

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

PRINTED: 05/03/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185154	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/21/2011
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NAME OF PROVIDER OR SUPPLIER  HOME OF THE INNOCENTS	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 EAST MARKET STREET LOUISVILLE, KY 40206
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F 000  F 223 SS=D	<p>INITIAL COMMENTS</p> <p>A Recertification Survey and an Abbreviated Survey investigating ARO#KY00016195 were initiated on 04/19/11 and concluded on 04/21/11. ARO#KY00016195 was substantiated and deficiencies cited at 483.13. A Life Safety Code Survey was conducted on 04/21/11 with the highest scope and severity of an "E".</p> <p>483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to protect one (1) of fifteen (15) sampled residents from abuse, (Resident #1): Interview and record review revealed, on 03/21/11 at 5:45 PM, State Registered Nurse Aide (SRNA) #1 was observed by the Speech Language Pathologist (SLP) to yell at Resident #1 and be forceful in removing the resident from the wheelchair and drop him/her to the bed.</p> <p>The findings include: Record review of the facility's policy "Protecting Residents/Clients from Abuse/Neglect", revised</p>	F 000  F 223	<p>"The Plan of Correction is prepared and submitted pursuant to Federal and State law. This Plan of Correction does not constitute an admission of, or agreement to, any alleged deficiencies or to any statements, findings, facts, or conclusions that form the basis of the alleged deficiencies. This facility reserves the right to challenge the alleged deficiencies in any legal proceeding".</p> <p>F223/N105 1. The facility initiated its investigation by checking the employee's schedule to determine her next scheduled work date, which was not until the following day at 3pm. All proper notifications were made, a meeting was held with the child's family, and the investigation was begun. The facility scheduled and held a meeting with the employee and Human Resources prior to her returning to work. The State Registered Nursing Assistant (SRNA) was interviewed and the decision was made to terminate the employee. The employee's behavior was deemed borderline however, the facility has a zero tolerance for such behavior and will continue the practice of zero tolerance, to ensure that no other resident is affected by this practice.</p>	5-13-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE President	(X6) DATE 6-9-11
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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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F 223	<p>Continued From page 1</p> <p>August 2007, revealed "...Residents have the right to be free from abuse and the facility shall protect the resident from physical and verbal abuse by anyone, including staff members...".</p> <p>Record review revealed the facility admitted Resident #1 (date of birth 11/23/04) on 01/05/11 with diagnoses which included Quadriplegic Cerebral Palsy, Mental Retardation and Dysphagia.</p> <p>Review of the facility's investigative report, dated 03/22/11, revealed the SLP reported to the Nursing Clinical Supervisor on 03/22/11 at 7:15 AM that she witnessed verbal abuse and "borderline" physical abuse to Resident #1 by SRNA #1 on 03/21/11 at 5:45 PM. The report indicated the SLP returned Resident #1 to his/her room and informed SRNA #1, who was assigned to Resident #1. Review of the report revealed Resident #1 started yelling and she witnessed SRNA #1 yell in the resident's face and threatened to "just put him/her in the bed". Further review of the report revealed the SLP indicated, SRNA #1 then pulled the resident out of the chair very quickly with a mad tone, and dropped the resident on his/her back from about six (6) inches above the mattress, while yelling that the resident would stay there for acting that way. The report further indicated the SLP stated, Resident #1 was crying.</p> <p>Interview with the SLP on 04/21/11 at 11:20 AM revealed she had witnessed the incident on 03/21/11 at 5:45 PM when she saw SRNA #1 yell at Resident #1 and be forceful in transferring the resident from the wheelchair to the bed. She further stated she was aware she should have</p>	F 223	<p>2. The facility identified other residents who may have been affected by this practice thru interviews with other staff from the unit, and found no other resident to be involved.</p> <p>3. The facility has all employees read and sign the Acknowledgement Statement of Commitment that serves to Protect Residents From Abuse Neglect and Misappropriation of Their Property. (Attachment #1) The facility's training on this topic begins in corporate orientation with the President and CEO explaining to all new employees that abuse and neglect in any form violates the resident's rights and the company's policy. The Vice President and Administrator will enforce the policy and procedure thru presented in-services and e-mail on Abuse and Neglect ensuring that the staff understands protection of the resident is the responsibility of every employee and failure to protect the resident may/can lead to termination. Social Services staff will educate bi-annually thru role playing scenarios of</p>	

