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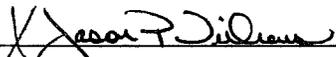
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OFFICE OF INSPECTOR GENERAL
DIVISION OF CONSTRUCTION FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2011
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NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000	This plan is in response to the Life Safety Code Survey that was conducted at Mercy Sacred Heart Village on January 20, 2011. Submission of this plan does not constitute an admission of agreement of the facts alleged or the conclusions set forth in this statement of deficiencies.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and staff interviews conducted on 01/20/11, the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments. The facility is licensed for one hundred and twenty five (125) beds and the census was one hundred and twelve (112) on the day of the survey. The deficiency has the potential to affect two (2) smoke compartments, to include forty eight (48) residents, staff and visitors. The findings include:	K 025	K025 The facility will continue to maintain smoke barriers that will resist the passage of smoke between smoke compartments. What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice? The smoke partition extending above the ceiling, located next to room 326 will be filled with material which will resist the passage of smoke.	3/1/11

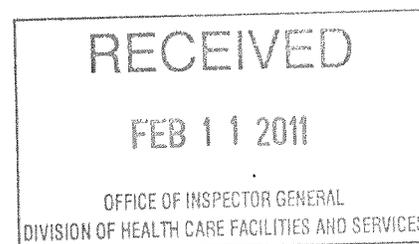
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE X President	(X8) DATE 2/11/11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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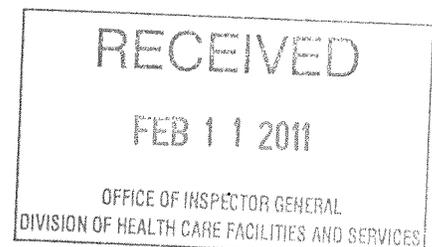
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NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206	
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K 025	Continued From page 1 A tour of the facility conducted on 01/20/11 at 12:45pm, revealed that the smoke partition extending above the ceiling, located next to room 326, was noted to be penetrated by data lines. The space around the data lines was not filled with a material which would resist the passage of smoke. An interview with the Maintenance Director 01/20/11 at 12:45pm revealed he was not aware of the penetrations. Reference to: NFPA 101 Life Safety Code 2000 Edition 8-2.4.4 Penetrations and Miscellaneous Openings in Smoke Partitions. 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke.	K 025	How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action/s will be taken. Maintenance Director/Designee will complete a facility audit to verify no other areas of penetrations. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director and Maintenance staff will be in-serviced on checking for areas of penetrations. Maintenance will implement a form for vendors to complete when necessary to work in areas where smoke barriers may be affected. The Maintenance staff will follow up in this area upon the vendor's departure from the work area.	
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1			



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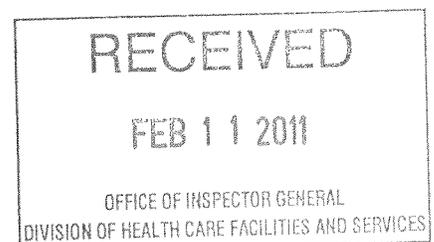
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K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1			



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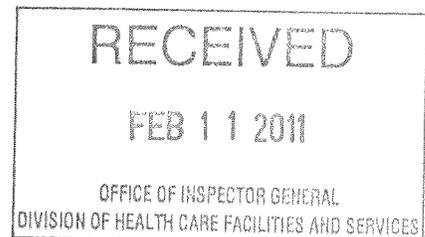
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K 038	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access and exit doors were maintained to be clearly recognizable as a means of egress, per NFPA standards. The findings include: Observation on 01/20/11 at 11:10am, revealed mini-blinds on the exit door located in the activities room. The mini-blinds could be an impediment to the operation of the doors or cause confusion in case of fire or other emergency. This observation was confirmed with the Maintenance Director. Interview on 01/20/11 at 11:10am with the Maintenance Director revealed they did not know they could not use mini-blinds on the door. Observation on 01/20/11 at 11:40am, revealed curtains on the exit door located near room 513. The curtains could be an impediment to the operation of the doors or cause confusion in case of fire or other emergency. This observation was confirmed with the Maintenance Director. Interview on 01/20/11 at 11:40am with the Maintenance Director, revealed they did not know they could not use curtains on the door.	K 038	K038 The facility will continue to ensure exit access and exit doors are maintained to be clearly recognizable as a means of egress, per NFPA standards. What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice? All mini-blinds will be removed from all exit doors. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action/s will be taken. Maintenance Director/Designee will complete an entire facility to verify no mini-blinds/curtains are on any exit doors.	3/1/11



