

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

PRINTED: 03/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/15/2013
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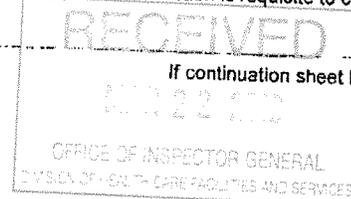
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR	STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217
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F 000	INITIAL COMMENTS A recertification survey was initiated on 02/13/13 and concluded on 02/15/13 and a Life Safety Code survey was conducted on 02/13/13 with the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 205 SS=B	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to provide two (2) of nine (9) sampled residents (Resident #4 and Resident #7) with the facility's	F 205	F 205: 1.) As of 2/26/13, a copy of the LSP Bed Hold Policy has been placed on every resident's chart. See attached sample. 2.) The original document is to be maintained in a plastic protective sheet cover in each resident's chart, and the nursing staff is to provide a copy of LSP Bed Hold Policy to any resident who is transferred or discharged to an acute care facility or who leaves the facility for a therapeutic visit. A checklist of all documents being sent out with the resident will be done at time of transfer. The Bed Hold document is double-sided with a table on the second side of the page where nursing staff is to document the reason and date of the resident's transfer or discharge. Medical Records Office also has copies of the LSP Bed Hold Policy to include with any medical papers that go out with a resident who is having a medical/surgical procedure outside of this facility. Copies of all documents being sent to the outside facility will be reviewed by the DON or ADON to assure a Bed Hold Policy is being sent and that checklist has been completed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Dr. Maureen Courtney* TITLE ADMINISTRATOR (X6) DATE 3/22/13

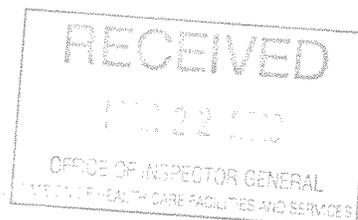
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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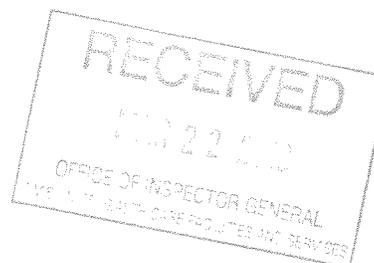
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F 205	Continued From page 1 bedhold policy when they were transferred to acute care for treatment. The findings include: Review of the facility's policy regarding Transfer/Discharge, dated 05/2006, revealed the facility provided a copy of a transfer form, a copy of the Advance Directives, a copy of the face sheet and a copy of relevant laboratory/x-ray reports upon transfer of a resident to another entity. Review of the clinical record for Resident #4 revealed the facility admitted the resident with a diagnosis of Moderately Severe Alzheimer's Disease. On 10/20/12 the facility transferred the resident to an acute care hospital with pneumonia. The resident was admitted to the hospital. There was no evidence to show the facility provided the resident with a copy of the facility's bedhold policy. Review of the clinical record for Resident #7 revealed the facility admitted the resident with a diagnosis of End Stage Renal Disease. On 12/02/12 the resident was transferred to an acute care hospital after sustaining a fall with injuries. The resident was admitted to the hospital. There was no evidence to show the facility provided the resident with a copy of the facility's bedhold policy. Interview with Registered Nurse (RN) #2, on 02/14/13 at 3:00 PM, revealed the facility did not provide residents with a copy of the bedhold policy when they were transferred to a hospital. She stated she was not aware the facility was	F 205	3.) All active nursing staff has been educated on the LSP Bed Hold Policy procedure by participating in an in-service created by ADON. All education was completed by 3/6/13. Residents who have been transferred or discharged will have the checklist reviewed to assure that Bed Hold Policies are being sent with residents at least quarterly by the QA committee.	3/7/13



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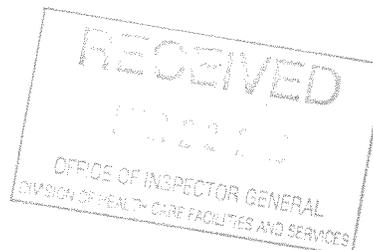
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F 205	Continued From page 2 required to do this. She stated resident beds were held so this notification was not necessary. Interview with the Director of Nursing, on 02/15/13 at 11:10 AM, revealed the facility did not provide residents with a bedhold notice when they were transferred to a hospital. She stated the notice was reviewed during the admission process so no other notice was needed.	F 205			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was	F 279	F 279 Comprehensive Care Plan Care plans are maintained in an electronic format with the most current care plan printed out and kept in a binder at each station. However, changes and revisions that are being made are not always seen in the current electronic version. (i.e. a sore throat was a problem a week ago and was care planned. The sore throat is now resolved and has been removed from the electronic version, but will not show up on a current copy or the electronic version and thus may not look as if it were not care planned). Therefore care plans will be changed out quarterly. Hard copy format will stay in the residents' record. This will show ongoing changes and revisions that have been made but may not directly be seen on the most current electronic record. The care plan will also continue to be maintained in the electronic format.		



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F 279		F 279	<p>F 279 Comprehensive Care Plan</p> <p>All care plans for all residents receiving any type of psychotropic medications have been reviewed and revised as necessary. These reviews were completed on March 6th 2013 by the MDS Coordinator.</p> <p>The Behavior/Intervention Monthly Flow Record form was reviewed and approved by the in house psychiatrist today while here on rounds. 3/7/2013.</p> <p>All care plans for all residents are currently in review by the MDS Coordinator. Completion of reviews and any revisions will be completed by March 22, 2013</p>	



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F 279	Continued From page 3 determined the facility failed to develop a comprehensive plan of care based on the comprehensive assessment for four (4) of the nine (9) sampled residents (#1, #2, #4 and #7) to address who was responsible for monitoring psychotropic medication side effects and how often the monitoring would be completed for Resident #2, #4 and #7, for Resident #1's assessed risk for pressure, and Resident #2's indwelling urinary catheter. The findings include: Review of the facility's policy regarding Care Plans, dated 05/2006, revealed every resident would have a care plan with quantifiable objectives for the highest level of functioning the resident may be able to attain. Review of the facility's policy regarding Behavior Management, dated 05/2006, revealed medication and environmental interventions may be used to manage behaviors. Medications are closely monitored for both side effects and desired effect. Residents and family members are encouraged to participate in the development of the behavior care plan and the assessment of the effectiveness of the interventions. Review of the facility's policy regarding Catheter Care-Urinary, dated 07/2005, revealed a responsibility of all nursing personnel was to provide safe and effective catheter care to prevent infection, maintain adequate urine flow, and to prevent the catheter from becoming dislocated. Review of the facility's policy regarding	F 279	F279 Comprehensive Care Plan When updates/revisions are made in the current care plan electronically, the binder copy will also be updated by hand. Information will always be current and up to date and accessible by the staff for reference and care information. This hard copy care plan will be replaced with the revised quarterly and maintained in the residents records. Any Discipline that needs notification of revisions in a care plan will be notified via electronic alert or communication on the electronic dashboard. The Department Heads will continue to be made aware of changes with the resident verbally at the morning meetings Monday through Friday at 10:00 am. The Computer On Wheels will be utilized at these meetings and revisions will also be made as needed at that time.	



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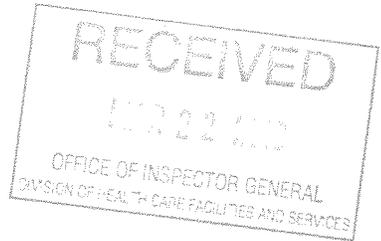
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F 279	<p>Continued From page 3</p> <p>determined the facility failed to develop a comprehensive plan of care based on the comprehensive assessment for four (4) of the nine (9) sampled residents (#1, #2, #4 and #7) to address who was responsible for monitoring psychotropic medication side effects and how often the monitoring would be completed for Resident #2, #4 and #7, for Resident #1's assessed risk for pressure, and Resident #2's indwelling urinary catheter.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care Plans, dated 05/2006, revealed every resident would have a care plan with quantifiable objectives for the highest level of functioning the resident may be able to attain.</p> <p>Review of the facility's policy regarding Behavior Management, dated 05/2006, revealed medication and environmental interventions may be used to manage behaviors. Medications are closely monitored for both side effects and desired effect. Residents and family members are encouraged to participate in the development of the behavior care plan and the assessment of the effectiveness of the interventions.</p> <p>Review of the facility's policy regarding Catheter Care-Urinary, dated 07/2005, revealed a responsibility of all nursing personnel was to provide safe and effective catheter care to prevent infection, maintain adequate urine flow, and to prevent the catheter from becoming dislocated.</p> <p>Review of the facility's policy regarding</p>	F 279	<p>F 279 RESIDENT # 7</p> <p>Residents care plan was revised to include observing specific medication side effects such as drowsiness or changes in physical movement. Mood and behavior will be closely monitored as CNA's will chart q shift per kiosk. Nurses will document every shift on medications and possible side effects using a Behavior/intervention Monthly Flow record form. Pharmacy will continue to review medications every month with facility staff taking these under advisement for possible reduction or elimination of medications. Psychiatrist will see resident at least every 3 months to monitor behavior and medications and all recommendations will be followed.</p> <p>All staff nurses will review and sign the Psychoactive Medication Policy. This has been initiated by the DON and will be completed by March 11th, 2013.</p> <p>All resident care plans will be reviewed at least every 3 months by the IDT members. All appropriate changes being made as they occur. Each care plan will be individually reviewed as assigned by a staff nurse to ensure that they are aware of changes in any plan of care. And to report any changes that are not effective. This will be monitored by electronic signature of review.</p>		



