North wing revealed room N7-B had a gouge in the wall next to the resident's bed. Observation of the South wing, on 12/19/13 at 10:31 AM and 11:10 AM, revealed room S2-B had a gouge in the wall next to the resident's bed. The	F 253	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: All resident rooms on the North and South halls will be repaired and painted beginning on Monday, January 6, 2014. One room will be repainted each weekday. It is estimated that all rooms will be finished in 5 weeks. The hallway bead board will be repaired and painted as well during the room renovation. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The Director of Maintenance will perform monthly audits of the facility condition and schedule repairs as indicated. Between these audits, staff will report issues on the maintenance log in the nurses station. These issues will be dealt with in a timely manner by the maintenance department. In this manner, all residents will be equally affected by the deficient practice and also by the plan of correction. MEASURES TO BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Routine, monthly audits will be performed by the Director of Maintenance. In addition, the staff will indicate any substandard condition on the maintenance log. The administrator will also monitor the condition of the rooms and common space during routine, monthly inspections.	1/31/2014



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F 253	<p>Continued From page 3</p> <p>South wing hallway doors and frames were scuffed and paint scraped for all twelve (12) resident rooms. Additional observation revealed bead board in the South wing hallway had pieces of wood chipped off and was pulled away from the wall.</p> <p>Interview with the Director of Maintenance, on 12/19/13 at 11:10 AM and 3:35 PM, revealed he would round in the facility every three months for safety issues to residents. He stated paint and bead board was considered a lower priority to other maintenance issues. The Director of Maintenance indicated he did not keep a record of when the doors and frames had been painted or wall gouges repaired. He further indicated he did not have any maintenance requests to complete work in the North or South wings related to rooms N7-B or S2-B, or for paint and bead board. He stated he would not like his home to have gouges in walls, broken and pulled bead board, or scuffed doors and frames, and was unaware how the physical appearance of the facility could affect residents.</p> <p>On 12/19/13 at 2:51 PM, interview with the Director of Nursing (DON), revealed a maintenance log was available for any staff member to document needed repairs throughout the facility. The DON stated the Director of Maintenance was responsible to ensure needed repairs were completed. She indicated the South Wing did not appear homelike and if it were her home, she would want it to be nice.</p> <p>Review of the facility's Maintenance Log, from 07/10/13 through 12/12/13, revealed no maintenance work requests were received or completed related to rooms N7-B or S2-B for</p>	F 253	<p>HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED:</p> <p>The Director of Maintenance will monitor the facility's condition during his monthly inspections and will order maintenance staff or contractors to complete necessary repairs. The condition of the facility will become a regular part of the monthly QA committee meetings and the committee will make appropriate recommendations to the maintenance director.</p> <p>STAFF PERSON RESPONSIBLE FOR COMPLIANCE: Director of Maintenance.</p>



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F 253	Continued From page 4 gouges in the walls. Continued review revealed no maintenance requests were identified or repaired for the South wing doors, frames, or bead board. Interview, on 12/19/13 at 3:46 PM, with the Administrator revealed the South Wing had been painted about one (1) year ago. The Administrator stated the Director of Maintenance was responsible to maintain the physical environment, including the hallways. He indicated he speaks with the Maintenance Director daily; however, the Maintenance Director was responsible to ensure the facility environment was kept up in a manner that was physically appealing to the residents.	F 253			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to implement the care plan for one (1) of fifteen (15) sampled residents. Resident #4 was care planned to wear Ted Hose support stockings (knee high) daily with application of the stockings in the morning and removal in the evenings. In addition, the resident was to wear space boots when in bed to prevent skin breakdown. The staff failed to consistently provide these preventive measures.	F 282	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #4 received new TED hose support stockings as ordered by the physician. These TED hose support stockings are being applied in the morning and are removed in the evening as ordered. In addition, the resident is wearing space boots when in bed to prevent skin breakdown. An on-the-spot in-service was initiated for all Slider Wing and PRN staff that provide care for resident #4 on 1/8/14 by the Staff Development Coordinator to ensure all staff understand the importance of following the assignment sheet/ plan of care for this resident to reduce the risk of skin breakdown. Also, the importance of reporting to the supervisor when critical items are not available for staff to complete or provide care. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by the same deficient practice. All residents receive care	01/20/2014	

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F 282 Continued From page 5
The findings include:

The facility did not provide a specific policy for care plans.

Review of the comprehensive skin care plan, revised on 12/11/13, revealed the resident was at risk for skin breakdown with interventions developed to prevent skin breakdown that included space boots when in bed, turn and reposition every two (2) hours, monitor skin during toileting, incontinent care and bathing, and treatment per physician orders.

Review of the most current physician orders, dated 12/12/13, revealed the physician had ordered knee high Ted Hose support stockings to be worn every morning with removal in the evening. The original order was dated 05/03/13. In addition, the resident was ordered to wear shoes when up in the wheelchair and space boots when in the bed.