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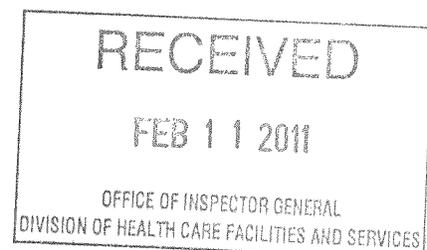
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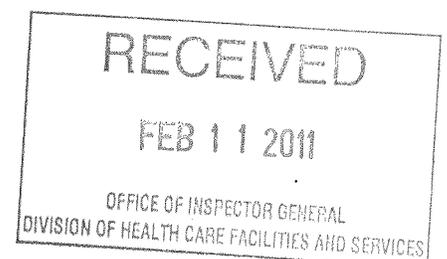
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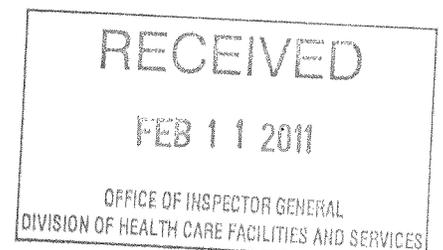
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K 038	Continued From page 3 Reference: 7.5.2.2 Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit.		K046 The facility will continue to provide emergency lighting in accordance with LSC 7.9.	3/1/11
K 046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on staff interview and observation, it was determined the facility failed to provide emergency lighting in accordance with LSC 7.9. The findings include: On 01/20/11 at 12:20pm, it was observed that an emergency light with battery backup located in the boiler room did not function properly. The deficiency had the potential to affect Maintenance Personnel working in the boiler room during the time of an emergency. This was verified with the Maintenance Director at the time of discovery. Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1	K 046	What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice? The emergency light with battery backup located in the boiler room will be corrected to function properly. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action/s will be taken. Maintenance Director/Designee will complete a facility audit to verify all emergency lighting is functioning properly.	



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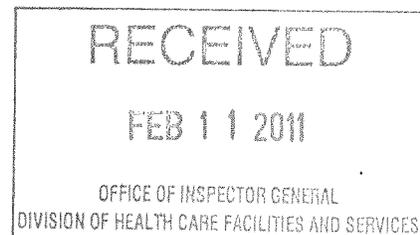
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K 038	Continued From page 3			
K 046 SS=E	<p>Reference: 7.5.2.2 Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and observation, it was determined the facility failed to provide emergency lighting in accordance with LSC 7.9.</p> <p>The findings include:</p> <p>On 01/20/11 at 12:20pm, it was observed that an emergency light with battery backup located in the boiler room did not function properly. The deficiency had the potential to affect Maintenance Personnel working in the boiler room during the time of an emergency.</p> <p>This was verified with the Maintenance Director at the time of discovery.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1</p>	K 046	<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Maintenance staff will be in-serviced to check all emergency lighting on a routine basis and to correct immediately if found not to be functioning.</p> <p>Maintenance Director/Designee will complete an audit monthly for three months and then quarterly for the remainder of the year to verify all emergency lighting is functioning properly. Findings will be reported to the QA committee.</p>	