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F 279	<p>Continued From page 4</p> <p>Catheter-Leg Bag, dated 07/2005, revealed leg bags were to be changed every two (2) weeks.</p> <p>1. Review of Resident #1's clinical record revealed the facility assessed the resident on the Minimum Data Set (MDS), dated 03/23/12, as being at risk for developing pressure areas related to the resident's limited bed mobility and diversional bowel and urinary devices. The Care Area Assessment (CAA) worksheet revealed risk for pressure development would be addressed on the comprehensive plan of care to avoid complications and minimize risks. However, review of the facility's comprehensive plan of care for Resident #1 revealed a risk for pressure development was not addressed.</p> <p>Observation of Resident #1's skin assessment, on 02/14/13 at 10:30 AM, revealed the resident required assistance with positioning and getting in and out of bed, no concerns were noted with skin integrity.</p> <p>Interview with Certified Nursing Assistant (CNA) #5, on 02/15/13 at 1:35 PM, revealed she was not aware of any interventions in place for pressure reduction. The CNA revealed Resident #1 did have difficulty with mobility and would be considered at risk for developing pressure areas.</p> <p>Interview with Registered Nurse (RN) #1, on 02/15/13 at 1:45 PM, revealed Resident #1 did have mobility issues and would be considered a risk for pressure development. The RN revealed she was not aware of the comprehensive plan of care including a risk for pressure development.</p> <p>Interview with the MDS Coordinator, on 02/15/13</p>	F 279	<p>F 279</p> <p>Resident #1 Comprehensive plan of care was reviewed by MDs Coordinator and risk for pressure development was addressed on the care plan. Intervention has been added as of February 18th, 2013.</p> <p>Hilrom Mattress</p> <p>Weekly skin checks by licensed staff</p> <p>Encourage Certified Nurse Aides to report skin issues</p> <p>Encourage Resident #1 to report any skin issues to staff</p> <p>Weekly weights to help monitor nutritional intake</p> <p>Assist Resident to lift legs into bed.</p> <p>The MDS Coordinator will review the plan of care for each resident to assure they reflect the comprehensive MDS.</p> <p>Completion date set for March 22nd, 2013.</p>



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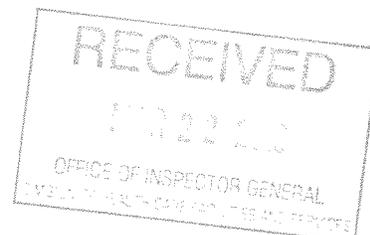
F 279	<p>Continued From page 5</p> <p>at 4:50 PM, revealed the comprehensive plan of care should identify actual and potential problems, establish a goal and have interventions in place to meet the goal. The MDS Coordinator revealed Resident #1 did trigger for pressure on the MDS due to the resident's mobility status. The MDS Coordinator revealed when developing a care plan each trigger was listed on a notepad and checked off once the trigger was developed, but the notepad was not retained once completed. The MDS Coordinator revealed a comprehensive plan of care should have been developed to include pressure, but did not remember why it was omitted.</p> <p>2. Review of Resident #2's clinical record revealed the facility admitted the resident on 04/11/12 with an indwelling urinary catheter due to a diagnosis of a Neurogenic Bladder with Urinary Retention. The MDS, dated 12/21/12, revealed the facility assessed the resident as having a brief interview for mental status score of 14 indicating the resident was cognitively intact. Review of the Care Area Assessment (CAA) for the indwelling catheter revealed the facility would proceed to care plan in order to monitor the residents toileting function and maximize the level of independent function.</p> <p>Review of the comprehensive plan of care revealed interventions to monitor for a urinary tract infection; however, there were no interventions for basic care of the catheter or how independent function would be achieved.</p> <p>Observation of catheter care for Resident #2, on 02/14/13 at 3:15 PM, with CNA #3 revealed a urinary drainage leg bag in place.</p>	F 279	<p>F 279</p> <p>RESIDENT #1</p> <p>To prevent this from re-occurring the Comprehensive MDS will be reviewed along with the plan of care by the DON or the ADON before it is transmitted.</p> <p>Staff nurses will review assigned care plan to ensure they are aware of changes in care and to report any plan of care that is not effective.</p> <p>This will be monitored by the electronic signature of review.</p>	
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F 279	Continued From page 6 Interview with Resident #2, on 02/14/13 at 3:30 PM, revealed the resident did not know how long it had been since the catheter or leg drainage bag had been changed. Interview with CNA #3, on 02/14/13 at 3:20 PM, revealed she was not aware of any particular plan or interventions to be used regarding care of the indwelling urinary catheter. Interview with RN #3, on 02/15/13 at 3:56 PM, revealed a care plan gave all nursing staff something structured to guide and monitor care. RN #3 revealed she was not aware what was care planned regarding catheter care. The RN revealed she thought catheter care was being provided with pericare and was not sure when the catheter or the bag was changed or how often it should be changed. Interview with the MDS Coordinator, on 02/15/13 at 3:56 PM, revealed routine catheter care should be included in the care plan and physician orders should be clarified regarding individualized needs for care of the indwelling catheter. The MDS Coordinator revealed she was not aware of the facility's policy regarding the frequency a leg bag should be changed Interview with Director of Nursing, on 02/15/13 at 2:30 PM, revealed care plans were reviewed quarterly by the MDS Coordinator and she was not monitoring the Comprehensive plan of care to ensure all triggered areas were addressed. 3. Further review of Resident #2's clinical record revealed the facility admitted the resident with a	F 279	F 279 RESIDENT # 2 Comprehensive plan of care was reviewed by the MDS Coordinator and the care plan was revised to include the facility policy on catheter care and that leg bags will be changed every 2 weeks and dated when changed. This will be added to task buttons on the KIOSK. The MDS Coordinator will review the care plan of any other residents with catheters to assure that policy for catheter care and the changing of leg bags are followed. All Certified nurse Aides will have a review on catheter care policy and drain bag/leg bag policy. Nursing staff will answer any questions by the CNA staff. Reviews have been initiated and are ongoing with most staff to be reviewed by March 8 th , 2013. Those not reviewed by then will be seen on their next day of work.		



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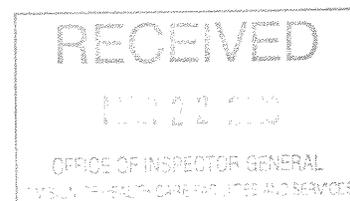
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F 279	Continued From page 7 diagnosis of Depression and Anxiety resulting in the use of an antidepressant and an anti-anxiety medication. Review of the CAA for psychotropic medications revealed the facility would monitor for the maximum therapeutic benefit of using the medication while attempting to avoid negative side effects and maintain the lowest effective dosages. Review of the residents comprehensive plan of care revealed an intervention to monitor side effects; however, information regarding what side effects would be monitored, who would be monitoring and when monitoring would occur was not included. Interview with RN #1, on 02/15/13 at 1:45 PM, revealed all charting was done by exception and specifically what side effects were being monitored was not included. 4. Observation of Resident #4, on 02/13/13 at 11:20 AM, revealed the resident standing outside the chapel watching the service. The resident became loud and verbalized not appreciating a remark after talking briefly to a passer-by from the chapel. The resident then left the area for a short time. Observation of Resident #4, on 02/13/13 at 2:00 PM, 2:25 PM and 3:40 PM, revealed the resident wandering up and down the hallways and in and out of common areas. The resident was observed to stop frequently and look around for several minutes before starting to walk again. Review of the clinical record for Resident #4	F 279	F 279 RESIDENT #2 Resident #2 will continue to make his/her toileting needs known. Rd. # 2 will notify the staff when the leg bag needs to be emptied or if wishes are to have it emptied prior to an activity etc. Resident # 2 will be allowed to assist with the changing and or emptying of the catheter bag following policy guidelines. To monitor the side effects of specific medications a Behavior/Intervention Monthly Flow Record form has been initiated. This will allow for documentation of behaviors and interventions as well as medication side effects on a daily basis and shift by shift. The licensed nursing staff and CMT will be instructed on the proper use of the form. This is ongoing and will be completed by Friday March 8 th , 2013. The use of the form and the side effects for specific medications will also be added to Resident#2 plan of care.		



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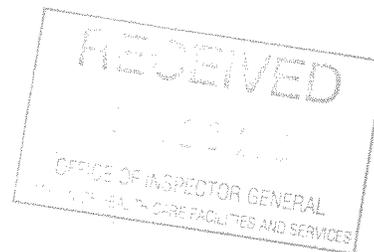
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/15/2013
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F 279	<p>Continued From page 7</p> <p>diagnosis of Depression and Anxiety resulting in the use of an antidepressant and an anti-anxiety medication. Review of the CAA for psychotropic medications revealed the facility would monitor for the maximum therapeutic benefit of using the medication while attempting to avoid negative side effects and maintain the lowest effective dosages.</p> <p>Review of the residents comprehensive plan of care revealed an intervention to monitor side effects; however, information regarding what side effects would be monitored, who would be monitoring and when monitoring would occur was not included.</p> <p>Interview with RN #1, on 02/15/13 at 1:45 PM, revealed all charting was done by exception and specifically what side effects were being monitored was not included.</p> <p>4. Observation of Resident #4, on 02/13/13 at 11:20 AM, revealed the resident standing outside the chapel watching the service. The resident became loud and verbalized not appreciating a remark after talking briefly to a passer-by from the chapel. The resident then left the area for a short time.</p> <p>Observation of Resident #4, on 02/13/13 at 2:00 PM, 2:25 PM and 3:40 PM, revealed the resident wandering up and down the hallways and in and out of common areas. The resident was observed to stop frequently and look around for several minutes before starting to walk again.</p> <p>Review of the clinical record for Resident #4</p>	F 279	<p>F279 RESIDENT #2</p> <p>Other residents/future residents that are known to be on/ or are placed on psychoactive medications will be seen at least every 3 months by the ordering psychiatrist.</p> <p>If the medications are ordered by a physician other than a psychiatrist, the medications will be reviewed every 2 months or as deemed necessary by the MD.</p> <p>Medications will continue to be reviewed on a monthly basis by the pharmacy consultant and recommendations will be forwarded on to the prescriber for review.</p> <p>On a monthly basis the pharmacy provides a current list of all residents on psychoactive medications. When it is received by the Director of Nursing, it will be brought to the weekly 10:00 am meeting and reviewed with all Department Heads Involved. Each resident will be reviewed for medication, behaviors, improvements, declines or any changes that are being noticed.</p>		