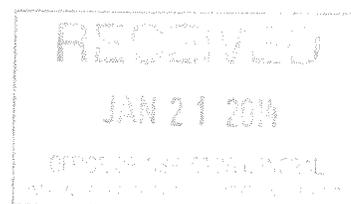
Observation of Resident #4, on 12/17/13 at 8:10 AM, revealed the resident was in the main dining room, sitting in a high back wheelchair with bilateral feet on foot pedals. The resident had space boots on with no Ted Hose support stockings. Observation at 1:00 PM revealed the resident was sitting in the wheelchair in the dining room for lunch. The resident wore regular shoes and socks. The resident was placed back in bed after the noon meal. No space boots were applied and no support stockings. Observation of a skin assessment with CNA #1 at 2:55 PM, revealed the resident was not wearing the space boots in bed nor were the support stockings applied. Observation of the resident's heels during the skin assessment revealed redness, but

F 282 under the guidance of a physician. This care is documented with interventions noted on the care plan and on the C.N.A. assignment sheet. Not providing care according to the resident plan of care places all residents at risk for possible complications. An on-the-spot in-service has been initiated to review with all staff the importance of reviewing the C.N.A. assignment sheet/resident plan of care each day before beginning care. Know the care you are providing and let your team leader know if you do not have all equipment or supplies available to you to complete care. It is critical that nurses review the care that the C.N.A.'s are providing and ensure that all care is completed according to the care plan and the CNA assignment sheet/resident plan of care.

WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:

The CNA assignment sheet/resident plan of care Policy has been reviewed and revised. The changes in this policy address the following concerns:

1. The nurse team leader will now be responsible for obtaining a copy of the CNA assignment sheet/resident plan of care, at the beginning of each work day.
2. The policy outlines the CNA's responsibility in reporting when items are not available to complete assigned care.
3. The policy outlines the nurse team leader's responsibility to check to see that the CNA's have performed all care according to the CNA assignment sheet/resident plan of care.
4. The policy changes will be reviewed in scheduled meetings with staff on January 9 and 10. These are mandatory meetings for all nursing staff (see attached meetings and times). All in-services will be presented by the staff development coordinator and the vice president of nursing and client services, and/or the Assistant Director of Nursing.
5. The medical director has reviewed and



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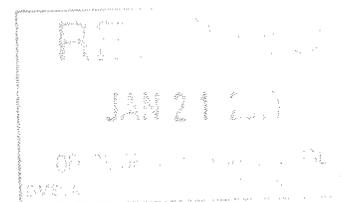
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F 282	<p>Continued From page 6 blanchable.</p> <p>Observation of Resident #4, on 12/18/13, at 8:30 AM, revealed the resident was in the main dining room, sitting in a high back wheelchair. The resident wore regular socks (white) and shoes. No support stockings were applied. Observation, on 12/19/13, at 9:20 AM, revealed the resident was up in the wheelchair with regular socks on. At 9:50 AM, the resident was placed in bed via a mechanical lift. Closer observation revealed the resident's space boots had been placed on a small table at the foot of the resident's bed. Observation revealed the resident's socks had been removed and the resident's heels were touching the mattress. At 10:10 AM until 10:30 AM, observation of catheter care was conducted with CNA #1. The resident was observed to be lying in bed without space boots or support stockings with heels directly touching the bed mattress.</p> <p>Interview with Certified Nurse Assistant (CNA #1), on 12/19/13 at 10:30 AM, revealed she had not applied the Ted Hose support stockings this morning because she could not find them. A search of the room found one support stocking in good condition with the resident's name on the stocking. She stated she had removed the resident's socks to perform catheter care and failed to put on the space boots. Observation revealed the space boots had been placed in the resident's wheelchair. They had been removed off the small table because that is where CNA #1 had placed the supplies to perform indwelling catheter care. Continued interview with the CNA revealed she had forgot to put the space boots on after placing the resident in bed. She acknowledged she had not informed the nurse of</p>	F 282	<p>approved the revisions in the policy.</p> <p>The resident plan of care policy was reviewed. This policy will also be reviewed in scheduled mandatory meetings with all nursing staff on January 9 and 10 (see attached meeting dates and times). All inservices will be presented by the staff development coordinator and the Vice President of nursing and client services and/or the Assistant Director of Nursing.</p> <p>HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED:</p> <p>An audit of the use of the CNA assignment sheet/ resident plan of care will be completed to ensure compliance between the care the staff is performing and the resident's plan of care. The nurse team leader assigned to the resident's care will perform this audit twice a week (once on day shift and once on evenings). the vice president of nursing and client services and/or the assistant director of nursing will perform the audit at least twice a month. Both groups will continue monitoring for 6 months or until 6 months of 100% compliance has been obtained. After 6 month of 100% compliance, the audit frequency will be reduced to once a week for the nurse team leader, but will continue at twice a month for the VP of Nursing and Client Services and/or the Assistant Director of Nursing for 1 year. If the audit remains at 100% compliance, the audit will be reduced to a quarterly random audit. The QA committee will track and trend the level of compliance monthly and make recommendations for change when warranted.</p> <p>PERSON RESPONSIBLE FOR COMPLIANCE: VP of Nursing & Client Services and the Assistant Director of Nursing.</p>	
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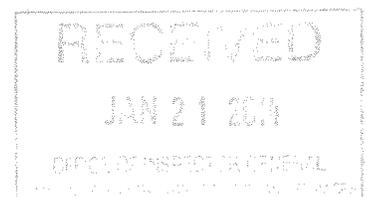
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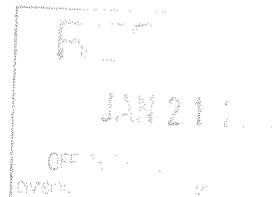
F 282	<p>Continued From page 7 the missing stockings.</p> <p>Interview with License Practical Nurse (LPN #1), on 12/19/13 at 10:45 AM, revealed the nurse had not noticed the resident was not wearing the space boots in bed when she came in and put the barrier cream on the resident's right buttock during perineal care. She did not recall seeing the resident wearing support stockings. Review of the treatment record (TAR) for December 2013 (with LPN #1) revealed the nurse had signed off indicating the resident was wearing the Ted hose support stockings and the space boots. Continued interview with the nurse revealed she had been busy passing medications and had not visualized the resident this morning. However, she had documented the space boots and Ted Hose were applied. She stated she was rushed and only signed off without visualizing the resident to ensure the space boots and Ted Hose stockings had been applied.</p> <p>On 12/19/13 at 11:12 AM, an interview with the North Unit Manager, revealed CNAs were provided a CNA care plan colored coded yellow. She stated the CNAs were supposed to receive one at the beginning of their shift. This care plan provided information on each resident's care needs. She stated the CNA care plans were updated with daily changes. The CNA were supposed to follow those instructions.</p> <p>Review of the yellow sheet, CNA care plans, on 12/19/13 for Resident #4, revealed instructions to put the Ted Hose support stockings on in the morning and take them off at bedtime. In addition, the resident was to wear shoes when up in the wheelchair and space boots when in bed.</p>	F 282		
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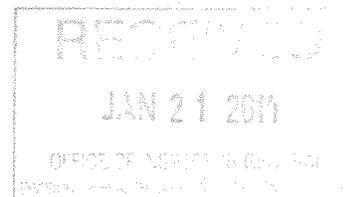
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F 282	Continued From page 8 Interview with CNA #1, on 12/19/13 at 11:20 AM, revealed she had a copy of the CNA care plan for that day and knew Resident #4 was suppose to wear support stockings and space boots.	F 282			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide necessary care and services to prevent pressure sore development for one of fifteen (15) sampled residents. The facility identified Resident #4 as currently having an open area to the right buttock. The facility assessed the resident to be at risk for skin breakdown on the heels related to decrease mobility and dependence on staff for transfers, turning, and repositioning. The physician ordered space boots to be applied whenever the resident was in bed to help prevent skin breakdown of the heels. The staff failed to consistently apply the space boots. The findings include: The facility did not provide the requested copy of	F 314	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #4 is wearing her space boots when in bed to keep her heels off the mattress as ordered by the physician. An on-the-spot in-service was initiated for all Slider Wing and PRN staff that provide care for resident #4 on 1/8/14 by the Staff Development Coordinator to ensure all staff understand the importance of following the assignment sheet/plan of care for this resident to reduce the risk of skin breakdown. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DIFICIENT PRACTICE: All residents have the potential to be affected by the same deficient practice. The majority of our residents have some degree of skin breakdown risk. These factors will vary based on the level of mobility, level of incontinence, and underlying health status. Interventions are based on the level of risk and are documented on the resident's care plan and are located on the CNA assignment sheet/ resident plan of care. Resident skin breakdown risk is determined during the assessment process. This occurs upon admission, quarterly, annually, and upon significant change. Weekly, the nurse team leaders assess the effectiveness of the current interventions and assess if skin breakdown has occurred. Observations of residents' skin during bi-weekly bathing are conducted by the CNA's. Skin Review Forms are utilized to record and report changes in the skin integrity. Nurse Team Leaders assess any changes noted on this form and based on their	01/20/2014	