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F 223	<p>Continued From page 2</p> <p>reported the incident to facility staff that evening instead of waiting to report it to her supervisor the next morning. Further interview revealed she was aware that by waiting, the alleged perpetrator was allowed to continued to work with the residents the remainder of the shift.</p> <p>Interview with SRNA #1 on 04/21/11 at 2:10 PM revealed Resident #1 returned from school and the SLP worked with him/her by feeding supper and taking for a walk around the unit before taking the resident to his/her room and turning on the television. She stated Resident #1 started crying (his/her normal mode of communication) because he/she liked the radio instead of television. Further interview revealed SRNA #1 was in a hurry to get him/her out of the wheelchair and into bed but denied any verbal or physical abuse.</p> <p>Interview with Director of Nursing (DON) on 04/21/11 at 2:35 PM revealed the investigation was began and concluded on the same day the report was made. She indicated SRNA #1 was not scheduled to work on 03/22/11, the day of the investigation. Further interview revealed SRNA #1 was instructed to come in early the next day and was terminated after she was interviewed about the incident.</p> <p>Interview with the Master Social Worker (MSW) on 04/21/11 at 2:45 PM revealed the "Abuse" elements were emphasized during Orientation and staff were fully aware of the ramifications of not following facility policy.</p>	F 223	<p>possible abuse during Resident Rights training. Social Services has refined its description of resident's behavior by identifying what staff can do to work with the residents who exhibit socially inappropriate behavior such as screaming. This is the systemic change the facility made to refine its practices to help staff identify interventions to reduce negative encounters with residents through role plays, please see attachment #2.</p> <p>4. This will be monitored by the Director of Nursing thru review of incident reports and trend analysis. The information will be reported to the Q.I. Committee quarterly.</p>	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	<p>Continued From page 3</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement policies and procedures to protect one (1) of fifteen (15) sampled residents (Resident #1) from physical abuse. Interview and record review revealed, on 03/21/11 at 5:45 PM, State Registered Nurse Aide (SRNA) #1 was observed by the Speech Language Pathologist (SLP) to yell at Resident #1 and forcefully transfer the resident from the wheelchair to the bed. However the SLP failed to follow the facility's policy by failing to report the incident immediately.</p> <p>The findings include:</p> <p>Record review of the facility's policy "Managing Allegations of Abuse/Neglect", revised August 2007, revealed that any witness of any form of abuse ...."shall immediately report the incident to their immediate supervisor..."</p> <p>Review of the facility's investigative report, dated 03/22/11, revealed the SLP reported to the Nursing Clinical Supervisor on 03/22/11 at 7:15 AM that she witnessed verbal abuse and "borderline" physical abuse to Resident #1 by SRNA #1 on 03/21/11 at 5:45 PM. The report indicated the SLP returned Resident #1 to his/her room and informed SRNA #1, who was assigned</p>	F 226	<p>F226/N106</p> <p>1. The facility will train and enforce with all staff it's principles to protect all residents from abuse and neglect as described in the policy and procedure by reporting all allegations or suspicion of abuse immediately to any person having the authority to act and protect the resident. The facility will train all staff to make the report immediately and leave it to the facility to determine the outcome. We will impress upon the minds of all employees the importance of reporting suspicion of abuse and allow the facility to determine whether the allegation meets the definition of abuse as described in F226 and F223.</p> <p>2. The corrective action to identify other residents affected by this deficiency is for the facility to ensure through education and training that staff understands they must report abuse immediately and that this report is not implied but is an expectation of employment in this facility. Because of the diminished cognitive abilities of the resident, the family and staff were interviewed. It was determined that no other residents were affected.</p>	5-13-11

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F 226	<p>Continued From page 4</p> <p>to Resident #1. Review of the report revealed Resident #1 started yelling and the SLP witnessed SRNA #1 yell in the resident's face and threatened to "just put him/her in the bed". Further review of the report revealed the SLP indicated, SRNA #1 then pulled the resident out of the chair very quickly with a mad tone, and dropped the resident on his/her back from about six (6) inches above the mattress, while yelling that the resident would stay there for acting that way. The report further indicated the SLP stated, Resident #1 was crying.</p> <p>Interview with the SLP on 04/21/11 at 11:20 AM revealed she had witnessed the incident on 03/21/11 at 5:45 PM when she saw SRNA #1 yell at Resident #1 and be forceful in transferring the resident from the wheelchair to the bed. She further stated she was aware she should have reported the incident to facility staff that evening instead of waiting to report it to her supervisor the next morning. Further interview revealed she was aware that by waiting, the alleged perpetrator was allowed to continued to work with the residents the remainder of the shift.</p> <p>Interview with the Director of Clinical Services on 04/21/11 at 2:35 PM revealed the SLP made the report to her supervisor the next morning, instead of reporting to the Supervisor immediately, at which time the Director of Clinical Services reminded her the incident should have been reported immediately.</p> <p>Interview with Director of Nursing on 04/21/11 at 2:35 PM revealed the investigation was initiated and concluded on the same day the report was made. She further stated at the conclusion of the</p>	F 226	<p>3. We will continue to teach our policy and procedure of training staff initially in orientation, during Resident Rights Training, during Annual Skills Validations and with one-on-one training as necessary to strengthen the understanding and importance of reporting allegations immediately and timely. We will initiate Leadership Administrative Rounds on all units to monitor the interaction between staff and the residents. Leaders will observe for inappropriate conversation, language or interactions, rough treatment of residents, staff member stress that may lead to the potential for abuse, and leaders will take corrective action when any of the above behaviors are observed.</p> <p>4. Leadership Rounds will be monitored by Director of Clinical Services, Staff Development, Social Services, Director of Nursing and the Administrator to ensure compliance.</p>	