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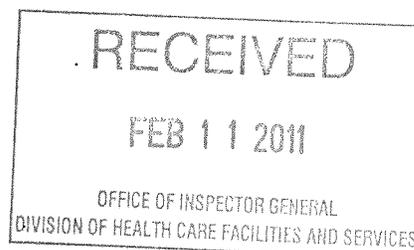
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K 038	Continued From page 3 Reference: 7.5.2.2 Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit.		<p>How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Maintenance Director/Designee will complete an audit monthly for three months and then quarterly for the remainder of the year to verify all emergency lighting is functioning properly. Findings will be reported to the QA committee.</p>	
K 046 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and observation, it was determined the facility failed to provide emergency lighting in accordance with LSC 7.9.</p> <p>The findings include:</p> <p>On 01/20/11 at 12:20pm, it was observed that an emergency light with battery backup located in the boiler room did not function properly. The deficiency had the potential to affect Maintenance Personnel working in the boiler room during the time of an emergency.</p> <p>This was verified with the Maintenance Director at the time of discovery.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1</p>	K 046		



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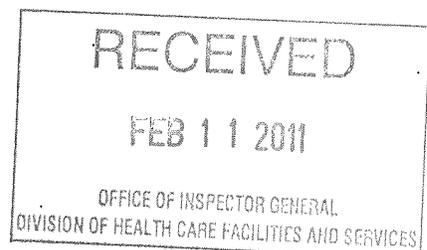
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K 046	Continued From page 4 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.				
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency could affect all (112) residents and staff. The facility is licensed for one hundred and twenty five (125) beds and the census on the day of the survey was one hundred and twelve (112). The findings include: Observation on 01/20/11 at 10:30am revealed hanging decorations were on the doors in various locations throughout the facility. The Maintenance Director indicated that the Activities Director was treating the decorations with a fire retardant spray, but did not have a written policy for documentation. This observation was confirmed with the Maintenance Director. Interview with the Administrator and Maintenance Director on 01/20/11 at 12:55pm, indicated they did not have a written policy for treating the	K 073	K073 Facility will continue to ensure that no combustible decorations are used in the facility according to NFPA standards. What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice? The various hanging decorations identified throughout the facility will be treated with fire retardant spray. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action/s will be taken. Maintenance Director/Designee will complete a facility audit to verify all appropriate items have been treated with fire retardant spray.	3/1/11	



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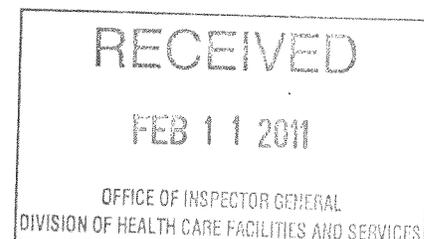
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2011
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206	
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K 046	Continued From page 4 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.			
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency could affect all (112) residents and staff. The facility is licensed for one hundred and twenty five (125) beds and the census on the day of the survey was one hundred and twelve (112). The findings include: Observation on 01/20/11 at 10:30am revealed hanging decorations were on the doors in various locations throughout the facility. The Maintenance Director indicated that the Activities Director was treating the decorations with a fire retardant spray, but did not have a written policy for documentation. This observation was confirmed with the Maintenance Director. Interview with the Administrator and Maintenance Director on 01/20/11 at 12:55pm, indicated they did not have a written policy for treating the	K 073	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director/Designee will implement a fire retardant policy. Maintenance Director/Designee will send a letter to family members regarding fire retardant policy. Maintenance Director/Designee will complete an audit monthly for three months and then quarterly for the remainder of the year to verify items are being treated with fire retardant spray as needed. Findings will be reported to the QA committee. How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance Director/Designee will complete an audit monthly for three months and then quarterly for the remainder of the year to verify items are being treated with fire retardant spray as needed. Findings will be reported to the QA committee.	



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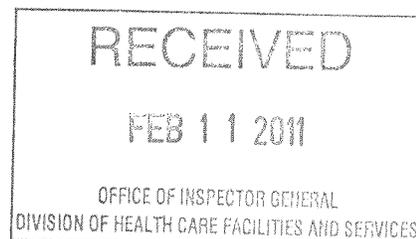
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K 073	Continued From page 5 decorations and will implement a policy for documentation.	K 073		
K 076 SS=E	Reference : NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored, according to NFPA standards. The findings include: Observation of the facility oxygen supply room on 01/20/11 at 11:00am revealed full and empty	K 076	K076 Facility will continue to ensure oxygen cylinders are stored according to NFPA standards. What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified to be affected. Oxygen cylinders identified as being stored together with no separation will be stored properly. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action/s will be taken. Maintenance Director/Designee will complete facility audit to verify oxygen cylinders are being stored according to NFPA standards.	3/1/11



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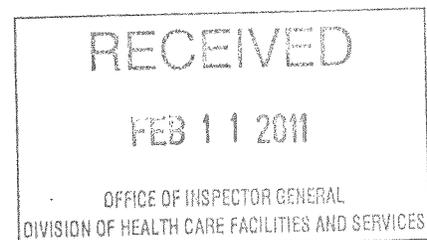
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K 076	Continued From page 6 oxygen cylinders were stored together with no separation. This observation was confirmed with the Maintenance Director and a Staff Nurse. The deficiency has the potential to affect residents, staff and visitors. The facility has the capacity for one hundred and twenty five (125) beds and a census of one hundred and twelve (112) at the time of the survey. Interview with the Administrator and the Maintenance Director on 01/20/11 at 1:00pm, indicated that the cylinders would be stored properly. Reference: NFPA 99 (1999 Edition). 4-3.1.1.2 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use. 4-3.5.2.2 2. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. 4-5.1.1.1 Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over. K 147 SS=D NFPA 101 LIFE SAFETY CODE STANDARD	K 076	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Signs have been placed on the wall to show proper placement of oxygen cylinders for staff. Nursing staff will be in-service on proper storage of oxygen cylinders for separation. Maintenance Director/Designee will audit monthly for three months and quarterly for the remainder of the year for proper separation of oxygen cylinders. Findings will be reported to QA committee. How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance Director/Designee will audit monthly for three months and quarterly for the remainder of the year for proper separation of oxygen cylinders. Findings will be reported to QA committee.	



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K 147	Continued From page 7 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical panel boxes had a clear area around them of at least 36 inches. The findings include: Observation on 01/20/11 at 12:05pm with the Maintenance Director revealed the electrical panels located in the Electrical room next to the loading dock were blocked by two (2) housekeeping carts. Interview with the Maintenance Director at 12:05pm indicated the blocked electrical panel boxes would be cleared of the obstructions. Reference: NFPA 70, National Electrical Code. 9.1.2	K 147	K147 The facility will continue to ensure electrical panel boxes have a clear area around them of at least 36 inches. What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action/s will be taken. Maintenance Director/Designee will complete a facility audit to verify no electrical panels are being blocked.	3/1/11



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K 147	<p>Continued From page 7</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 panel boxes had a clear area around them of at least 36 inches.</p> <p>The findings include:</p> <p>Observation on 01/20/11 at 12:05pm with the Maintenance Director revealed the electrical panels located in the Electrical room next to the loading dock were blocked by two (2) housekeeping carts.</p> <p>Interview with the Maintenance Director at 12:05pm indicated the blocked electrical panel boxes would be cleared of the obstructions.</p> <p>Reference: NFPA 70, National Electrical Code. 9.1.2</p>	K 147	<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Staff will be in-serviced to ensure electrical panel boxes have a clear area around them of at least 36 inches.</p> <p>Maintenance Director/Designee will audit monthly for three months and then quarterly for the remainder of year to verify electrical panels have a clear path around them of at least 36 inches. Findings will be reported to the QA committee.</p> <p>How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Maintenance Director/Designee will audit monthly for three months and then quarterly for remainder of the year to verify electrical panels have a clear path around them of at least 36 inches. Findings will be reported to the QA committee.</p>	