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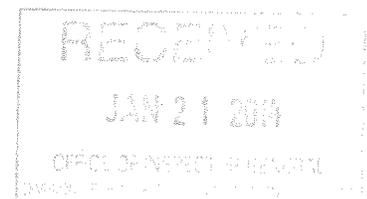
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F 314	<p>Continued From page 9 a policy regarding pressure ulcers.</p> <p>Record review revealed the resident had resided at the nursing facility since August 2012. Review of the most current comprehensive Minimum Data Set (MDS), dated 03/19/13, revealed the facility assessed the resident to be dependent on staff for bed mobility, transfers, and toileting needs and was identified non-ambulatory. The facility assessed Resident #4 to have a severe cognitive impairment. Review of the clinical record and observation of a skin assessment with CNA #1, on 12/17/13 at 2:55 PM, revealed Resident #4 had an open area to the right buttock and bilateral heels were red, but blanchable. Review of the comprehensive care plan, revised 12/11/13, revealed the facility developed approaches to prevent additional skin breakdown as following: pressure reduction mattress, monitor skin, space boots when in bed, turn and reposition every two hours, turning side to side only. Review of the Certified Nursing Assistant (CNA) care plan for Resident #4 revealed instructions to turn and reposition the resident every two hours, keep off back, and apply space boots when in bed.</p> <p>Observation of Resident #4, on 12/17/13 at 1:00 PM, revealed the resident was sitting in a high back wheelchair in the main dining room for lunch. Observation at 1:55 PM, revealed the resident was placed in bed after the noon meal. The space boots were not applied. Observation during a skin assessment with CNA #1, on 12/17/13 at 2:55 PM, revealed the resident was not wearing the space boots in bed and the heels were resting on the mattress. Observation of the resident's heels during the skin assessment revealed the heels were red, but blanchable.</p>	F 314	<p>assessment, they contact the physician for orders/interventions to begin appropriate treatment as needed.</p> <p>WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <p>The skin breakdown/pressure ulcer policy has been revised.</p> <ol style="list-style-type: none"> The revised policy more clearly outlines risk factors, definitions as outlines in the regulatory guidelines, prevention, interventions, and infection control and quality assurance. Mandatory in-services will be presented to all nurses on the policy changes January 9 and 10 (see attached). The Medical Director has reviewed and approved the revision in the Skin Breakdown/Pressure Ulcer Policy. All in-services will be presented by the Staff Development Coordinator, Vice President of Nursing and Client Services, and/or the Assistant Director of Nursing. <p>HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED:</p> <ol style="list-style-type: none"> The Assistant Director of Nursing (ADON) will review the Weekly Skin Reports at the beginning of the following week to ensure all new skin concerns have been addressed or to ensure that skin breakdown that is not healing or is worsening is being addressed. All new skin breakdown cases will receive an order for the Wound Care Physician to see the resident. All information is placed in the binder for Dr. Milam (wound care physician) to see resident. The Assistant Director of Nursing will ensure this has occurred. The ADON will review all completed Skin Review Forms completed by the CNA's and signed by the Team Managers. The ADON will monitor to ensure all skin concerns identified during bathing are 		



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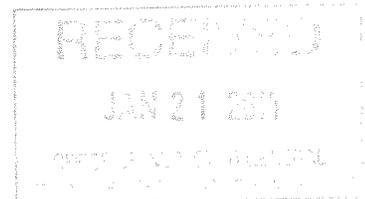
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F 314	<p>Continued From page 10</p> <p>Observation of Resident #4, on 12/18/13 at 9:20 AM, revealed the resident was sitting in the wheelchair in the resident's room. At 9:50 AM, the resident was placed in bed via mechanical lift. Closer observation revealed the resident was not wearing the space boots because they had been placed on a small table at the foot of the resident's bed. Observation revealed the resident's socks had been removed and the resident's bare heels were touching the mattress. At 10:10 AM until 10:30 AM, observation of catheter care was conducted. The resident was observed to be lying in bed without the space boots with the heels directly touching the bed mattress.</p> <p>Interview with Certified Nurse Assistant (CNA #1), on 12/19/13 at 10:30 AM, revealed she had removed the resident's socks to perform catheter care and failed to put on the space boots. Observation revealed the space boots had been placed in the resident's wheelchair. Continued interview with the CNA revealed she had forgot to put the space boots on after placing the resident in bed.</p> <p>Interview with License Practical Nurse (LPN #1), on 12/19/13 at 10:45 AM, revealed the nurse had not noticed the resident was not wearing the space boots in bed when she came in and put the barrier cream on the resident's right buttock during perineal care. Review of the treatment record (TAR) for December 2013 (with LPN #1) revealed the nurse had signed off that the resident was wearing the space boots. Continued interview with the nurse revealed she had been busy passing medications and had not visualized the resident this morning. However, she had documented the space boots had been applied.</p>	F 314	<p>ensure all skin concerns identified during bathing are addressed promptly. All results will be reported to the QA committee to track and trend on-going compliance and make recommendations for change as warranted.</p> <p>PERSON RESPONSIBLE FOR COMPLIANCE: Assistant Director of Nursing</p>		



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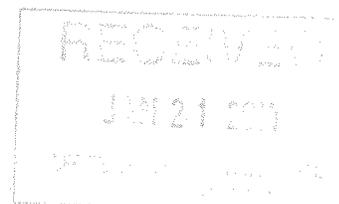
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F 314	Continued From page 11 She stated she was rushed and only signed off without visualizing the resident and did not ensure the space boots had been applied. The nurse acknowledged the resident is at risk for skin breakdown. On 12/19/13 at 11:12 AM, an interview with the North Unit Manager, revealed CNAs were supposed to receive the CNA care plan at the beginning of their shift. This care plan provided information on each resident's care needs. She stated the CNA care plans were dated with daily changes and the CNAs were supposed to follow those instructions. Interview with CNA #1, on 12/19/13 at 11:20 AM, revealed she had a copy of the CNA care plan for that day and knew Resident #4 was suppose to wear space boots in bed, but she had forgot. Interview with the Director of Nursing, on 02/19/13 at 2:51 PM, revealed the CNAs were supposed to follow their care plans and apply devices to prevent any skin breakdown. The staff nurse assigned to that resident was responsible to ensure that occurred.	F 314			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #4 currently does not have any signs or symptoms of an UTI. Her last treatment for an UTI was August, 2013. A physician's order was received to obtain an UA with C&S as indicated. The ARNP for the Medical Director is scheduled to see the residents on January 9, 2014 to provide a complete assessment. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE	01/20/2104	



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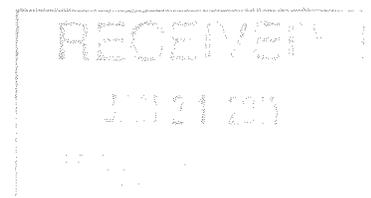
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F 315	Continued From page 12 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure one (1) of three (3) residents with an indwelling catheter, of the fifteen (15) sampled residents, received appropriate treatment and services to prevent Urinary Tract Infections. (UTI). Resident #4 utilized an indwelling catheter for Urinary Retention and the resident had a history of UTIs. The staff failed to use appropriate techniques for perineal and catheter care according to facility policy to prevent infections. The findings include: Review of the Perineal Care policy (that included indwelling catheter care), not dated, revealed the policy instructed the staff to wash the perineal area with peri-wash, wiping front to back. Separate the labia and if a resident had an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about three (3) inches. Continue to wash the perineum with peri-wash moving from inside outward and then to the thighs alternating sides using downward strokes. Do not reuse the washcloth or water to clean the urethra or labia. Use a clean part of the washcloth for each stroke. Observation of perineal and catheter care with CNA #1, on 12/19/13 at 10:10 AM, revealed the Certified Nursing Assistance used alcohol sanitizer before putting on clean gloves. She sprayed Peri-wash onto a clean washcloth. She washed the resident's left thigh crease with	F 315	AFFECTED BY THE SAME DEFICIENT PRACTICE: Any resident with an indwelling catheter has been assessed for signs and symptoms of infection. Currently, there are 2 residents with an indwelling catheter (residents #1 and #4). Resident #1 does have a pending US with C&S as indicated. This was sent to lab on January 8, 2014 related to on-going hallucinations, but no elevated temperature, no change in urine color or odor. No other signs or symptoms of UTI were noted. MEASURES TO BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECURR: 1. The Perineal Care Policy was reviewed and revised on January 6, 2014. 2. The Perineal Care Checklist was revised on January 6, 2014 to include care for a resident with an indwelling catheter. 3. The Perineal Care Policy and Checklist will be reviewed with all Nursing Staff. All nursing staff will receive hands-on demonstration and check-off with anatomical models for perineal care with an indwelling catheter. All nursing staff will receive an annual check-off on perineal care with an indwelling catheter as part of their annual evaluation process. Each new nursing employee will be provided demonstration on perineal care during orientation and check-off by the completion of the probationary period. 4. Any nursing staff that is unable to successfully complete the demonstration and check-off of perineal care with an indwelling catheter will be removed from the schedule to provide additional training and ensure compliance and safety. 5. The Medical Director has reviewed and approved the revision on the Perineal Care Policy and Checklist. 6. Perineal Care, Catheter Care demonstrations and Check-offs, are scheduled for January 13 thru 16.		



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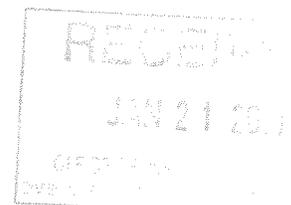
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F 315	<p>Continued From page 13</p> <p>downward strokes. She then washed the right thigh crease toward the perineum with the same portion of the washcloth. She then took the same portion of the washcloth and cleaned the labia and urethra. The resident had become incontinent of bowel. She cleaned the feces with the disposable brief, removed the brief, and placed it into the trash. She removed her gloves; however, she did not perform hand hygiene. She then applied clean gloves and placed the soiled washcloths used to clean the feces into a bag that contained clean washcloths. She proceeded to clean the resident's bottom using front to back techniques. She obtained a clean washcloth from the bag where she had placed the washcloth soiled with feces. She then proceeded to clean the resident's catheter and tubing.</p> <p>Interview with CNA #1, on 12/19/13 at 10:30 AM, revealed she had been trained on the proper way to perform perineal/catheter care. She didn't realize she had used the same portion of the washcloth. She thought she had folded the washcloth and used different areas.</p> <p>Review of the August 2013 infection log revealed Resident #4 had a UTI in August 2013.</p> <p>Interview with the Staff Development Nurse, on 12/19/13 at 3:12 PM, revealed all staff had been trained on proper hand hygiene and how to perform appropriate perineal/catheter care in July 2013 to correct deficiencies noted on a previous survey. She was able to provide evidence CNA #1 had been trained on 7/19/13 and 8/17/13.</p> <p>Interview with the Director of Nursing (DON), on 12/19/13 at 2:51 PM, revealed she was not</p>	F 315	<p>These are all mandatory sessions. Staff that fail to attend one of these sessions will be removed from the schedule and will not be permitted to work until demonstration and successful check-off has been completed.</p> <p>HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED: The Staff Development Coordinator will, at random, select 3 employees monthly (that are not due for an evaluation) and ask that employee to perform perineal care, including demonstration on proper indwelling catheter care. Staff unable to perform the procedure with 100% accuracy will be removed from the schedule to allow for additional training to ensure compliance and safety. All monthly completed Perineal Checklists will be turned into the QA Committee for review and recommendation, if any.</p> <p>PERSON RESPONSIBLE FOR COMPLIANCE: The Staff Development Coordinator/Assistant Director of Nursing.</p>		



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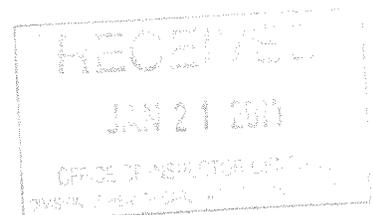
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F 315	Continued From page 14 conducting audits of hand hygiene. The nursing staff was trained upon hire and during the annual competency training. She stated the Assistant Director of Nursing (ADON) tracks and trends infections in the facility and if they saw an increase in infections, she would consider retraining. They would take this information to the QA meetings to check against the state and national average. She stated they look for clusters of infections that may indicate a problem. She stated staff were only observed performing perineal care during their yearly competency testing.	F 315			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: 1. Resident #4 currently does not have any signs or symptoms of an UTI. Her last treatment for an UTI was August, 2013. A physician's order was received to obtain an UA with C&S as indicated. The ARNP for the Medical Director is scheduled to see the resident on January 9, 2014, to provide a complete assessment. 2. No other residents were identified related to this deficient practice. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by the same deficient practice. Staff failing to complete hand hygiene or failing to complete hand hygiene after the removal of gloves are a violation of the facility's policies and place the resident at increased risk of infection. MEASURES TO BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT	01/20/2014	



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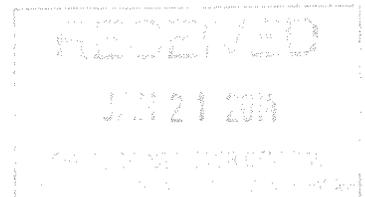
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F 441	Continued From page 15 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to consistently implement their Infection Control Program related to hand hygiene during passing of food trays for one (1) of three (3) units, the South Wing. The staff failed to complete hand hygiene between residents after assisting the residents during meal tray pass In addition, Facility staff failed to perform hand hygiene after removal of gloves during perineal/catheter care for one (1) of fifteen (15) sampled residents. Resident #4. The findings include: Review of the facility's policy regarding Hand Washing/ Hand Hygiene, revised July 2013, revealed all personnel would follow hand hygiene procedures to prevent the spread of infection to other residents. Employees should perform hand hygiene before and after direct resident contact, before and after handling food, before and after	F 441	RUCUR: 1. The policy, Feeding Residents in the Main Dining Room, was updated to include staff using hand sanitizer or washing hands whenever in contact with resident equipment, between each resident, touching resident food, etc. 2. The policy, Hand Washing and Hand Hygiene, was reviewed for compliance. 3. All staff will be inserviced on all policies January 9 and 10. 4. All staff will receive hand-washing check-offs January 13 thru 16. Focus on the check-off will not only include technique, but for the nursing staff, to be able to discuss when hands should be washed and when hand sanitizers should be used. Discussion around moving beyond the task, not thinking so much about the entire task they have ahead of them, that they do not focus on the one function before them. 5. Each month, the Staff Development Coordinator will provide Infection Control Tips or statistics to the staff, and information on how proper hand-washing could prevent the spread of infection. This information will be posted in the break room, bathroom and other various places that employees use to increase awareness to the importance of hand hygiene. 6. The Medical Director has reviewed and approved policy changes and has provided guidance to staff intervention to improve hand hygiene. HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED: 1. A hand-washing audit will be completed weekly. It will be completed once weekly by each of the following management staff: The Staff Development Coordinator, the RAI Coordinator, the ADON and the Vice President of Nursing and Client Services. Twice a month, the manager will audit the dining room and twice a month they'll audit another area of care.		



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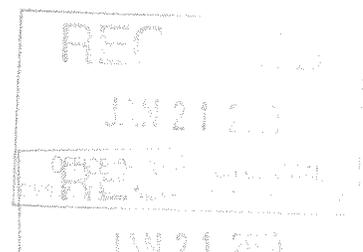
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F 441	<p>Continued From page 16</p> <p>assisting residents with meals, and after contact with objects in the immediate vicinity of a resident. Hand hygiene is to be conducted after removal of gloves.</p> <p>1. Observation of the breakfast tray pass on the South Wing, on 12/17/13 at 8:17 AM, revealed Registered Nurse (RN) Supervisor #1 delivered a breakfast tray to Resident #11 in the resident's room. The RN assisted the resident to move the table into position and took a towel from the resident's bathroom to be used as a clothing protector. The RN then delivered a meal tray to Resident #10 in the resident's room. The nurse was then observed to deliver the meal tray to Unsampled Resident F and assisted to set up the meal tray in the resident's room.</p> <p>Interview with RN #1, on 12/19/13 at 1:47 PM, revealed she should have cleansed her hands after assisting each resident, and before assisting the next resident. The RN stated there was hand sanitizer pumps in the hallway and a bottle of alcohol gel that staff could keep in their pockets. She indicated she had been trained to use hand sanitizer or to wash hands before and after assisting a resident. The nurse stated the purpose of cleansing her hands was to prevent the spread of infection to others.</p> <p>2. Observation of perineal and catheter care, on 12/19/13 at 10:10 AM, revealed CNA #1 used alcohol sanitizer before putting on clean gloves. She sprayed Peri-wash onto a clean washcloth and continued to perform perineal care. Refer to F-315. When CNA #1 changed her soiled gloves to clean gloves, she did not perform hand hygiene. In addition, after providing perineal and catheter care, the CNA emptied the urine from</p>	F 441	<p>2. All results will be reported monthly to the QA committee to track and trend on-going compliance and make recommendations for change as warranted.</p> <p>3. The audits will be done weekly for 4 months - compliance rate of 100% will provide an opportunity to decrease the audits to twice a month for 4 months, and then monthly if 100% compliance is maintained.</p> <p>PERSON RESPONSIBLE FOR COMPLIANCE: The Vice President of Nursing and Client Services and/or Assistant Director of Nursing</p>	



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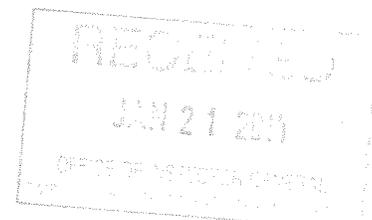
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F 441	<p>Continued From page 17</p> <p>the drainage bag, discarded the urine into the toilet, removed her gloves but did not perform hand hygiene. The CNA was observed to touch the resident's bed linens and privacy curtain with the hands that had not been cleaned after emptying the urine.</p> <p>Interview with CNA #1, on 12/19/3 at 10:30 AM, revealed she thought she had used hand sanitizer after she removed her gloves. She stated she did change gloves between the tasks, but guessed she forgot to use hand sanitizer. Observation revealed the CNA had placed a small bottle of alcohol gel on the table with supplies to perform perineal care. She stated she waited to wash hands after emptying the drainage bag until she reached the dirty utility room where she disposed of soiled linens.</p> <p>On 12/19/13 at 2:29 PM and 2:51 PM, interview with the Director of Nursing (DON) revealed hand hygiene should be performed before and after care of a resident, including handling resident food. The DON stated she randomly observed food tray pass, but had not done so recently. She stated hand hygiene training was conducted in August for all employees. The DON indicated the staff was trained on hand hygiene on hire and annually. She further indicated when passing food trays, gloves should be worn to prevent the spread of infection to others. She further stated hand hygiene should be performed after removal of gloves.</p> <p>Interview, on 12/19/13 at 3:12 PM, with the Staff Development Coordinator (SDC) revealed employees received hand hygiene training within the first sixty (60) days of hire and then annually. She stated she was responsible to conduct staff</p>	F 441		



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F 441	<p>Continued From page 18</p> <p>training for new employees; however, each supervisor conducted the training for his or her staff. The SDC indicated she trained the Nurse Supervisors so they could train the nurses and Certified Nurse Aides (CNA).</p> <p>Interview with the Administrator, on 12/19/13 at 3:46 PM, revealed the DON was responsible to monitor hand hygiene during food tray pass and the SDC was responsible to train employees on hand hygiene. The Administrator stated he was not aware of any issues with hand hygiene during food tray pass. He indicated without using hand sanitizer or washing hands before and after assisting residents during food tray pass, employees could spread infection and residents could become sick.</p>	F 441		



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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: 1976</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic 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 12/17/13. Wesley Manor Nursing Center was found to be not in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire). The facility is certified for sixty eight (68) beds with a census of sixty five (65) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X JERRY L. HOGANSON</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>X January 21, 2014</i>
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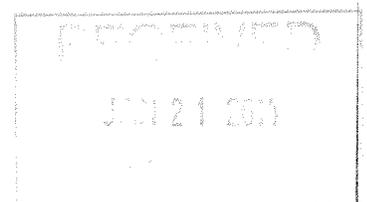
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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DIVISION OF HEALTH CARE SERVICES

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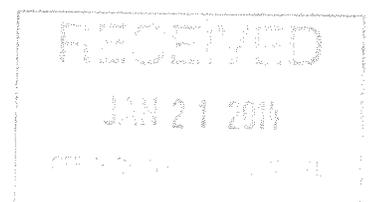
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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "D" level.	K 000			
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, twenty four (24) residents, staff and visitors. The facility is certified for sixty eight (68) beds with a census of sixty five (65) on the day of the survey. The findings include: Observation, on 12/17/13 at 11:48 AM, with the Director of Maintenance revealed the smoke barrier located in the attic of the Slider Wing was not protected with drywall on both sides of the	K 025	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: A drywall installer has been contacted and will complete installation of drywall on the 2nd side of the smoke barrier on January 21, 2014. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents residing in the adjoining smoke compartments have the potential to be affected by the same deficient practice. MEASURES TO BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The repair to the smoke barrier will ensure that the deficient practice does not recur. Other smoke barriers have been inspected and it was determined that they are in compliance. The Director of Maintenance was informed by the state inspector of the requirement to have drywall on both sides of the smoke barrier. The Director of maintenance was educated about this requirement of the NFPA standards on 12/20/2013 by the administrator. The Director of Maintenance will perform monthly checks of the condition of the smoke barrier to ensure that any penetrations made by vendors or anyone else are properly sealed according to NFPA standard.	02/02/14	



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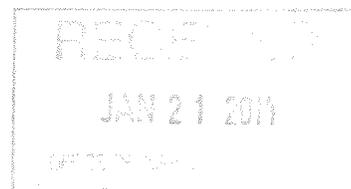
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K 025	<p>Continued From page 2</p> <p>smoke barrier leaving the bare wood framing studs exposed on one side of the smoke barrier.</p> <p>Interview, on 12/17/13 at 11:48 AM, with the Director of Maintenance revealed he was not aware the smoke barriers only had drywall on one side of the framing.</p> <p>Reference: NFPA 101 (2000 edition) 19.3.7.3</p> <p>Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.</p> <p>Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor.</p> <p>Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.</p> <p>8.3 SMOKE BARRIERS</p> <p>8.3.1* General.</p> <p>Where required by Chapters 12 through 42, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke.</p> <p>8.3.2* Continuity.</p> <p>Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous</p>	K 025	<p>HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED:</p> <p>The Director of Maintenance will perform monthly inspections of the smoke barriers and compartments to ensure continued compliance. He will also report monthly to the QA committee on the fire safety condition of the building. The QA committee will suggest changes to the building and related procedures when needed.</p> <p>PERSON RESPONSIBLE FOR COMPLIANCE: Director of Maintenance.</p>	



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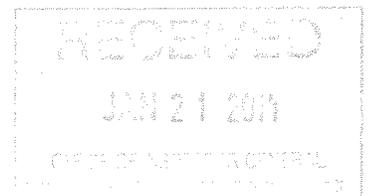
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K 025	Continued From page 3 through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free	K 072	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:	02/01/14



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K 072	<p>Continued From page 4</p> <p>of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty eight (68) beds with a census of sixty five (65) on the day of the survey. The facility failed to ensure the means of egress was free of all obstructions or impediments.</p> <p>The findings include:</p> <p>Observations, on 12/17/13 at 1:22 PM, with the Director of Maintenance revealed six (6) mattresses, a lift, and two (2) folding chairs being stored in the Laundry Hall.</p> <p>Interview, on 12/17/13 at 1:22 PM, with the Director of Maintenance revealed items were routinely stored in this hall.</p> <p>Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p>	K 072	<p>A new policy has been written to state that no items are to be stored in corridors or in any areas of egress. This policy is being shared with all facility staff who are involved in receiving supplies and equipment during on-the-spot in-services. These inservices will be completed before February 1, 2014.</p> <p>HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents in the facility have the same potential to be affected by the deficient practice.</p> <p>MEASURES TO BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Hallways and means of egress will be inspected on a daily basis by the Director of Maintenance to ensure that these areas are not used for storage. Any items found to be stored in these areas will be removed immediately.</p> <p>HOW THE FACILITY WILL MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED: The daily inspection of these areas will ensure that solutions are sustained. A report of these inspections will be submitted to the QA committee on a monthly basis.</p> <p>PERSON RESPONSIBLE FOR COMPLIANCE: Director of Maintenance.</p>		