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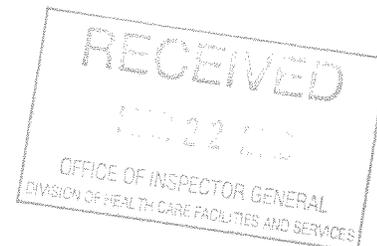
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F 279	<p>Continued From page 8</p> <p>revealed the facility admitted the resident on 08/04/10 with diagnoses of Moderately Severe Alzheimer's Disease and Dementia. On 04/02/12 the attending physician added a diagnosis of Dementia with Disturbance of Behavior and the resident was placed on an anti-psychotic medication. Review of the Psychiatric Notes, dated 04/12/12, revealed the resident was placed on Risperdal for the behaviors of irritability, aggression and depression. In addition, the resident displayed wandering and poor hygiene. Review of the Social Services note, dated 01/22/13 at 10:42 AM, revealed Resident #4 was more cooperative and continued to walk throughout the facility. There was no documented information regarding the frequency of the resident's behaviors or specifics regarding Irritability aggression and depression. There was no documentation located to show regular mood/behavior interviews were completed per the care plan.</p> <p>Review of the annual Minimum Data Set (MDS) assessment completed by the facility on 07/20/12 revealed the resident had impaired cognition and behaviors of wandering and intruding on other residents. The facility completed a quarterly Minimum Data Set (MDS) assessment on 01/11/13 which indicated the resident was cognitively impaired, declining and received an anti-psychotic medication (Risperdal).</p> <p>Review of the Care Area Assessment (CAA) for psychotropic medications for Resident #4 revealed the facility would monitor the resident and avoid negative side effects.</p>	F 279	<p>F 279 RESIDENT #4</p> <p>Resident # 4 care plan was revised to include non-pharmaceutical interventions to manage "wandering" type behaviors which include keeping outside door locked; front desk will alert nursing staff if the resident is at the front door. This will allow the staff to make contact with Resident # 4 and redirect him/her. A picture of the resident is placed at the entrance of his/her doorway. Elopement policy is in place. Resident #4 is cued to meals. If he/she does not go to meal after 2 attempts to redirect a supplement will be offered. Staff integrates care for Resident #4 by allowing his/her routine to be maintained and less disrupted. He/she is cared for by staff that he/she is familiar and comfortable with and this decreases risk for agitation. Family is involved with and willing to come to facilitate in care. For all staff to monitor residents whereabouts especially at night.</p> <p>The care plan was also updated to monitor for specific medication side effects such as drowsiness or changes in physical movement.</p>	



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F 279	<p>Continued From page 8</p> <p>revealed the facility admitted the resident on 08/04/10 with diagnoses of Moderately Severe Alzheimer's Disease and Dementia. On 04/02/12 the attending physician added a diagnosis of Dementia with Disturbance of Behavior and the resident was placed on an anti-psychotic medication. Review of the Psychiatric Notes, dated 04/12/12, revealed the resident was placed on Risperdal for the behaviors of irritability, aggression and depression. In addition, the resident displayed wandering and poor hygiene. Review of the Social Services note, dated 01/22/13 at 10:42 AM, revealed Resident #4 was more cooperative and continued to walk throughout the facility. There was no documented information regarding the frequency of the resident's behaviors or specifics regarding irritability aggression and depression. There was no documentation located to show regular mood/behavior interviews were completed per the care plan.</p> <p>Review of the annual Minimum Data Set (MDS) assessment completed by the facility on 07/20/12 revealed the resident had impaired cognition and behaviors of wandering and intruding on other residents. The facility completed a quarterly Minimum Data Set (MDS) assessment on 01/11/13 which indicated the resident was cognitively impaired, declining and received an anti-psychotic medication (Risperdal).</p> <p>Review of the Care Area Assessment (CAA) for psychotropic medications for Resident #4 revealed the facility would monitor the resident and avoid negative side effects.</p>	F 279	<p>F279 RESIDENT #4</p> <p>Other residents/future residents that are known to be on/ or are placed on psychoactive medications will be seen at least every 3 months by the ordering psychiatrist.</p> <p>If the medications are ordered by a physician other than a psychiatrist, the medications will be reviewed every 2 months or as deemed necessary by the MD.</p> <p>Medications will continue to be reviewed on a monthly basis by the pharmacy consultant and recommendations will be forwarded on to the prescriber for review.</p> <p>On a monthly basis the pharmacy provides a current list of all residents on psychoactive medications. When it is received by the Director of Nursing, it will be brought to the weekly 10:00 am meeting and reviewed with all Department Heads involved. Each resident will be reviewed for medication, behaviors, improvements, declines or any changes that are being noticed.</p>		



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F 279	<p>Continued From page 8</p> <p>revealed the facility admitted the resident on 08/04/10 with diagnoses of Moderately Severe Alzheimer's Disease and Dementia. On 04/02/12 the attending physician added a diagnosis of Dementia with Disturbance of Behavior and the resident was placed on an anti-psychotic medication. Review of the Psychiatric Notes, dated 04/12/12, revealed the resident was placed on Risperdal for the behaviors of irritability, aggression and depression. In addition, the resident displayed wandering and poor hygiene. Review of the Social Services note, dated 01/22/13 at 10:42 AM, revealed Resident #4 was more cooperative and continued to walk throughout the facility. There was no documented information regarding the frequency of the resident's behaviors or specifics regarding irritability aggression and depression. There was no documentation located to show regular mood/behavior interviews were completed per the care plan.</p> <p>Review of the annual Minimum Data Set (MDS) assessment completed by the facility on 07/20/12 revealed the resident had impaired cognition and behaviors of wandering and intruding on other residents. The facility completed a quarterly Minimum Data Set (MDS) assessment on 01/11/13 which indicated the resident was cognitively impaired, declining and received an anti-psychotic medication (Risperdal).</p> <p>Review of the Care Area Assessment (CAA) for psychotropic medications for Resident #4 revealed the facility would monitor the resident and avoid negative side effects.</p>	F 279	<p>F279 RESIDENT #4</p> <p>As of 3/7/13 for Resident #4 mood/behavior interviews will be conducted at least quarterly per federal requirement. In addition, mood/behavior interviews will be conducted as needed, depending on any change in the status of mood/behavior of Resident #4. Proper documentation of all completed mood/behavior interviews will be entered in Social Services progress notes for Resident #4 per the care plan. Mood/behavior interviews to monitor wandering behavior has been placed on care plan for Resident #4.</p>		



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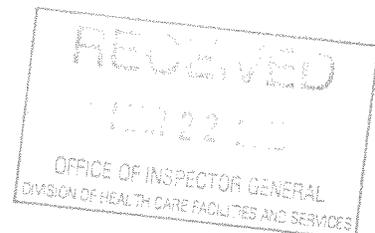
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F 279	<p>Continued From page 9</p> <p>Review of the comprehensive care plan for Resident #4 revealed the facility identified the resident routinely received psychotropic medication to help establish routines and promote sleep. Interventions included: monitor for negative side effects; provide consistent medication routine; and regular mood/behavior interviews to determine the effectiveness of the psychotropic medication. There was no documentation in the care plan of the specific behaviors the resident had exhibited or non-pharmaceutical interventions for staff to follow should the behaviors occur.</p> <p>Interview with MDS Coordinator, on 02/15/13 at 10:30 AM, revealed Resident #4 was assessed by nursing and social services and a care plan was developed to address the resident's behaviors and use of psychotropic medication. She stated the care plan did not contain adequate interventions regarding the specific behaviors and the interventions did not address how to manage irritability and aggression. She stated monitoring for side effects or adverse drug reactions should have been more specific and documented.</p> <p>Interview with the Director of Nursing, on 02/15/13 at 10:30 AM, revealed the care plan should have addressed the behaviors of Resident #4 in order to effectively assist staff in providing the appropriate care for the resident when exhibiting behaviors.</p> <p>5. Review of the clinical record for Resident #7 revealed the facility admitted the resident with diagnoses of Bipolar Disease and End-Stage Renal Disease. The facility completed a significant change MDS assessment of the</p>	F 279	<p>F 279 RESIDENT #4</p> <p>Resident #4's mood and behavior will be closely monitored as CNA's will document every shift per kiosk. All nurses will chart on a Behavior/Intervention Monthly Flow Record form to monitor behavior and possible medication side effects. Pharmacy will continue to review all psychotropic medications each month and facility staff will take these under advisement for possible reduction or elimination of medication.</p> <p>Psychiatrist will be in house on 3/7/2013 to evaluate continued benefit of antipsychotic medication vs elimination of medication for Resident #4.</p> <p>All actively working staff nurses will review and sign policy on proper completion of the Behavior/Intervention Monthly Flow record form. This will be completed by March 11th, 2013. It has been initiated by the DON.</p> <p>All resident care plans will be reviewed at least every 3 months by the IDT members with all appropriate changes being made as they occur. Each care plan will be individually reviewed by a staff nurse to ensure that all care plans reviewed twice.</p>	
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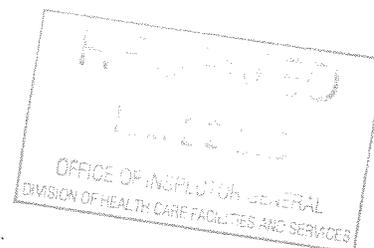
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F 279	<p>Continued From page 9</p> <p>Review of the comprehensive care plan for Resident #4 revealed the facility identified the resident routinely received psychotropic medication to help establish routines and promote sleep. Interventions included: monitor for negative side effects; provide consistent medication routine; and regular mood/behavior interviews to determine the effectiveness of the psychotropic medication. There was no documentation in the care plan of the specific behaviors the resident had exhibited or non-pharmaceutical interventions for staff to follow should the behaviors occur.</p> <p>Interview with MDS Coordinator, on 02/15/13 at 10:30 AM, revealed Resident #4 was assessed by nursing and social services and a care plan was developed to address the resident's behaviors and use of psychotropic medication. She stated the care plan did not contain adequate interventions regarding the specific behaviors and the interventions did not address how to manage irritability and aggression. She stated monitoring for side effects or adverse drug reactions should have been more specific and documented.</p> <p>Interview with the Director of Nursing, on 02/15/13 at 10:30 AM, revealed the care plan should have addressed the behaviors of Resident #4 in order to effectively assist staff in providing the appropriate care for the resident when exhibiting behaviors.</p> <p>5. Review of the clinical record for Resident #7 revealed the facility admitted the resident with diagnoses of Bipolar Disease and End-Stage Renal Disease. The facility completed a significant change MDS assessment of the</p>	F 279	<p>F 279 RESIDENT #4</p> <p>Other residents/future residents that are known to be on/ or are placed on psychoactive medications will be seen at least every 3 months by the ordering psychiatrist.</p> <p>If the medications are ordered by a physician other than a psychiatrist, the medications will be reviewed every 2 months or as deemed necessary by the MD.</p> <p>Medications will continue to be reviewed on a monthly basis by the pharmacy consultant and recommendations will be forwarded on to the prescriber for review.</p> <p>On a monthly basis the pharmacy provides a current list of all residents on psychoactive medications. When it is received by the Director of Nursing, it will be brought to the weekly 10:00 am meeting and reviewed with all Department Heads involved. Each resident will be reviewed for medication, behaviors, improvements, declines or any changes that are being noticed.</p>	
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F 279	<p>Continued From page 10</p> <p>resident on 11/30/12 which revealed the resident was cognitively intact and received two (2) separate anti-psychotic medications and an anti-depressant.</p> <p>Review of the CAA for Resident #7 revealed the facility would monitor and attempt to avoid negative side effects of the anti-psychotic medications.</p> <p>Review of the care plan for Resident #7 revealed the resident received anti-depressant and anti-psychotic medications. The facility monitored the resident for signs of tardive dyskinesia; however, there were no interventions found for the facility to monitor the resident for side effects of psychotropic medications and anti-depressants. In addition, the care plan did not address how the side effects or adverse drug reactions were to be addressed and who was responsible for the monitoring.</p> <p>Interview with Registered Nurse (RN) #1, on 02/15/13 at 9:00 AM, revealed the care plans for Resident #4 and Resident #7 did not address how the facility would monitor residents on psychotropic medication, who would be responsible or how often monitoring would occur. She stated a plan on monitoring should have been developed.</p> <p>Interview with the Pharmacist, on 02/15/13 at 2:05 PM, revealed a plan for monitoring anti-psychotic medications was recommended in order to recognize concerns associated with the medications.</p> <p>Interview with the MDS Coordinator, on 02/15/13</p>	F 279	<p>F 279 Resident # 7</p> <p>Specific side effects for the medications Resident #7 is taking are added to the care plan. Included in these side effects would be the inability to sit still, tremors, drooling or excessive salivation, mask like face, shuffling gait back arching and an upward gaze.</p> <p>The Certified Nurse Aide and/or the CMT will report to the nurse on duty any changes they see in Resident #7 as associated with side effects listed above. The nurse will then notify/report to the physician for orders. If indicated the adverse drug reaction/side effect will be reported to the pharmacy.</p> <p>The Director of Nursing or the Assistant Director of Nursing will also be notified by the nurse.</p> <p>To monitor Resident # 7 for potential side effects of the medication he/she is receiving, a Behavior/ Intervention Monthly Flow Record form has been implemented. It allows the nurse/CMT to document every shift if a behavior has occurred or if a potential side effect has been identified.</p>	