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F 226	<p>Continued From page 5 Investigation, SRNA #1 was terminated.</p> <p>Interview with the Master Social Worker (MSW) on 04/21/11 at 2:35 PM revealed the "Abuse" elements, including the reporting aspect of the policy were emphasized during Orientation and staff were fully aware of the ramifications of not following facility policy.</p>	F 226		



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K 011	Continued From page 1 it was observed on 04/21/11 at 9:55 AM, that the facility failed to ensure that penetrations in the fire wall were sealed to maintain a 2-hour separation from the non-conforming building. The deficient practice was caused by the installation of two (2) 4 " plastic sleeves through the fire walls to run data cables. The sleeves were fire caulked on the exterior of the sleeve, but the interior of the sleeve was open to the other side of the fire wall.  Actual NFPA standard: Additions shall be separated from any existing structure not conforming to the provisions within Chapter 19 by a fire barrier having not less than a 2-hour fire resistance rating and constructed of materials as required for the addition. NFPA 101 section 19.1.1.4.1	K 011		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	K018 - The wedge holder was removed from the door immediately and the staff was informed that wedges and door openers in the medical record area are prohibited. Storage room doors located in the corridor of the physical therapy wing received automatic door closers. The automatic door closers were installed May 13, 2011.	

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K 018	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure there were no impediments to the closing of corridor doors, according to NFPA standards. The deficiency had the potential to affect residents and staff within two (2) smoke compartments.</p> <p>The findings include:</p> <p>Observations on 04/21/11 at 2:00 PM revealed:</p> <p>(1) a wedge holding the door to 0253 Medical Records office door open. The observation was confirmed with the Maintenance Director, who was present at that time.</p> <p>(2) Storage room doors located in the corridor of the Physical Therapy Wing did not have self closing devices.</p> <p>Interview with the Maintenance Director revealed that he was unaware that the wedge was in use, and that the storage room doors needed to be self closing.</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.</p>	K 018	<p>The facility staff checked all doors and found them to meet K018 regulation.</p> <p>The maintenance staff will continue to check and monitor doors regularly and replace automatic door closers when needed.</p> <p>The maintenance supervisor will monitor work orders and assign a staff member to replace broken door closures when needed.</p> <p>Attachment # 1 Training Medical Records Staff Attachment #2 WillisKlein Purchase of Closure</p>	

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K 018	<p>Continued From page 3</p> <p>A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.</p>	K 018		
K 025 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p>	K 025		

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K 025	<p>Continued From page 4</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments per NFPA standards. The facility has the capacity for seventy six (76) beds and the census was sixty (60) on the day of the survey. The deficiency has the potential to affect all eight (8) smoke compartments, sixty (60) residents, staff and visitors.</p> <p>The findings include:</p> <p>A tour of the facility conducted on 04/21/11, revealed that all the smoke partitions extending above the ceiling, located throughout the facility, were noted to be penetrated by newly installed 4" plastic data line sleeves, and data lines. The space around the data line sleeves were filled with a material rated equal to the rated partition but the interior of the sleeves were not filled with material rated to resist the passage of smoke.</p> <p>An interview with the Maintenance Director 04/21/11, revealed he was not aware of the penetrations. The Maintenance staff was instructed to immediately fill the penetrations with the required sealant.</p>	K 025	<p>K025 -Fire caulking was used to seal all fire wall penetrations, and all 4" plastic sleeves were sealed inside and out with a smoke barrier insulation and all work was completed before the surveyors left the facility.</p> <p>The facility will ensure that all future contractors, maintenance staff and IT support staff will repair fire wall penetrations as they occur.</p> <p>The facility will inspect the fire walls after each service call which may penetrate the fire barrier. This will be added to the preventive maintenance program.</p> <p>This solution will be monitored by the Maintenance Supervisor.</p> <p>The completion date was April 21, 2011.</p>	5-13-11

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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 025	Continued From page 5	K 025		
K 038 SS=F	<p>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.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that an exit was properly marked with delayed egress signage, and another exit did not have delayed egress according to NFPA standards. This deficiency has the potential to affect one (1) of</p>	K 038	<p>K038 -Signage was purchased and placed on door #113E identifying that the delayed egress system is functional.</p> <p>The facility maintenance and management staff will monitor all doors with delayed egress signage to ensure that the signage remains visible.</p>	5-13