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K 076 K 076 SS=D	Continued From page 5 NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty eight (68) beds with a census of sixty five (65) on the day of the survey. The facility failed to ensure oxygen storage over 300 cu ft. was stored five (5) feet away from any combustibles and ignition sources were located five (5) feet from the floor. The findings include: Observation, on 12/17/13 at 1:18 PM, with the Director of Maintenance revealed twenty seven (27) E type oxygen tanks stored in the Clean	K 076 K 076	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Oxygen company was contacted by phone during the survey and informed of the deficient practice. They were ordered to remove some of the Oxygen cylinders so that the storage room was once again in compliance, and that they are to adjust their delivery schedule so that the needs of the facility residents are met while maintaining compliance with regulations. This was completed before the survey exit on December 19, 2013. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents in the facility have the potential to be equally affected by the deficient practice. MEASURES TO BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Oxygen company has been informed of their need to comply with this regulation. The Director of Maintenance will perform monthly audits of the Oxygen storage room to ensure that the facility remains in compliance. HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED: The monthly audits will ensure that solutions are sustained. The audits will also be reported to the monthly QA committee meetings and the committee will make recommendations for changes when warranted. PERSON RESPONSIBLE FOR COMPLIANCE: Director of Maintenance.	02/01/14	



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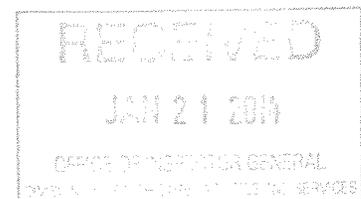
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K 076	Continued From page 6 Linen Room/Oxygen Room. The room had a light switch installed below five (5) foot from the floor. Further observation revealed combustibles stored within five (5) feet of the oxygen tanks. Interview, on 12/17/13 at 1:18 PM, with the Director of Maintenance revealed he was not aware of the requirements for oxygen storage. Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall	K 076			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 12/17/2013
NAME OF PROVIDER OR SUPPLIER WESLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 5012 EAST MANSLICK RD LOUISVILLE, KY 40219	
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K 076	Continued From page 7 meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076		
K 147 SS=D	8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments,	K 147	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE: The power strips were removed one the same day as the survey. The person(s) responsible for using the power strips were informed by the Director of Maintenance that they are not to be used in the facility. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents in the facility, or all offices in the facility as well and that utilize portable electrical equipment have the potential to be affected by this deficient practice.	02/01/14



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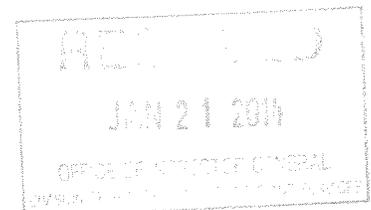
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185136	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2013
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K 147	<p>Continued From page 8</p> <p>residents, staff, and visitors. The facility is certified for sixty eight (68) beds with a census of sixty five (65) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 12/17/13 between 11:30 AM and 3:00 PM, with the Director of Maintenance revealed:</p> <ol style="list-style-type: none"> 1) An oxygen concentrator was plugged into a power strip located in room S12. 2) A microwave was plugged into a power strip located in the Activities Office. 3) A refrigerator was plugged into a power strip located in room N12. <p>Interview, on 12/17/13 between 11:30 AM and 3:00 PM, with the Director of Maintenance revealed he was not aware of the misuse of power strips.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>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.</p> <p>Reference: NFPA 70 400-8</p> <p>(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</p>	K 147	<p>WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <p>The Director of Maintenance will conduct monthly inspections of all resident rooms and offices to ensure that power strips are not inappropriately utilized. The maintenance, nursing, and housekeeping staff were informed verbally on 12/20/13 of this requirement by the Director of Maintenance and they have been instructed to report any misuse of power strips or extension cords. A memo has been placed near the time clock reminding employees to not use power strips or extension cords for any equipment that has not been approved by the Director of Maintenance. (See attachment K147)</p> <p>HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED:</p> <p>The monthly inspections of resident rooms and offices will ensure that the solutions are sustained. The inspection reports will be presented to the QA committee on a monthly basis and appropriate recommendations made when warranted.</p> <p>PERSON RESPONSIBLE FOR COMPLIANCE: Director of Maintenance.</p>		



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K 147	<p>Continued From page 9</p> <p>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p> <p>(3) Where run through doorways, windows, or similar openings</p> <p>(4) Where attached to building surfaces</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>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>	K 147		





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Policy Reminder

January, 2014

Use of power strips and extension cords in the Health Care Center

Power strips and/or extension cords shall not be used in the health care center for any portable equipment in resident rooms or in office space as well. For example, power strips should not be used to power microwaves, refrigerators, or Oxygen concentrators.

If extension cords or power strips are found to be in use, the situation should be reported immediately to the Director of Maintenance. (ref. NFPA 101, 200 edition)