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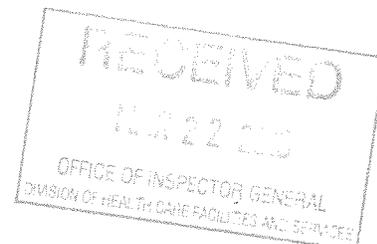
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F 279		F 279	<p>F 279 Comprehensive Care Plan</p> <p>Care plans are maintained in an electronic format with the most current care plan printed out and kept in a binder at each station. However, changes and revisions that are being made are not always seen in the current electronic version. (i.e. a sore throat was a problem a week ago and was care planned. The sore throat is now resolved and has been removed from the electronic version, but will not show up on a current copy or the electronic version and thus may not look as if it were not care planned). Therefore care plans will be changed out quarterly. Hard copy format will stay in the residents' record. This will show ongoing changes and revisions that have been made but may not directly be seen on the most current electronic record. The care plan will also continue to be maintained in the electronic format.</p>		

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F 279		F 279	<p>F 279 Comprehensive Care Plan</p> <p>When updates/revisions are made in the current care plan electronically, the binder copy will also be updated by hand. Information will always be current and up to date and accessible by the staff for reference and care information. This hard copy care plan will be replaced with the revised quarterly and maintained in the residents records.</p> <p>Any Discipline that needs notification of revisions in a care plan will be notified via electronic alert or communication on the electronic dashboard. The Department Heads will continue to be made aware of changes with the resident verbally at the morning meetings Monday through Friday at 10:00 am. The Computer On Wheels will be utilized at these meetings and revisions will also be made as needed at that time.</p>		



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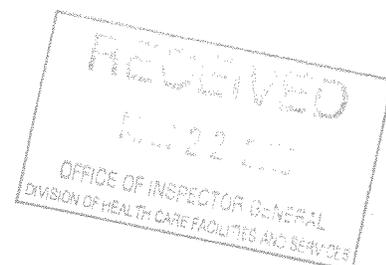
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/15/2013
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
		F 279	<p>The Facility will have a resident-specific log with areas for review listed. Each resident will have his/her own log sheet. These log sheets will be kept in a binder in the Medical Office. As areas for QA are reviewed, a check and/or initials and date will be placed in the corresponding month's box to verify that a QA check has been completed. If a review is not indicated (i.e. is not on psychotropic medication) then N/A will be placed in the box.</p> <p>The reviews will be conducted on a monthly basis by the DON, ADON, and/or the MDS coordinator. Information may be entered on the log sheet by the medical secretary.</p> <p>Each resident's log sheet will be reviewed quarterly by the IDT at the time of the resident's care conference and as needed.</p> <p>Utilizing the Compliance Log details how continued compliance can be achieved and the QA process can be maintained and monitored on an individual basis for each resident. See attached sample. 3/18/13</p>	3/23/13	

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F 279	Continued From page 11 at 10:30 AM, revealed she talked with staff and reviewed the nursing report to determine if a resident experienced problems with side effects or adverse drug reactions. She stated a care plan to monitor these events was not developed. She stated monitoring was important to recognize side effects and adverse drug reactions.	F 279	F 280 Revise Care Plan Members of the Interdisciplinary Team meet weekdays at 10:00 am. During this meeting the Department Heads will review any Accident/Incident Reports that pertain to a Resident. During the review, causal factors and remedial measures/interventions will be discussed. Once the appropriate intervention has been decided upon the care plan will be updated during the meeting.	
F 280 SS=D	Interview with the Director of Nursing, on 02/15/13 at 10:30 AM, revealed there was no formal plan to monitor residents on anti-psychotic medication. She stated the facility did not have a policy to develop care plans to address what the side effects of anti-psychotic medications were, who was responsible, how monitoring would be accomplished and how frequently monitoring would be completed. She indicated residents' care plans should contain this information to prevent negative outcomes. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280	The facility has a COMPUTER ON WHEELS and it will be taken to every 10:00 am meeting. Utilizing the Computer On Wheels. The DON, ADON or the MDS Coordinator (or other Discipline) will update /revise the care plan with the decided upon interventions, before leaving the morning meeting. To maintain continuity of care when revisions are made, the revision will not only be made in the electronic format but also by hand in the CARE PLAN BINDER at the Nurses Station of the Unit were the resident resides. This will ensure the staff has current and up to date information for the residents and reflects the electronic care plan. This will be implemented by the MDS Coordinator.	



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F 280	<p>Continued From page 12 and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to review and revise the comprehensive plan of care for one (1) of the nine (9) sampled residents (Resident #2) after multiple falls.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Accident/Incident Reports, dated 05/2006, revealed a procedure to update the resident care plan as necessary.</p> <p>Review of the facility's policy regarding Care Plans, dated 05/2006, revealed at least every ninety (90) days and as needed, the nurse, the social worker, the dietary staff, activity staff, other staff and the resident and/or family are to update the comprehensive care plan.</p> <p>Review of the clinical record for Resident #2 revealed the facility admitted the resident on 04/11/12 with diagnoses of Hydrocephalus, Spinal Stenosis, Glaucoma and recurrent falls. Review of the Minimum Data Set (MDS) dated 12/21/12 revealed the facility assessed the resident with a brief interview for mental status score of 14</p>	F 280	<p>F 280 Revise Care Plan</p> <p>Other residents/future residents that are known to be on/ or are placed on psychoactive medications will be seen at least every 3 months by the ordering psychiatrist.</p> <p>If the medications are ordered by a physician other than a psychiatrist, the medications will be reviewed every 2 months or as deemed necessary by the MD.</p> <p>Medications will continue to be reviewed on a monthly basis by the pharmacy consultant and recommendations will be forwarded on to the prescriber for review.</p> <p>On a monthly basis the pharmacy provides a current list of all residents on psychoactive medications. When it is received by the Director of Nursing, it will be brought to the weekly 10:00 am meeting and reviewed with all Department Heads involved. Each resident will be reviewed for medication, behaviors, improvements, declines or any changes that are being noticed.</p>	
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F 280	Continued From page 13 indicating the resident was cognitively intact. Further review of the MDS revealed the resident required a two person assist with transfers, ambulation and bed mobility. Observation of Resident #2, on 02/13/13 at 11:05 AM, revealed the resident lying in the bed with rails up on either side of bed with a bed alarm attached to the bed and a call light lying on the recliner arm-rest tray. Interview with the resident at that time revealed the resident was able to easily reach the call light if it was needed.	F 280		
	Interview with Resident #2, on 02/15/13 at 9:40 AM, revealed there had been multiple falls. The resident stated he/she was losing their balance despite multiple attempts at therapy. The resident revealed he/she did get up without assistance on several occasions which resulted in a fall. The resident revealed knowing to call for assistance, but stated resistance in giving up their independence. Review of the facility's Accident/Incident report, dated 07/03/12, revealed the resident fell off the edge of the wheelchair after being transferred by the Certified Nursing Assistant (CNA) on 07/03/12 resulting in an abrasion. The facility investigation revealed an inappropriate transfer to be the cause of the fall and the use of a gait belt during transfers was determined to be the remedial action to prevent a similar accident. However, review of the resident's plan of care revealed the fall was not updated on the care plan and the intervention was not added as a revision. Review of the facility's Accident/Incident report, dated 07/12/12, revealed the resident was found		RESIDENT #2 Fall 7/3/2012 Care plan has been reviewed. Revised to include gait belt for transfers this includes at bath time. Staff has been instructed to have gait belt with them at all times .	



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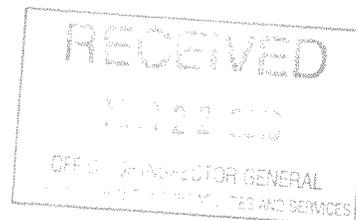
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F 280	Continued From page 14 on the floor after attempting to ambulate without assistance on 07/12/12 with no apparent injury. The report indicated a chair alarm was sounding which alerted staff. Causal factors were determined to be the call light had fallen out of reach of the resident. Remedial action to prevent similar falls was to ensure the call light was firmly in place and within reach at all times. Review of the resident's plan of care revealed neither the chair alarm nor the call light firmly positioned in reach were noted on the plan of care. Review of the facility's Accident/Incident report, dated 08/16/12, revealed the resident fell on 08/16/12 with no apparent injury after attempting to ambulate self to the bathroom. The resident was reminded and encouraged to use the call light and wait for assistance. Review of the resident's plan of care revealed the intervention was not added as a revision of the care plan. Review of the facility's Accident/Incident report, dated 08/20/12, revealed the resident fell on 08/20/12 while standing at the bathroom sink. The report indicated a staff member was in the bathroom but had turned away to retrieve a towel. The facility determined to have hands on assist with the resident at all times while up as a remedial measure to prevent a similar accident. Review of the resident's plan of care revealed a revision was not made to include the hands on assist. Review of the facility's Accident/Incident report, dated 11/11/12, revealed on 11/11/12 the resident was found sitting on the floor in front of the closet. The facility notified the therapy department for evaluation and encouraged the resident to use	F 280	F 280 Resident # 2 Fall 7/12/12. Care plan has been reviewed. Goals and interventions revised to maximize his/her level of safety and to prevent further falls. Interventions include chair alarm use and firm placement of call light. Fall 8/16/2012. Care plan has been reviewed. Interventions reviewed. Continue use of call light included in care. Staff was verbally instructed to never leave resident during care until he/she was safely positioned. Resident #2 verbalizes awareness of his/her need for staff assistance with all movement/transfers. Fall 8/20/12. Care plan reviewed. Interventions remain in place to ensure resident's safety and to prevent future falls. Staff is reminded to never leave Resident # 2 alone. Not to leave his/ her side while she is up and to always have hands on him/her while up. (gait belt on resident and staff holding gait belt) Fall 11/11/2012. Care plan reviewed. Goals and interventions remain the same. Reminders to Resident #2 to NEVER be up unassisted. He/she verbalizes understanding and agreement. Therapy department was listed on care plan.		



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F 280	Continued From page 15 the call light for assist. Review of the resident's plan of care revealed a revision was not made to include these interventions. The Accident/Incident report for 12/08/13 revealed the resident fell on 12/08/12 after standing up with the expressed attempt to look in dresser drawers. Review of the resident's plan of care revealed a revision was not made to include an intervention to prevent future falls. Review of the facility's Accident/Incident report, dated 12/27/12, revealed the Resident fell on 12/27/12 after attempting to transfer self from the recliner to the wheelchair without calling for assistance. Review of the clinical record revealed the facility had the resident evaluated by neurology due to a previously diagnosed normal pressure Hydrocephalus and frequent falls. However, review of the resident's plan of care revealed no revisions were made to prevent future falls. Review of the facility's Accident/Incident report, dated 01/10/13 revealed the resident fell on 01/10/13 after attempting to rise from the bathroom toilet and not using the bathroom call light. The facility determined to stay with the resident while in the bathroom at all times to prevent future accidents. Review of the facility's plan of care revealed no revision was made to reflect the intervention. Interview with CNA #3, on 02/15/13 at 11:07 AM, revealed Resident #2 was repeatedly getting up without assistance or calling for assistance. The CNA revealed the resident was very independent and had difficulty adjusting to being at the facility.	F 280	F 280 Resident # 2 Fall 12/08/2012. Care plan reviewed. Goals and interventions are unchanged. Emphasized with Resident #2 the continued need for staff assistance with all movement/transfers/position transitioning/standing to assure his/her safety. Resident #2 verbalizes agreement. Fall 12/08/2012 & 12/27/2012. Care plan reviewed. Fall during transfer, states that he/she needs extensive assistance during transfers. Care plan includes hydrocephalus diagnosis and its effect on the resident's balance Measures were added of never to be left unattended in bath room. Gait belt on resident and staff hands on if standing for any reason. Neurology evaluation reflected only intervention from outside source would be surgical and /or medication and Resident # 2 and family decided against this. They verbalize awareness that falls may continue to occur.		



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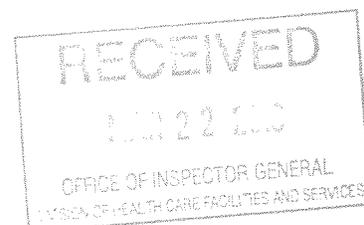
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F 280	Continued From page 16 The CNA revealed the falls prevention plan included utilizing a bed and chair alarm, a gait belt, never leaving the resident alone in the bathroom and to keep items in reach. The CNA revealed the nurses would verbally provide any other information needed to provide care.	F 280	F 280 The MDS coordinator has initiated a one to one in- service for the Certified Nurse Aides. This will include finding and		
	Interview with CNA #5, on 02/15/13 at 1:35 PM, revealed Resident #2's falls had been a challenge due to the resident being cognitively intact and the resident's refusal to use call light. The CNA revealed the resident had also removed chair alarms or turned them off, making it difficult to choose which type was best to use. The CNA revealed the resident had recently been using the call light and feels the resident was starting to realize their physical limitations and need for assistance. The CNA revealed receiving communication regarding potential new interventions verbally. The CNA revealed information could also be obtained from the care plans; however, the CNA revealed not knowing what interventions were in place on the care plan. Interview with Registered Nurse (RN) #1, on 02/15/13 at 1:45 PM, revealed the interventions in place to prevent falls included the bed/chair alarm restorative therapy and keeping the call light within reach. The RN revealed information was relayed verbally when changes were made regarding the plan to prevent falls. The RN revealed the Director of Nursing (DON) and the resident's physician reviewed each fall and determined a plan of action. The RN revealed she did not know what interventions were listed on the resident's comprehensive plan of care. Upon review the RN revealed the comprehensive plan of care was missing a lot of information		reviewing and utilizing the information in the electronic record and in the care plan binders at each unit. The MDS coordinator will show the staff specifically where the interventions are in the care plan. All future staff will be in-serviced in the same manner. This will be completed by March 22, 2013.		



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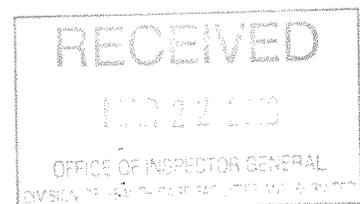
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F 280	Continued From page 17 needed for communication regarding the current care and safety of the resident. The RN revealed the purpose of the care plan was to direct the care that was being provided. The RN revealed everyone was responsible to ensure the care plan accurately reflected the resident's status and contained interventions to provide the appropriate care. Interview with the MDS Coordinator, on 02/15/13 at 3:10 PM, revealed she was not shown or provided with the information on the Accident/Incident form to review and revise the comprehensive plan of care. Interview with the Director of Nursing (DON), on 02/15/13 at 2:30 PM, revealed the care plan was used to monitor, document and communicate the resident's needs. The DON revealed each fall was reviewed and discussed with the physician and the Assistant Director of Nursing. The DON revealed interventions were initiated and placed in the computer kiosk after each fall; however, the MDS Coordinator was responsible to update the care plans and she was not privy to the reports or decisions made after the review.	F 280	F 280 Licensed staff will now be reviewing care plans. Care plans will be assigned according to when the care conference is due. The MDS coordinator will assign a nurse to a residents care plan for this review and monitored as such by the completion of review electronic signature. Changes made will be communicated via electronic dashboard communication button and/or electronic alerts. This will take effect immediately. MDS coordinator is part of the IDT. As a member she attends the Monday through Friday 10:00 am morning meetings. Accident /Incident reports will be reviewed and input will be obtained from all of the IDT. Changes to the care plan will be made during the meeting utilizing the Computer On Wheels. Alerts and communications via electronic dashboard will be sent. The hard copy care plan will be updated by hand to reflect any changes in the electronic format. This will take affect immediately.		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371			

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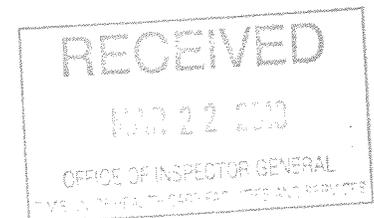
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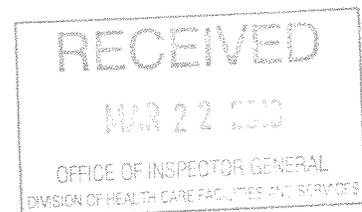
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure potentially hazardous cold food remained at forty-one (41) degrees Fahrenheit (F) or below prior to being served to ten (10) of sixteen (16) residents in the Small Dining Room. The facility failed to ensure potato salad, cottage cheese, cole slaw and pea salads were at the proper temperature prior to serving to prevent food-borne illness. In addition, the walk-in freezer had an area of ice build-up on the floor from a leaking freezer component, staff were observed to handle plate covers then reuse them during the meal services in the main dining room and two (2) ice scoops were on top of the ice machine uncovered. The findings include: Facility policies for storing equipment, reporting equipment repair needs and monitoring food for temperatures were not provided. Observation of the kitchen, on 02/13/13 at 8:15 AM, revealed an area of ice build-up on the freezer floor. There were droplets of moisture falling from the ceiling and a freezer component. In addition, there were two (2) uncovered ice scoops on top of the ice machine. Interview with the Dietary Manager, on 02/13/13 at 8:45 AM, revealed clean equipment, such as ice scoops were to be stored covered to prevent contamination. She stated a work request	F 371	In order to insure that all potentially hazardous cold foods remain at or below 41 degrees Fahrenheit (F) prior to being served, and to ensure that the problem does not recur, the following measures have been taken: a) The Dietary Manager in-serviced staff on proper holding temperatures of all cold foods served on 3/4/13. b) Temperatures will be documented on a daily log sheet. c) The Dietary Manager has made staff aware of foods that are potentially hazardous, why they are considered potentially hazardous, and how to prevent food-borne illnesses due to improper holding temperatures. d) Staff are placing salad bar dishes in refrigerated units to chill dishes before dishing up cold foods as a means to maintain the temperature at 41 degrees F or lower.	



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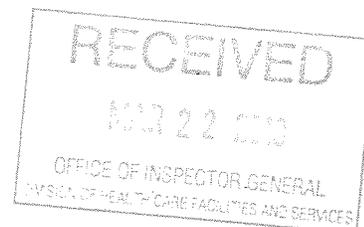
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F 371	Continued From page 19 needed to be given to maintenance for the freezer to prevent contamination of the food stored in the freezer.	F 371	
	<p>Observation of the Small Dining Room, on 02/14/13 at 11:40 AM, revealed dietary staff was ready to serve salads to the residents. The salads were removed from the refrigerator placed on a cart and staff started to move the salads out into the dining room. When questioned regarding the temperatures of the potentially hazardous foods, staff found a thermometer and obtained the food temperatures. The temperature of the cottage cheese was 58 degrees F. The temperature of the cole slaw was 57 degrees F. The temperature of the egg salad was 50 degrees F. The temperature of the yogurt was 57 degrees F.</p> <p>Interview with Dietary Aide #1, on 02/14/13 at 11:45 AM, revealed cold foods were never tested for temperature prior to serving. She stated she needed to talk to her supervisor to find out what to do. She stated she had not been trained to obtain temperatures on cold foods and did not know what the temperatures should have been.</p> <p>Interview with the Dietary Manager, on 02/14/13 at 11:55 AM, revealed the salads were not served as they were too warm. She stated cold food temperatures were not obtained in the Small Dining Room and was unable to give an explanation. She stated the cold foods served in the Main Dining Room were tested for the appropriate temperature prior to serving. She stated serving potentially hazardous food without monitoring temperatures could result in food-borne illness in residents. She revealed she</p>		<p>To correct the problem of ice build-up on the freezer floor and moisture falling from the ceiling and to ensure that the problem does not happen again, the following steps were taken:</p> <ul style="list-style-type: none"> a) Maintenance Dept resealed all seams on the back walls of the walk-in and added fire-rated insulation on roof of the freezer. b) Maintenance re-insulated Freon lines for ice cream freezer component. c) Removed ice buildup. d) Weekly inspections will be done by stockperson. If any repairs are needed or if ice build-up recurs, staff will inform Dietary Manager of the need for work order for repairs. Dietary Manager will complete proper paperwork to request routine repairs or will page the Maintenance Dept. for immediate assistance. e) Any outstanding projects will be mentioned at the weekly staff meeting.



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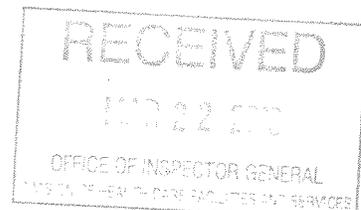
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F 371	<p>Continued From page 20</p> <p>was responsible for managing the dietary department and supervising the staff. She stated she did not notice the staff serving foods without obtaining temperatures.</p> <p>Observation of the meal service on 02/13/13 and 02/14/13 revealed the staff received a plate of food from the steam table, covered the food with a plate cover, delivered the plate to a resident and then removed the cover by sticking their fingers down into the middle hole of the cover and lifting up. Covers were then placed face down on the cart and again reused to cover a new plate of food from the steam table and delivered to a different resident.</p> <p>Interview with Certified Nursing Assistant (CNA) #4, on 02/14/13 at 12:15 PM, revealed she was trained to reuse the plate covers unless food residue could be visibly seen on the inside of the cover. The CNA revealed she did not feel the inside was contaminated by sticking fingers inside the center opening to lift the cover and was not sure if the practice of reusing the plate covers would pose a risk of cross contamination for residents with food allergies.</p> <p>Interview with the Dietary Manager, on 02/15/13 at 4:10 PM, revealed she was aware of residents with food allergies. However, the Dietary Manager revealed she could not ensure cross-contamination did not occur by reusing the plate covers. She stated plate covers were reused after a plate was served and had not realized staff was touching the inside as well as the outside of the tops. She stated a clean plate top should be used to prevent</p>	F 371	<p>To correct and eliminate the problem of possible cross-contamination due to the re-use of plate covers during the same meal period, new plate covers have been purchased. From this point forward, there will be a clean cover available for each plate, and no covers will be re-used during the same meal period without being washed first. Effective 3/6/13.</p> <p>To correct the problem of ice scoops being left out uncovered and to ensure that the problem will not recur, the following measures have been put in place:</p> <ul style="list-style-type: none"> a) Clean ice scoops are stored in a covered ice scoop container that sits on top of the ice machine. b) Ice scoops and the container are washed daily. c) The clean ice scoops in the container are placed back on top of the ice machine. 		



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F 371	Continued From page 21 cross-contamination.	F 371	This citation will be discussed at the next Quality Assurance (QA) meeting to monitor and ensure continued compliance.	3/7/13	



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OFFICE OF INSPECTOR GENERAL

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

185260

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - BUILDING 0101

B. WING

(X3) DATE SURVEY
COMPLETED

02/13/2013

NAME OF PROVIDER OR SUPPLIER

LITTLE SISTERS OF THE POOR

STREET ADDRESS, CITY, STATE, ZIP CODE

15 AUDUBON PLAZA DRIVE
LOUISVILLE, KY 40217

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5)
COMPLETION
DATE

K 000

INITIAL COMMENTS

K 000

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1990

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: one (1) story, Type II
(222)

SMOKE COMPARTMENTS: Eight (8) smoke
compartments.

FIRE ALARM: Complete fire alarm system with
heat and smoke detectors.

SPRINKLER SYSTEM: Complete automatic (wet)
sprinkler system.

GENERATOR: Type II generator. Fuel source is
diesel.

A standard Life Safety Code survey was
conducted on 02/13/13. Little Sisters of the Poor
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 thirty
five (35) beds with a census of thirty five (35) on
the day of the survey.

The findings that follow demonstrate
noncompliance with Title 42, Code of Federal

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

TITLE

(X6) DATE

S. Maureen Courtney

Administrator

3/22/13

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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K 000 Continued From page 1
Regulations, 483.70(a) et seq. (Life Safety from Fire).

K 027 SS=D Deficiencies were cited with the highest deficiency identified at "F" level.
NFPA 101 LIFE SAFETY CODE STANDARD

Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, residents, staff and visitors. The facility is certified for thirty five (35) beds with a census of twelve (12) on the day of the survey.

The findings include:
Observation, on 02/13/13 at 11:53 AM, with the Maintenance Engineer revealed the cross corridor doors located next to room #1217 had a gap too large and would not resist the passage of

K 000

K 027

(a) In order to correct the deficiency cited, the cross-corridor doors located next to room #1217 have been re-leveled and adjusted and mounted to ensure proper closing. Completed by Maintenance Staff on 2/25/13.

(b) All residents were made aware of the importance of proper care of these doors. Residents and Staff were also made aware of the immediate danger of being close to these doors when the alarm sounds for any reason. To determine that the other cross-corridor doors would resist the passage of smoke in accordance with NFPA standards, the doors were checked with a level then the gap was measured to make sure the it was not too large. 2/25/13

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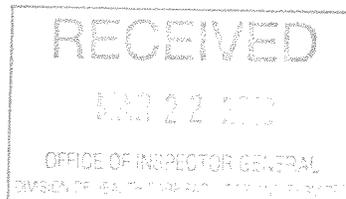
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NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR	STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217
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K 027	<p>Continued From page 2 smoke.</p> <p>Interview, on 02/13/13 at 11:53 AM, with the Maintenance Engineer revealed he was not aware the door had developed a gap that was too large to resist smoke.</p> <p>Interview, on 02/13/13 at 3:00 AM, with the Administrator revealed she was not aware the door had developed a gap that was too large to resist smoke.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.</p>	K 027	<p>(c) The Maintenance Department will maintain doors with a check of all corridor doors located in a smoke barrier bi-weekly to ensure that there are no gaps that will not resist the passage of smoke. Completed by Maintenance Staff.</p> <p>(d) This citation will be discussed at the next Quality Assurance (QA) meeting to monitor and ensure continued compliance. The next QA meeting is scheduled for April 10, 2013</p>	2/26/13
K 029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed</p>	K 029		



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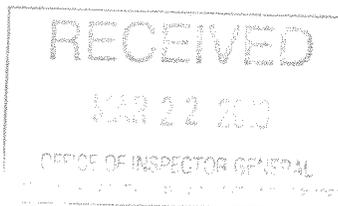
LITTLE SISTERS OF THE POOR

STREET ADDRESS, CITY, STATE, ZIP CODE

15 AUDUBON PLAZA DRIVE

LOUISVILLE, KY 40217

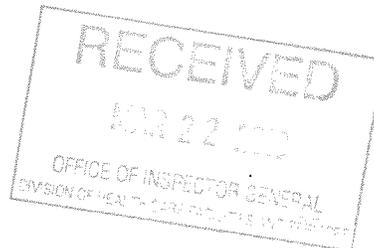
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K 029	<p>Continued From page 3</p> <p>48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of eight (8) smoke compartments, residents, staff and visitors. The facility has thirty five (35) certified beds with a census of thirty five (35) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/13/13 between 9:00 AM and 3:00 PM, with the Maintenance Engineer revealed doors to storage closets identified as room #1, 2, 3, 6, 7, 8, 9, and 10 would swing out into the egress path and extended out more than seven (7) inches from the wall. The doors were not equipped with a self-closing device to ensure the doors would close in an emergency.</p> <p>Interview, on 02/13/13 between 9:00 AM and 3:00 PM, with the Maintenance Engineer revealed he was not aware the doors identified were required to be self-closing.</p> <p>Interview, on 02/13/13 between 9:00 AM and 3:00 PM, with the Administrator revealed she was</p>	K 029	<p>(a) Storage closets identified as rooms #1, 2, 3, 6, 7, 8, 9, and 10 have been equipped with self-closing devices. Completed by Maintenance Staff on 2/20/13.</p> <p>(b) Maintenance checked all other closet doors for proper closers on 2/20/13. The Maintenance Supervisor reported his findings to the Administrator and submitted the proper Purchase Orders for the Administrator's approval to obtain the proper closing devices. The Maintenance Dept. equipped additional doors with self-closing devices as needed for safety and proper closing. 3/4/13 Charles Amback, Maintenance Supervisor, educated the Maintenance Staff about the required use of door closers in his review of the Standards for the Protection of Hazards on 2/20/13.</p> <p>(c) Maintenance will perform a walk-through check of doors monthly to ensure that doors that require self-closing devices still have them and that they are working properly.</p> <p>(d) This citation will be discussed at the next Quality Assurance (QA) meeting to monitor and ensure continued compliance.</p>	3/5/13



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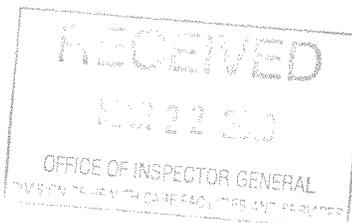
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K 029	Continued From page 4 aware of the requirement but not aware the doors identified were required to be self-closing. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or	K 029		



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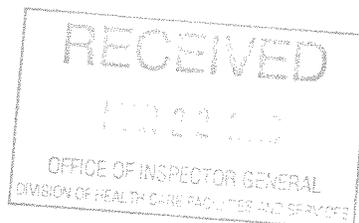
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K 029 K 047 SS=D	Continued From page 5 field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility is certified for thirty five (35) beds with a census of thirty five (35) on the day of the survey. The facility failed to ensure exits were clearly recognizable with proper exit signage. The findings include: Observation, on 02/13/13 at 1:29 PM, with the Maintenance Engineer revealed the exit doors located in the Kitchen did not have an exit sign above the door making the path of egress clearly recognizable. Interview, on 02/13/13 at 1:29 PM, with the Maintenance Engineer revealed he was not aware the exits did not have proper signage.	K 029 K 047	(a) A new exit sign was installed above the door in the Kitchen on 2/28/13, making the path of egress clearly recognizable. (b) The Maintenance Staff performed a walk-through of the building to make sure that all paths of egress were clearly recognizable. 2/28/13 (c) Maintenance Dept. will continue to monitor all exit signs monthly to keep them in working order. Completed by Maintenance Staff. (d) This citation will be discussed at the next Quality Assurance (QA) meeting to monitor and ensure continued compliance.	3/1/13	



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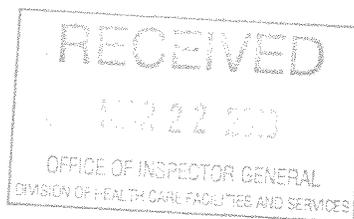
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0101 B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217		
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K 047	Continued From page 6 Interview, on 02/13/13 at 3:00 PM, with the Administrator revealed she was not aware the exits did not have proper signage. Reference: NFPA 101 (2000 edition) 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047			
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to	K 050			



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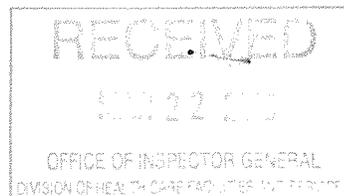
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K 050	<p>Continued From page 7</p> <p>affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is certified for thirty five (35) beds with a census of thirty five (35) on the day of the survey. The facility failed to ensure the fire drills were conducted quarterly on all shifts.</p> <p>The findings include:</p> <p>Fire Drill review, on 02/13/13 at 9:38 AM, with the Maintenance Engineer revealed the facility failed to conduct a fire drill in the fourth quarter on third shift of 2012.</p> <p>Interview, on 02/13/13 at 9:38 AM, with the Maintenance Engineer revealed he was not aware the fire drill in the fourth quarter had been missed.</p> <p>Interview, on 02/13/13 at 3:00 AM, with the Administrator revealed she was on medical leave during the fourth quarter of 2012 and was not aware the fire drill in the fourth quarter had been missed.</p> <p>Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p> <p>Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7* OPERATING FEATURES 19.7.1 Evacuation and Relocation Plan and Fire Drills.</p>	K 050	<p>(a) A Quarterly Fire Drill chart has been created and will be maintained by the Maintenance Supervisor in order to ensure that all fire drills will be performed. 2/18/13 See Chart K050.</p> <p>(b) This citation included the entire facility, so there are no other residents that could be affected.</p> <p>(c) Administration will ensure that all drills are completed according to the chart.</p> <p>(d) This citation will be discussed at the next Quality Assurance (QA) meeting to monitor and ensure continued compliance.</p>	2/19/13



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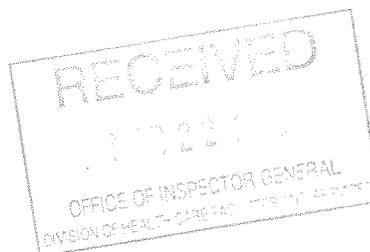
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K 050	Continued From page 8 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator 's position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050			
K 056 SS=D	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	K 056			



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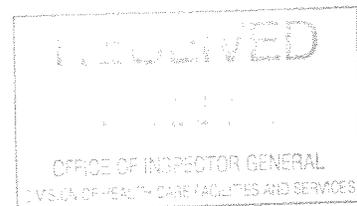
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K 056	<p>Continued From page 9</p> <p>Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, installed in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, residents, staff and visitors. The facility is certified for thirty five (35) beds with a census of thirty five (35) on the day of the survey. The facility failed to ensure sprinkler heads installed in a compartment were of the same temperature response type.</p> <p>The findings include:</p> <p>Observations, on 02/13/13 at 11:20 AM, with the Maintenance Engineer revealed mixed response sprinkler heads located in the Arts and Crafts Room and the Large Dining Room.</p> <p>Interview, on 02/13/13 at 11:20 AM, with the Maintenance Engineer revealed he was not aware of the requirement for sprinkler heads being of the same response rating.</p> <p>Interview, on 02/13/13 at 3:00 PM, with the Administrator revealed she was aware of the</p>	K 056	<p>(a) Variant sprinkler heads were replaced on 3/8/13 by Brown Sprinkler Company so as to ensure that all are of the same temperature response type.</p> <p>(b) The Maintenance Supervisor with Brown Sprinkler Company determined that no other sprinklers needed to be changed by surveying the sprinkler heads in the building on 2/25/13 and 3/8/13.</p> <p>(c) In the future, the Maintenance Dept. will monitor outside vendors doing repair/replacement work to ensure that all sprinkler heads remain of the same type by monitoring the vendors' work while it is happening to prevent the installation of incorrect sprinkler heads.</p> <p>The Maintenance Supervisor educated the maintenance staff about proper use of sprinkler heads on 3/7/13.</p> <p>(d) This citation will be discussed at the next Quality Assurance (QA) meeting to monitor and ensure continued compliance.</p>	3/9/13	



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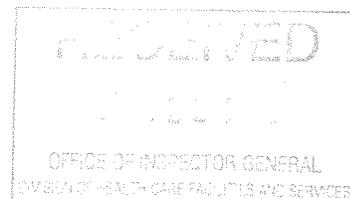
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K 056	Continued From page 10 installation requirements for sprinklers but not aware of the mixed response sprinkler heads located in the Arts and Crafts Room or the Large Dining Room. Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be	K 056			



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K 056	Continued From page 11 permitted to be used. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. Reference: NFPA 13 (1999 edition) 5-6.3.3 Minimum Distance from Walls. Sprinklers	K 056		



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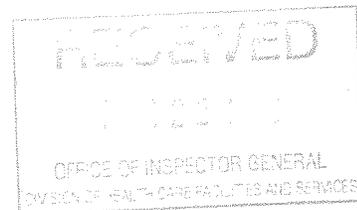
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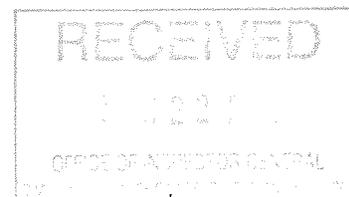
K 056	<p>Continued From page 12 shall be located a minimum of 4 in. (102 mm) from a wall.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.</p> <p>Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="1"> <thead> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A)</th> <th>Maximum Allowable Distance of Deflector Obstruction (in.) (B)</th> </tr> </thead> <tbody> <tr><td>Less than 1 ft</td><td>0</td></tr> <tr><td>1 ft to less than 1 ft 6 in.</td><td>2 1/2</td></tr> <tr><td>1 ft 6 in. to less than 2 ft</td><td>3 1/2</td></tr> <tr><td>2 ft to less than 2 ft 6 in.</td><td>5 1/2</td></tr> <tr><td>2 ft 6 in. to less than 3 ft</td><td>7 1/2</td></tr> <tr><td>3 ft to less than 3 ft 6 in.</td><td>9 1/2</td></tr> <tr><td>3 ft 6 in. to less than 4 ft</td><td>12</td></tr> <tr><td>4 ft to less than 4 ft 6 in.</td><td>14</td></tr> <tr><td>4 ft 6 in. to less than 5 ft</td><td>16 1/2</td></tr> <tr><td>5 ft and greater</td><td>18</td></tr> </tbody> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).</p>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector Obstruction (in.) (B)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18	K 056		
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4 ft 6 in. to less than 5 ft	16 1/2																									
5 ft and greater	18																									
K 064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all</p>	K 064																								



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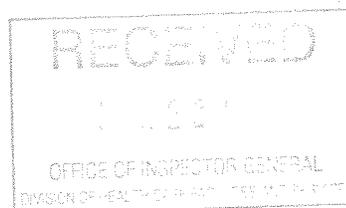
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K 064	<p>Continued From page 13</p> <p>health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that fire extinguishers were maintained in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff, and visitors. The facility is certified for thirty five (35) beds with a census of thirty five (35) on the day of the survey. The facility failed to ensure the designated smoking areas had a fire extinguisher.</p> <p>The findings include:</p> <p>Observation, on 02/13/13 at 2:07 PM, with the Maintenance Engineer revealed there was no fire extinguisher located in the designated smoking areas.</p> <p>Interview, on 02/13/13 at 2:07 PM, with the Maintenance Engineer revealed he was not aware that a fire extinguisher was required to be located in the smoking areas.</p> <p>Interview, on 02/07/13 at 3:00 PM, with the Administrator revealed she was not aware that a fire extinguisher was required to be located in the smoking areas.</p>	K 064	<p>(a) A fire extinguisher was installed in the designated smoking area on 2/25/13 by Koorsen Fire & Security.</p> <p>(b) It was determined that no other areas require a fire extinguisher because there are no other designated smoking areas in or next to the building. The Maintenance Supervisor educated the Maintenance Staff about the proper placement of fire extinguishers in smoking areas on 2/25/13.</p> <p>(c) The Maintenance Dept. will monitor monthly to ensure the fire extinguisher remains in place and in good working order. Maintenance Dept. will mark the extinguisher tag when it is checked.</p> <p>(d) This citation will be discussed at the next Quality Assurance (QA) meeting to monitor and ensure continued compliance.</p>	2/26/13	



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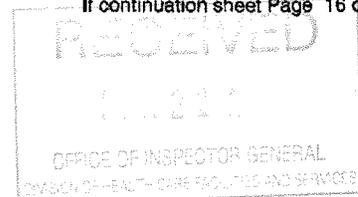
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K 064	Continued From page 14 Reference: NFPA 10 1999 4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d)* Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place 4-3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 4-3.2 (a), (b), (h), and (i), immediate corrective action shall be taken.	K 064		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING	K 066		



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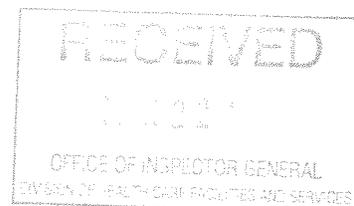
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K 066	Continued From page 15 or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff and visitors. The facility is certified for thirty five (35) beds with a census of thirty five (35) on the day of the survey. The facility failed to ensure the smoking areas had a metal container with a self-closing lid to dump ashtrays. The findings include: Observation, on 02/13/13 at 2:07 PM, with the Maintenance engineer revealed the facility failed to provide a metal container with a self-closing lid to dump the ashtrays, located in the designated smoking areas.	K 066	(a) A metal container with a self-closing lid to dump ashtrays was installed in the designated smoking area and was labeled for cigarette waste only on 3/4/13. (b) It was determined that no other areas require a container because there are no other designated smoking areas in or next to the building. (c) The Maintenance Dept. will monitor weekly to ensure the container remains in good working order. The Maintenance Supervisor educated the Maintenance Staff on the need for and use of the metal container with the self-closing lid on 2/25/13. (d) This citation will be discussed at the next Quality Assurance (QA) meeting to monitor and ensure continued compliance.	3/5/13



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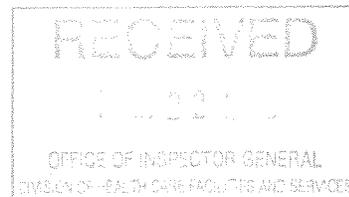
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0101 B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2013
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K 066	Continued From page 16 Interview, on 02/13/13 at 2:07 PM, with the Maintenance Engineer revealed he was not aware of the requirement for metal containers with a self-closing lid for dumping ashtrays. Interview, on 02/13/13 at 3:00 PM, with the Administrator revealed she was not aware of the requirement for metal containers with a self-closing lid for dumping ashtrays. Reference: NFPA Standard 101 (2000 Edition). 19.7.4 Smoking (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066			
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076			



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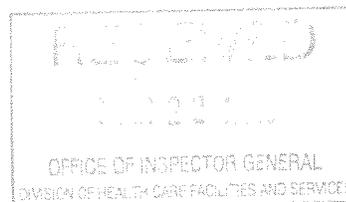
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K 076	<p>Continued From page 17</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility is certified for thirty five (35) beds with a census of thirty five (35) on the day of the survey. The facility failed to ensure oxygen tanks stored in the oxygen room were marked full or empty.</p> <p>The findings include:</p> <p>Observation, on 02/13/13 at 12:05 PM, with the Maintenance Engineer revealed the oxygen storage room did not have the empty and full oxygen tanks separated or identified by signage if the tanks were full or empty.</p> <p>Interview, on 02/13/13 at 12:05 PM, with the Maintenance Engineer revealed he was not aware the full and empty tanks were to be separated.</p> <p>Interview, on 02/13/13 at 12:05 PM, with the Administrator revealed she was aware the full and empty tanks were to be separated; however, she was not aware the signs had been removed.</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than</p>	K 076	<p>(a) The full oxygen tanks were separated from the empty tanks on 3/4/13 by the Maintenance Supervisor. The empty tanks were placed along the back wall, and the full tanks were placed along the side walls. Signage was replaced to indicate full and empty oxygen tanks.</p> <p>(b) The nursing staff was in-serviced by ADON by 3/15/13. The Maintenance Dept was educated about the placement of oxygen tanks on 3/4/13 by the Maintenance Supervisor.</p> <p>(c) The storage room will be monitored weekly by the Maintenance Staff in the future to ensure compliance.</p> <p>(d) This citation will be discussed at the next Quality Assurance (QA) meeting to monitor and ensure continued compliance.</p>
			3/16/13



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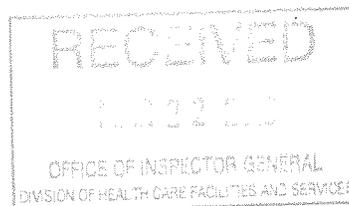
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K 076	Continued From page 18 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) 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.	K 076		
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on fire damper testing record review, and interview, it was determined the facility failed to ensure fire/smoke dampers were maintained in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8)	K 104		



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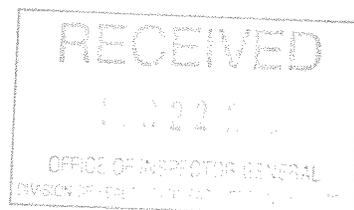
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K 104	Continued From page 19 smoke compartments, residents, staff and visitors. The facility is certified for thirty five (35) beds with a census of thirty five (35) on the day of the survey. The facility failed to provide documentation that the smoke/fire dampers were tested within the last four (4) years. The findings include: Fire damper testing record review, on 02/13/13 at 11:28 AM, with the Maintenance Engineer revealed the facility did not have documentation that fire/smoke dampers had been tested within the last four (4) years. Interview, on 02/13/13 at 11:28 AM, with the Maintenance Engineer revealed he was not aware of the requirements for fire/smoke damper testing. Interview, on 02/13/13 at 3:00 PM, with the Administrator revealed she was aware of the requirements for fire/smoke damper testing; however, she was not aware the testing had not been done. Reference: NFPA 101 (2000 Edition) 8.3.6 Penetrations and Miscellaneous Openings in Floors and Smoke Barriers. 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:	K 104	(a) Koorsen Fire tested all fire dampers throughout the building on 3/7/13. We have attached documentation of this testing. (b) Koorsen also checked links and lubed as necessary. The Maint staff educated on fire damper inspections on 3/7/13. (c) In the future we will schedule an inspection a minimum of every four years. Records of visits and inspections by those servicing equipment will be kept in the Maintenance Supervisor's office. (d) Administrator will review on a quarterly basis.	3/8/13



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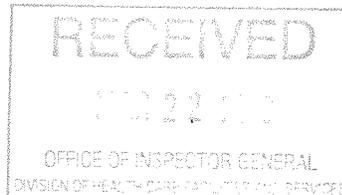
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K 104	Continued From page 20 (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) 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 meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose. Reference: NFPA 90A (1999 edition)	K 104			



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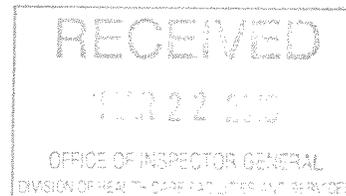
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K 104	Continued From page 21	K 104			
K 147 SS=E	<p>3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of eight (8) smoke compartments, residents, staff, and visitors. The facility is certified for thirty five (35) beds with a census of thirty five (35) on the day of the survey. The facility failed to maintain proper space around electrical panels, and the proper use of power strips and extension cords.</p> <p>The findings include:</p> <p>Observations, on 02/13/13 between 9:00 AM and 3:00 PM, with the Maintenance Engineer revealed:</p> <p>1) A power strip plugged into another power</p>	K 147	<p>(a) 1) The power strip plugged into another power strip was removed from Office D and replaced with a single power strip. 2/14/13</p> <p>2) The curio cabinet outside the Human Resources office was removed to correct the problem of running the cord through the doorway. 2/20/13</p> <p>3) The extension cord was removed from the power strip in room #1218 2/14/13</p> <p>4) The power strip was removed from the Holy Family sitting area, and the microwave and toaster were plugged directly into the wall. 2/14/13</p> <p>5) The desk was removed from the electrical panel in the Holy Family charting room. Signage was installed on the electrical panels. 2/21/13</p> <p>The above items were completed by the Maintenance Staff.</p>		



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K 147	<p>Continued From page 22 strip located in Office D. 2) The power cord to a curio cabinet was run through the doorway of the Human Resources Office. 3) An extension cord was plugged into a power strip located in room #1218. 4) A microwave and toaster were plugged into a power strip located in the Holy Family sitting area. 5) Storage in front of electrical panels located in the Holy Family Charting Room.</p> <p>Interview, on 02/13/13 between 9:00 AM and 3:00 PM, with the Maintenance Engineer revealed he was not aware the storage in front of the electrical panels and not aware the power strips and extension cords had been misused.</p> <p>Interview, on 02/13/13 at 3:00 PM, with the Administrator revealed she was aware of the requirements for storage around electrical panels, and the proper use of power strips and extension cords; however, she was not aware of the storage or the misuse.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D 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	<p>(b) Residents and Staff were made aware of the importance of the proper use of power strips and extension cords. (c) Weekly walk-through inspections will be completed by members of the maintenance staff to make sure that power strips and extension cords are not misused and will check for storage around electrical panels. (d) Reports will be made directly to the Supervisor and Administrator. This citation will be discussed at the next Quality Assurance (QA) meeting to monitor and ensure continued compliance.</p>	2/22/13	



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K 147	Continued From page 23 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147			