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165154	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  04/21/2011
NAME OF PROVIDER OR SUPPLIER  HOME OF THE INNOCENTS			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 EAST MARKET STREET LOUISVILLE, KY 40206	
(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 038	<p>Continued From page 6</p> <p>eight (8) smoke compartments and approximately fourteen (14) residents, staff and visitors. The facility has the capacity of seventy six (76) beds with a census of sixty (60) at the time of the survey.</p> <p>The findings include:</p> <p>Observation on 04/21/11 at 1:20 PM revealed the facility did not have delayed egress locks on exit door #1273E, located in the new PCC building. Another exit in the new PCC building, #113E, has delayed egress but does not have proper signage for egress. This was confirmed by the Director of Maintenance during the observations.</p> <p>Interview on 04/21/11 at 1:20 PM, with the Director of Maintenance, revealed he was unaware that exit door #113E did not display the required signage, and had never noticed that exit #1273E did not have delayed egress.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system</p>	K 038	<p>The exit door in the new Kosair Charities Pediatric Convalescent Center building door # 1273E with locking system, which remains locked except during activation of the fire alarm, a new locking system was ordered with a delayed egress locking mechanism with alarm. The new equipment ordered has arrived, installation completed by May 13, 2011 by ECT Services. The new system will now open when pressure is applied consistently for more than 3 seconds, a count down will start and the door will unlock in 15 seconds. The maintenance supervisor and staff will monitor to ensure that the door works per the manufacture's recommendation.</p>	

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NAME OF PROVIDER OR SUPPLIER  HOME OF THE INNOCENTS	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 EAST MARKET 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 038	Continued From page 7 in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 147 SS=E	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	K 147	K147 -The maintenance staff placed new plate covers on the open junction boxes near ceiling #11-11 and 1250B at the end of the NFPA survey inspection. The maintenance department inspected all other junction boxes in the facility and found the plate covers were all present.	

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NAME OF PROVIDER OR SUPPLIER  HOME OF THE INNOCENTS		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 EAST MARKET STREET LOUISVILLE, KY 40206		
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K 147	<p>Continued From page 8</p> <p>wiring was maintained according to NFPA standards. The deficient practice affected two (2) of eight (8) smoke compartments, staff and approximately thirty (30) residents. The facility has the capacity for seventy six (76) beds with a census of sixty (60) the day of the survey.</p> <p>The findings include:</p> <p>Observations on 04/21/11, with the Director of Maintenance revealed: Open junction boxes were observed above the ceiling near door #11-11, and #1250B.</p> <p>Interview with the Director of Maintenance and the Administrator, confirmed that they were unaware of the open junction boxes and would get the covers and install immediately.</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>370.28(c) Covers.</p> <p>All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.</p>	K 147	<p>The facility will ensure that all electrical contractors who remove junction box plate covers to perform their work will replace the covers when work is completed. This will be monitored by the Supervisor of Maintenance and his staff.</p> <p>The maintenance department inspected junction boxes in other areas where electrical contractors worked and found junction box covers to be in place.</p> <p>The maintenance department will go behind all contractors after each job and inspect the junction boxes to ensure covers were replaced. This will be monitored by the maintenance supervisor.</p> <p>Attachment # 5</p>	5-13-11

Attachment #1  
K018

According to the NFPA 101 Life Safety Code Standard

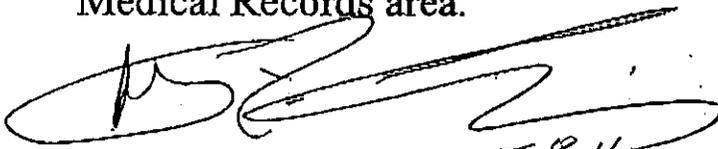
Date Survey completed: 4/21/2011

Tag: K018

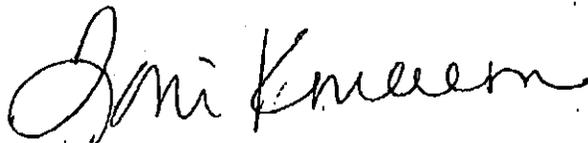
A wedge was holding the door open, to room 0253, Medical Records office. The observation was confirmed with the maintenance supervisor.

Based on observation and interview it was determined the facility failed to ensure there were no impediments to the closing of corridor doors according to NFPA standards.

Teaching was done by Jeff Lewis on 05/09/2011 with Toni Knierem, (Health Information Management Coordinator) regarding the door being held opened with a wedge and potential fire safety issues. That wedges and door openers are prohibited in the Medical Records area.



Jeff Lewis, Instructor: 5-9-11



Toni Knierem: