

Attachment E

SNF Monitor: Observation of Blood Glucose Monitoring and Isolation Precautions

Direct Care Staff Observed	Date	Compliant Proper Use and Cleaning of Glucometer		Compliant Protocol for Maintaining Isolation Precautions		Comment/Action Taken
		Y	N	Y	N	
Judy Kecklin, PT	4/4	NA		Y		5102-1 @ 1130 ^{ended in cleaning} handheld glucose (Education handouts provided + verbal interaction)
Sonya Markesberg, CNA	4/4	Y		NA		5323-1 @ 1145
Sonya Markesberg, CNA	4/4	Y		NA		5321 ^L @ 1200
Annette Jacobson, OT	4/4	NA		Y		5106 @ 1205 reminded of brought resident back from PT gym. Education as well as verbal interaction. Administrator informed + infection control to provide Q&A session on 4/5
Laura Herald, CNA	4/4	Y		NA		5322 ^L @ 1625
Kelly Harris, CNA	4/4	Y		NA		5103-1 @ 1630
Pat Riggs, CNA	4/5	Y		NA		5322 ^L @ 1125 ^{ended}
Pat Riggs, CNA	4/5	Y		NA		5321 ^L @ 1130 ^{Flu → good}
James Reeves	4/5	NA		Y		5102-1 @ 1200
Stephanie Ryan, OT	4/5	NA				5102 ^L ADLs - Skinning Dressing
Pat Riggs, CNA	4/6	Y		NA		5322 ^L @ 0910
Pat Riggs, CNA	4/6	Y		NA		5323 ^L @ 0850
Kelly Harris, CNA	4/6	Y		NA		5103-1 @ 1625
Laura Herald, CNA	4/6	Y		NA		5322-2 @ 1630 ^{ended}
Laura Herald, CNA	4/6	Y		NA		5322-1 @ 1640 ^{Flu → good}
Pat Riggs, CNA	4/7	Y		NA		5323-1 @ 1120
Pat Riggs, CNA	4/7	Y		NA		5322 ^L @ 1130
Nope Dotson, CNA	4/7	Y		NA		5103-1 @ 1135
Paul Siffel, CNA	4/7	Y		NA		5315 @ 1530 ^{kept admit.}

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 DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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		Y	N	Y	N	
Charlynn Lambert, LRN	3/31/11	Y		NA		5322-2 @ 1100 - good technique!
Pat Riggs, CNA	3/31/11	Y		Y		5101 @ 1200
Paul Siffel, CNA	3/31/11	NA		Y		5106 @ 1700
Heather McQuillan, CNA	4/1/11	NA		Y	reminded to	have instrument passed nearby 5106 @ 0930 ^{passed tray}
Mary Steiner, RN	4/1/11	NA		Y		5102-1 @ 0750
Heather McQuillan, CNA	4/1/11	NA		Y		5102-1 @ 0800
Gloria Guilfoyle, RN	4/1/11	NA		Y		5102-1 @ 0805 ^{mod pass.}
James Reeves, CNA	4/1/11	Y		NA		5321 @ 1110 ^{reviewed cleaning technique}
James Reeves, CNA	4/1/11	Y		NA		5323 @ 1120 ^{FLU - good.}
Olivia Heitzman, RN	4/2/11	NA		Y		5106 @ 0515
Debbie Steene Fowler, CNA	4/2/11	NA		Y		5102-1 @ 0545 ^(minimal)
Linda Chandler, CNA	4/2/11	NA		Y		5106 @ 0510 ^(minimal cues)
Julie Drake, Lab Tech	4/2/11	Y	(scanner)	Y		5106 @ 0500 ^{reminded meter/scanner clean before exiting. (sent notice to lab manager/supervisor)}
2 Residents in isolation - checked carts / fully stocked; signs on doors						
Tracy Reiger, CNA	4/3/11	NA		Y		5106 @ 0615 ^{answered legit - provided ca}
Heather McQuillan, CNA	4/3/11	Y		NA		5105 @ 0710
Sanya Markberry, CNA	4/3/11	Y		NA		5315 @ 0720
Virginia Brandenburg, Olivia Heitzman, Tracy Reiger, Kyla Riddell - IC and Glucometer review - oral quiz.						

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SNF Monitor: Observation of Blood Glucose Monitoring and Isolation Precautions

Direct Care Staff Observed	Date	Compliant Proper Use and Cleaning of Glucometer		Compliant Protocol for Maintaining Isolation Precautions		Comment/Action Taken
		Y	N	Y	N	
Pat Riggs CNA	3/26/11	N/A		Y		Bathing, Stockings Linen change CC
Sandy Barber LPN	3/26/11	N/A		Y		Med Pass 110PB CC
Kelly Harris CNA	3/26/11	N/A		Y		53212 BR, Empty Urinal CC
Melissa Gagnon LPN	3/27/11	Y		Y		2 nd - Repeat BGI & sugar New arm band
3/27/11 4 in violation - all have contact precaution signs and violation cards - all stacked.						
Sonya Marksherry	3/28/11	Y		Y		01 @ 0715 BGI
EKG Tech	3/28/11	NA		Y		212 @ 8 AM
Kyla Riddell	3/29/11	NA		Y		222 @ 0930 Bathing 01 @ 1030 Med
Jane Feldman	3/29/11	NA		Y		01 @ 0930 Bathing where error
Therapy staff Stephanie, Missy	3/29/11	NA		Y		01 @ 1030 in Rehab
Gene Wash	3/29/11			Y		02 @ 1000 Wound Assess.
Paul Sypel	3/29/11	Y		Y		01 @ 1610 BGI
Kathy Katz	3/29/11	NA		Y		02 @ 1530 Change Shift Eding
Pat Riggs	3/30/11	Y		Y		01 @ 1115 some cleaning reviewed steps
Jennifer Ruote, RD	3/30/11			Y		01 @ 1130 reminded to phone before entering. Sent notice to RD Supervisor
Pat Riggs	3/30/11	Y		NA		222 2nd assess.
Erin Dodges, SW	3/30/11	NA		Y		
Pat Riggs, CNA	3/31/11	Y				5315 @ 1130
Kyla Riddell, CNA	3/31/11	Y				5103 @ 1115 reminded to scan ID band.
Pat Riggs, CNA	3/31/11	Y				5322 @ 1145

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SNF Monitor: Observation of Blood Glucose Monitoring and Isolation Precautions

Direct Care Staff Observed	Date	Compliant Proper Use and Cleaning of Glucometer		Compliant Protocol for Maintaining Isolation Precautions		Comment/Action Taken
		Y	N	Y	N	
Unknown	3/24/11				N	Strip was left in 5101 to be recycled. Was not reused
3/24/11 Surgeon Observations						According to CNA - left by therapy. Removed and disposed of properly. Therapy remained to discard. in Room
Kyla Riddell CNA	3/25/11	N/A		Y	5373	0730 Setup tray GG
Betty Turner RN	3/25/11	N/A		Y	5111	0810 Assess RG GG
Gina Wash LPN	3/25/11	N/A		Y	5101	0830 Assessment GG
Kyla Riddell CNA	3/25/11	Y		Y	532P	1045 BS GG
Heather McQuillan CNA	3/25/11	Y		Y	5111	1110 BS GG
Betty Turner RN	3/25/11	N/A		Y	5111	1123 Meds. GG
Melissa Meek	3/25/11 0830am					Reviewed gown technique for isolation residents. Always use gown only once & place in laundry. GG
Linda Rechin						
Amber Abel						
Brandy Neace						
Nancy Montgomery						
Kathy Ritz LPN		N/A		Y	532P	1555 up to BR / Assess GG
Paul Siffel CNA		N/A		Y	532P	1610 up to BR GG
Betty Turner RN		N/A		Y	5111	1614 med Pass / Assess GG
Mary Schalk CNA		Y		Y	5111	1622 BS / Glucometer GG
Paul Siffel CNA		Y		Y	5101	1635 BS / Glucometer GG
Valerie Vaden RN		N/A		Y	5101	0645 Med Pass GG
Kyla Riddell CNA		Y		Y	532P	0840 BS / Glucometer GG

GG - Gloria Guilfoyle RN

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Direct Care Staff Observed	Date	Compliant Proper Use and Cleaning of Glucometer		Compliant Protocol for Maintaining Isolation Precautions		Comment/Action Taken
		Y	N	Y	N	
Mary Schalk	3/19/11	Y		Y		11 - 1st time using plastic cover @ 1600
Mary Schalk	3/19/11	Y		NA		13 @ 1600
Mary Schalk	3/19/11	Y		NA		14 @ 1600
Paul Siffel	3/19/11	Y		Y		21 st Same Curing @ 1630
Paul Siffel	3/19/11	Y		Y		21 st @ 1700
Mary Schalk	3/19/11	Y		Y		11 - @ 2100
Patricia Riggs	3/20/11	Y		Y		11 @ 0700
Patricia Riggs	3/20/11	Y		Y		21 st @ 0700
Patricia Riggs	3/20/11	Y		Y		21 st @ 0700
Kyla Riddell	3/21/11	NA		Y		11 @ 0900 - Bathing / Bed
Kyla Riddell	3/21/11	Y		Y		11 @ 1120
Kyla Riddell	3/21/11	Y		NA		14 @ 1130
James Reeves	3/21/11	NA		Y		21 st @ 1000 Bathing
James Reeves	3/21/11	Y		Y		21 st @ 1110
Sandy Harris, LPN	3/21/11	NA		Y		11 @ 1030 Wking with gt
Melinda Gilbert, LPN	3/21/11	NA		Y		21 st @ 1300 Wking @ gt
Laura Herald	3/21/11	Y		Y		21 st @ 1630 1st time / plastic
Kathryn Harris	3/21/11	Y		NA		14 @ 1645
Sanya Marksberry	3/22/11	Y		Y		11 @ 0710 completed insurance
Gene Wash, LPN	3/22/11	NA		Y		21 st @ 930 med pass
Debbie Shene Fowler	3/22/11	Y		Y		21 st @ 0700 Mary Steiner
Charlynn Lambert	3/22/11	Y		Y		21 st @ 0715 Mary Steiner
Sanya Marksberry	3/22/11	Y		Y		11 @ 1120
Gene Wash	3/23/11	NA		Y		01 @ 0845 med pass
Gene Wash	3/23/11	NA		Y		21 st @ 0915 med pass
Sue Johnson	3/22/11					21st @

2011
2/25

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Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007

Jane D. Siegel, MD; Emily Rhinehart, RN MPH CIC; Marguerite Jackson, PhD;
Linda Chiarello, RN MS; the Healthcare Infection Control Practices Advisory
Committee

Acknowledgement: The authors and HICPAC gratefully acknowledge Dr. Larry Strausbaugh
for his many contributions and valued guidance in the preparation of this guideline.

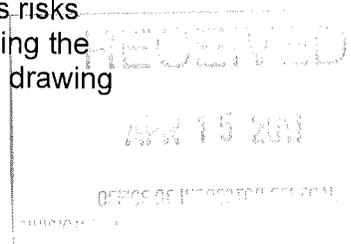
*Suggested citation: Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection
Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing
Transmission of Infectious Agents in Healthcare Settings, June 2007*
<http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf>



addition to Standard Precautions. See Appendix A for recommended precautions for specific infections. When Transmission-Based Precautions are indicated, efforts must be made to counteract possible adverse effects on patients (i.e., anxiety, depression and other mood disturbances⁹²⁰⁻⁹²², perceptions of stigma⁹²³, reduced contact with clinical staff⁹²⁴⁻⁹²⁶, and increases in preventable adverse events⁵⁶⁵ in order to improve acceptance by the patients and adherence by HCWs.

III.B.1. Contact Precautions Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment as described in I.B.3.a. The specific agents and circumstance for which Contact Precautions are indicated are found in Appendix A. The application of Contact Precautions for patients infected or colonized with MDROs is described in the 2006 HICPAC/CDC MDRO guideline⁹²⁷. Contact Precautions also apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission. A single-patient room is preferred for patients who require Contact Precautions. When a single-patient room is not available, consultation with infection control personnel is recommended to assess the various risks associated with other patient placement options (e.g., cohorting, keeping the patient with an existing roommate). In multi-patient rooms, ≥ 3 feet spatial separation between beds is advised to reduce the opportunities for inadvertent sharing of items between the infected/colonized patient and other patients. Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g., VRE, *C. difficile*, noroviruses and other intestinal tract pathogens; RSV)^{54, 72, 73, 78, 274, 275, 740}.

III.B.2. Droplet Precautions Droplet Precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions as described in I.B.3.b. Because these pathogens do not remain infectious over long distances in a healthcare facility, special air handling and ventilation are not required to prevent droplet transmission. Infectious agents for which Droplet Precautions are indicated are found in Appendix A and include *B. pertussis*, influenza virus, adenovirus, rhinovirus, *N. meningitides*, and group A streptococcus (for the first 24 hours of antimicrobial therapy). A single patient room is preferred for patients who require Droplet Precautions. When a single-patient room is not available, consultation with infection control personnel is recommended to assess the various risks associated with other patient placement options (e.g., cohorting, keeping the patient with an existing roommate). Spatial separation of ≥ 3 feet and drawing



- potential adverse psychological impact on the infected or colonized patient^{920, 921}. *Category II*
- V.B.2.c. In *ambulatory settings*, place patients who require Contact Precautions in an examination room or cubicle as soon as possible²⁰. *Category II*
- V.B.3. Use of personal protective equipment
- V.B.3.a. Gloves
- Wear gloves whenever touching the patient's intact skin^{24, 89, 134, 559, 746, 837} or surfaces and articles in close proximity to the patient (e.g., medical equipment, bed rails)^{72, 73, 88, 837}. Don gloves upon entry into the room or cubicle. *Category IB*
- V.B.3.b. Gowns
- V.B.3.b.i. Wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. Don gown upon entry into the room or cubicle. Remove gown and observe hand hygiene before leaving the patient-care environment^{24, 88, 134, 745, 837}. *Category IB*
- V.B.3.b.ii. After gown removal, ensure that clothing and skin do not contact potentially contaminated environmental surfaces that could result in possible transfer of microorganism to other patients or environmental surfaces^{72, 73}. *Category II*
- V.B.4. Patient transport
- V.B.4.a. In *acute care hospitals and long-term care and other residential settings*, limit transport and movement of patients outside of the room to medically-necessary purposes. *Category II*
- V.B.4.b. When transport or movement in any healthcare setting is necessary, ensure that infected or colonized areas of the patient's body are contained and covered. *Category II*
- V.B.4.c. Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions. *Category II*
- V.B.4.d. Don clean PPE to handle the patient at the transport destination. *Category II*
- V.B.5. Patient-care equipment and instruments/devices
- V.B.5.a. Handle patient-care equipment and instruments/devices according to Standard Precautions^{739, 836}. *Category IB/IC*
- V.B.5.b. In *acute care hospitals and long-term care and other residential settings*, use disposable noncritical patient-care equipment (e.g., blood pressure cuffs) or implement patient-dedicated use of such equipment. If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient^{24, 88, 796, 836, 837, 854, 1016}. *Category IB*
- V.B.5.c. In *home care settings*



ATTACHMENT G1

INITIAL SKILL/EQUIPMENT COMPETENCY CHECKLIST (CLINICAL/NON-CLINICAL) ST. ELIZABETH HEALTHCARE

Classroom Orientation Checklist for Certified Nurse Assistant/ Nurse Assistant

Associate [REDACTED]

Hospital & Unit Ft. Thomas/Skilled

Job Title CNA #4

Date of NSD orientation 12-8-10

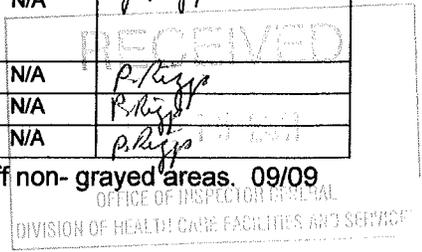
Instructions: Date and place Educator's initials by each content area after it is covered. This indicates the Associate met the performance expectations for that content. A rating of "Does Not Meet" indicates that expectations for that content were not met by the Associate and requires documentation of an action plan for correction with the Associate's nurse manager. Note any relevant comments in the adjacent column.

CONTENT	DATE REVIEWED// REVIEWED BY (Educator Initials)	DNM = Does Not Meet EXPECTATIONS N/A= Not Applicable	COMMENTS
General Information			
CNA State Registry Maintenance	KK 12-8-10	DNM N/A	
Performance Evaluations	KK 12-8-10	DNM N/A	
Continuing Education	KK 12-8-10	DNM N/A	
Patient Satisfaction	KK 12-8-10	DNM N/A	
Delegation and Supervision	KK 12-8-10	DNM N/A	
Patient Safety			
Hospital National Safety Goals	KK 12-8-10	DNM N/A	
Patient Identification	KK 12-8-10	DNM N/A	
Hand Hygiene	KK 12-8-10	DNM N/A	
Fingernails	KK 12-8-10	DNM N/A	
Infection Control Precautions	KK 12-8-10	DNM N/A	
SMART	KK 12-8-10	DNM N/A	
Patient Mobility Safety	KK 12-8-10	DNM N/A	
Fall Protection/ Prevention Interventions	KK 12-8-10	DNM N/A	
CARE- Nursing Care Rounds	KK 12-9-10	DNM N/A	
Restraints (*return demo quick release tie)	KK 12-9-10	DNM N/A	
Patient Emergency Care (Advance Directives, Rapid response, Code Blue)	KK 12-9-10	DNM N/A	
Seizure Precautions	KK 12-9-10	DNM N/A	
Routine Nursing Care			
Weights	KK 12-9-10	DNM N/A	
Meals	KK 12-9-10	DNM N/A	
Blood Glucose Monitoring Training- FSBS (*return demo)		DNM N/A	
Precision Xceed Pro Training- Edgewood/ Grant/ Gov Accu Check- Ft/ Flo/ Fal	KK 12-9-10		
Fresh Drinking Water	KK 12-9-10	DNM N/A	
Intake and Output	KK 12-9-10	DNM N/A	
Emptying a Bulb Suction Reservoir	12/10/10 KK	DNM N/A	
Emptying a Colostomy Bag	12/10/10 KK	DNM N/A	
Vital Signs	KK 12-9-10	DNM N/A	
Activity	KK 12-9-10	DNM N/A	
Environment	KK 12-9-10	DNM N/A	
Personal Care: Bathing, Oral Care	KK 12-9-10	DNM N/A	
Catheter Care	KK 12-9-10	DNM N/A	
Pericare	KK 12-9-10	DNM N/A	
HS Care	KK 12-9-10	DNM N/A	
Skin Care- Pressure Ulcer Prevention	KK 12-9-10	DNM N/A	
Wound Care	12/10/10 KK	DNM N/A	

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SKILL/ PROCEDURE/ EQUIPMENT <i>ATTACHMENT H CNA #4</i>	DATE REVIEWED/ REVIEWED BY (Initials)	M = MEETS CRITERIA DNM = DOES NOT MEET CRITERIA N/A = NOT APPLICABLE TO UNIT	COMMENTS/ ACTION PLAN
III. UNIT RESOURCES			
A. Identifies and states role of Safety Representative	01/14	(M) DNM N/A	W
B. Locates and reads Staff Meeting Minutes	01/14	(M) DNM N/A	W
C. Locates and reads Memo Book	01/14	(M) DNM N/A	W
D. Locates and utilizes Additional Reference Manuals	01/14	(M) DNM N/A	W
E. Accesses and utilizes Net Learning	01/14	(M) DNM N/A	W
F. Reads/ Responds appropriately to department, unit, and corporate e-mail	01/14	(M) DNM N/A	W
IV. EQUIPMENT (Demonstrates proper operation of each)			
A. Phone System	01/14	(M) DNM N/A	W
B. Call Lights/ Intercom/ Pocket Pagers/ Portable phones	01/14	(M) DNM N/A	W
C. Beds used on unit(Name/ Model: _____)	01/14	(M) DNM N/A	W
D. Locates information on operation of specialty beds	01/14	(M) DNM N/A	W
E. Heat Therapy System (operation, application, use- dry and moist applications) (Name/ Model: _____)	11/14	(M) DNM N/A	W
F. Anti- Embolism Stockings & Athrombic Boots (Name/ Model: _____) (operation, application, use, observation of skin on heels)	01/14	(M) DNM N/A	W
G. Heel lift boots (application, use)	01/14	(M) DNM N/A	W
H. Blood Glucose Monitor Machine(Name _____)	01/14	(M) DNM N/A	W
I. Pneumatic Tube System	01/14	(M) DNM N/A	W
J. Electronic Vital Signs Machine(Name/ Model: _____)	01/14	(M) DNM N/A	W
V. SAFETY			
A. Uses 2 patient identifiers comparing 2 independent sources prior to performing all care (ex: FSBS, delivering meals, patient care)	1/4/11 ZP	(M) DNM N/A	P. Rizzo
B. Demonstrates correct restraint application	1/4/11 ZP	(M) DNM (N/A)	P. Rizzo
C. Demonstrates correct care of patient in restraints	1/4/11 ZP	(M) DNM (N/A)	P. Rizzo
D. Implements all Fall Prevention Interventions as appropriate to individual patient need	1/4/11 ZP	(M) DNM N/A	P. Rizzo
E. Implements Wandering Risk Interventions as appropriate to individual patient need	1/4/11 ZP	(M) DNM N/A	P. Rizzo
F. Implements Seizure Precautions as appropriate to individual patient need	01-2 ZP	(M) DNM N/A	W
G. Demonstrates Proper Disposal of Sharps	1/4/11 ZP	(M) DNM N/A	P. Rizzo
VI. PATIENT CARE- SPECIFIC SKILLS			
A. Weighing Patient (states rationale, frequency, safety considerations) (Demonstrates operation of each)			
1. Standing Scale (Name/ Model: <u>TRONIX, W/C - STAIN</u>)	1/4/11 ZP	(M) DNM N/A	P. Rizzo
2. In Bed Scale (Name/ Model: _____)	1-4 ZP	(M) DNM N/A	W
3. Digital Scale (Name/ Model: _____)	1-4 ZP	(M) DNM N/A	W
4. SMART Equipment (Name _____)	1-4 ZP	(M) DNM N/A	W
B. Oxygen Therapy (states use/ safety considerations)			
1. O2 emergency Tank (demonstrates operation)	1-4 ZP	(M) DNM N/A	W
2. Reapplication of nasal cannula (demonstrates)	1-4 ZP	(M) DNM N/A	W
3. Reapplication of oxygen masks (demonstrates)	1-4 ZP	(M) DNM N/A	W
C. Admission, Transfers, and Discharge of Patients (accurately assists nurse in each)			
D. Patient's Nutritional Needs	1-4 ZP	(M) DNM N/A	W
1. Observes and implements individual patient dietary restrictions and requirements (ex: NPO, NA restrictions, Consistent Carb diets, supplements) and Infection Control precautions	1/4/11	(M) DNM N/A	P. Rizzo
2. Assures correct meal is safely delivered to patients	1/24/11	(M) DNM N/A	P. Rizzo
3. Collects Trays and accurately records dietary intake	1/24/11	(M) DNM N/A	P. Rizzo
4. Verbalizes method to obtain Late Tray	1/14/11	(M) DNM N/A	P. Rizzo

Nurse evaluates and signs off competency for grayed areas. A CNA may evaluate and sign off non- grayed areas. 09/09



SKILL/ PROCEDURE/ EQUIPMENT	DATE REVIEWED/ REVIEWED BY (Initials)	M = MEETS CRITERIA DNM = DOES NOT MEET CRITERIA N/A= NOT APPLICABLE TO UNIT	COMMENTS/ ACTION PLAN
S. Performing Pre- Op/ Post- Op Care (Demonstrates)			
1. Assisting patient with incentive spirometer	1-4 JB	M DNM N/A	KW
2. Assisting patient to cough	1-4 JB	M DNM N/A	
3. Maintenance of Abdominal Binder	1-4 JB	M DNM N/A	
T. Performing Infection Control Precautions			
1. Verbalizes and demonstrates Standard Precautions	1-4 JB	M DNM N/A	KW
2. Verbalizes and demonstrates Contact Precautions	1-4 JB	M DNM N/A	
3. Verbalizes and demonstrates Droplet Precautions	1-4 JB	M DNM N/A	
4. Verbalizes and demonstrates Airborne Precautions	1-4 JB	M DNM N/A	

INITIALS

SIGNATURE

P.R.	P. Ryan CNA
KW	Karen W
JB	Jessica Borders

"I have been instructed in/ have knowledge of the above mentioned skills, procedures and equipment."

CNA #4

Orientee Signature

[Redacted Signature]

Date

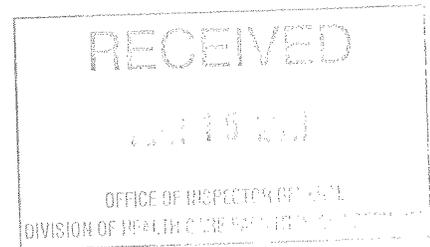
1-13-11

Nurse Manager's Signature

Jessica Borders

Date

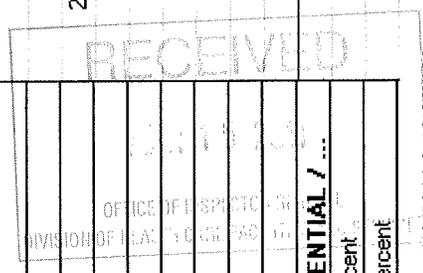
1/21/2011



ATTACHMENT I

Resident #12 H.S.

	13 3/9/2011 0510	12 3/9/2011 0530	11 3/9/2011 1407	10 3/10/2011 0700	9 3/13/2011 0607	8 3/16/2011 0633	7 3/18/2011 0618	6 3/20/2011 0925	5 3/25/2011 0448
CHEM PROFILE									
Sodium							136*		136*
Potassium							4.4*		4.5*
Chloride							103*		103*
CO2							30*		29*
Calcium							8.5*		8.5*
Glucose Lvl							149*		78*
BUN							15*		22*
Creatinine, Ser							1.0*		1.0*
GFR Afr Am							>60*		>60*
GFR Non Afr Am							>60*		>60*
Anion Gap							3*		4*
GI - LIVER PROFILE									
Prealbumin							10.2*		
IRON /ANEMIA PR...									
%Saturation		9							
Ferritin									
Folic Acid Lvl									
Iron		18							
TIBC		210							
Vitamin B12									
DIABETES									
Glucose Lvl									
THYROID									
TSH Reflex									
CBC									
WBC					1.870*				
RBC		3.9			6.9*				5.2*
Hgb		3.22			3.01*				3.13*
Hct		10.2			9.7*				10.5*
MCV		30.9			28.7*				31.1*
MCH		95.8			95.6*				99.2*
MCHC		31.6			32.3*				33.4*
RDW		33.0			33.8*				33.7*
Platelets		138			13.7*				15.1*
MPV		120			150*				306*
DIFFERENTIAL / ...									
Neut Percent		10.0			10.1*				9.5*
Lymph Percent									



	4 3/27/2011 0610	3 3/28/2011 1700	2 3/29/2011 1730	1 3/30/2011 0445
CHEM PROFILE				
Sodium				137
Potassium				4.8
Chloride				100
CO2				31
Calcium				9.2
Glucose Lvl				67 !↓
BUN				19
Creatinine, Ser				1.0
GFR Afr Am				>60*
GFR Non Afr Am				>60
Anion Gap				6 !↓
GI - LIVER PROFILE				
Prealbumin				
IRON / ANEMIA PR...				
%Saturation				
Ferritin				
Folic Acid Lvl				
Iron				
TIBC				
Vitamin B12				
DIABETES				
Glucose Lvl				67 !↓
THYROID				
TSH Reflex				
CBC				
WBC	5.1*			5.9
RBC	3.16*			3.26 !↓
Hgb	10.1*			11.1 !↓
Hct	31.0*			32.5 !↓
MCV	98.2*			99.8 !△
MCH	32.1*			34.0 !△
MCHC	32.7*			34.1
RDW	15.7*			16.3 !△
Platelets	262*			244
MPV	9.1*			9.5
DIFFERENTIAL / ...				
Neut Percent				65.0
Lymph Percent				19.9

	4	3	2	1
	3/27/2011 0610	3/28/2011 1700	3/29/2011 1730	3/30/2011 0445
Mono Percent				9.8
Eos Percent				5.0
Baso Percent				0.3
Neut#				3.8
Lymph#				1.2
Mono#				0.6
Eos#				0.3
Baso#				0.0
MAIN MICRO/VIRO...				
RPR				
URINE CULTURE				
GENERAL ID				
Organism				
				<i>Providencia stu...</i>
URINALYSIS				
UA Color		<i>Yellow *</i>		<i>Yellow</i>
UA Glucose		<i>Negative *</i>		<i>Negative</i>
UA Bili		<i>Negative *</i>		<i>Negative</i>
UA Ketones		<i>Negative *</i>		<i>Negative</i>
UA Blood		<i>Negative *</i>		<i>Negative</i>
UA pH		<i>5.5 *</i>		<i>6.0</i>
UA Protein		<i>Negative *</i>		<i>Negative</i>
UA Urobilinogen		<i>0.2 mg/dl *</i>		<i>Normal</i>
UA Nitrite		<i>Negative *</i>		<i>Negative</i>
UA Leuk Est		<i>Negative *</i>		<i>Negative</i>
UA Spec Grav		<i>1.020 *</i>		<i>1.015</i>
UA Appear		<i>Clear *</i>		<i>Clear</i>
GENERAL DIAGNOSTIC				
XR HIP LEFT AP ...				
OTHERS				
Final		<i>>100,000 ctu/ml...</i>	<i>10,000 ctu/ml P...</i>	

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RESIDENT #12 H.S.

(91 y.o. M) (Adm: 03/10/11)

FTT Skilled-E5313-
E531301

Date/Time	Temp	Pulse	Resp	BP	SpO2	O2 Flow Rate (L/min)	O2 Device	Wt - Scale	Patient Position	Arterial Line BP	Who
03/29/11 0500	98.2 ° F (36.8 °C)	72	18	154/54 mmHg	92 %	--	Room Air	--	Semi Fowlers	--	VB
03/28/11 2100	98.5 ° F (36.9 °C)	74	18	144/50 mmHg	95 %	--	Room Air	--	Semi Fowlers	--	MS
03/28/11 1416	98.4 ° F (36.9 °C)	79	16	131/49 mmHg	95 %	--	Room Air	--	Semi Fowlers	--	SM
03/28/11 0509	98.2 ° F (36.8 °C)	73	16	145/66 mmHg	99 %	--	Room Air	--	Semi Fowlers	--	VY

Attending Provider: (none)

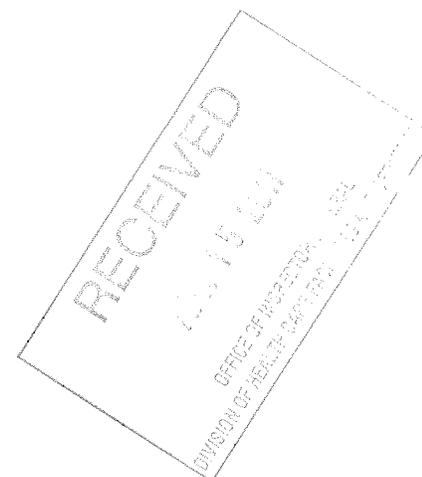
Add/Edit Comment

Allergies: **No Known Allergies**

Isolation: (none)
Code Status: None

HT: 5' 10" (1.778 m)
WT: 166 lb 3.2 oz (75.388 kg)
Admission Wt: 166 lb 3.2 oz (75.388 kg)

Admission Cmt: (none)



ATTACHMENT J

3/22/11

To: Wendy Bauer
St Elizabeth Healthcare
Director, Skilled Nursing Facilities

From: Karen Koss, RN, MSN
St Elizabeth Healthcare
Education Specialist, Staff Development

Re: _____, CNA

Be it known that on 3/21/11, I educated _____ in the use and disinfection procedures of the Accu-Chek Inform glucose meter. The education included maintaining Contact Isolation precautions when obtaining a blood glucose value using the Accu-Chek Inform meter.

_____ demonstrated, without cues, accurate performance of these aforementioned nursing care skills. _____ also verbalized that she understood the instructions and that she believed she could accurately carry out these tasks on the unit.

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2011 MAR 25 10:30 AM

2011 PERFORMANCE IMPROVEMENT (PI) SUMMARY

ANALYSIS/STUDY			
MONTH 1	MONTH 2	MONTH 3	QUARTERLY SUMMARY

ACTION					
MONTH 1	WHO	DATE	MONTH 2	WHO	DATE
MONTH 3	WHO	DATE	QUARTERLY SUMMARY	WHO	DATE

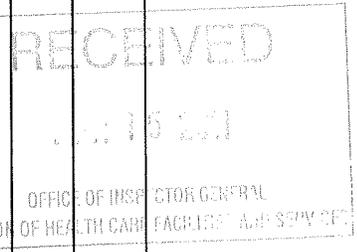
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 STATE OF CALIFORNIA

ATTACHMENT L

	1 st QTR 2010				TOTAL 2010				TOTAL 2009			
	EDGEWOOD	FLORENCE	FT THOMAS		EDGEWOOD	FLORENCE	FT THOMAS		EDGEWOOD	FLORENCE	FT THOMAS	
ABD HYSTERECTOMY SSI: (CLASS 2)	1.3% (1)	(0)	(0)		1.3% (1)	(0)	(0)		2.3% (7)	1.1% (1)	(0)	
C SECTION SSI: (CLASS 2)	0.4% (1)	0.6% (1)	n/a		0.4% (1)	0.6% (1)	n/a		0.8% (9)	0.9% (4)	0.5% (1)	
IMPLANTABLE CARDIAC DEVICES: Cardiac Cath Lab:	0.1% (2)	(0)	(0)		0.1% (2)	(0)	(0)		(2)	(0)	(0)	
POST PROCEDURAL:	(0)	(0)	(0)		(0)	(0)	(0)		0.1% (2)	(0)	(0)	
• Cardiac Cath Lab:	(0)	(0)	(0)		(0)	(0)	(0)		(0)	(0)	(0)	
• Interventional Radiology:	(0)	(0)	(0)		(0)	(0)	(0)		(0)	(0)	(0)	
GI - CLOSTRIDIUM DIFFICILE:	5.1/pd (18)	2.9/pd (3)	2.2/pd (2)		5.1/pd (18)	2.9/pd (3)	2.2/pd (2)		5.5/pd (78)	4.5/pd (19)	3.3/pd (14)	
UTI (CATHETER ASSOCIATED): (Critical Care)	1.3/cd (3)	(0)	1.9/cd (1)		1.3/cd (3)	(0)	1.9/cd (1)		0.7/cd (7)	0.8/cd (2)	1.3/cd (3)	
SKILLED NURSING:	n/a	(0)	(0)		n/a	(0)	(0)		n/a	0.4/rd (2)	0.3/rd (2)	
• Bloodstream	(0)	(0)	(0)		(0)	(0)	(0)			0.2/rd (1)	(2)	
• UTI (Catheter Associated)	(0)	(0)	(0)		(0)	(0)	(0)			(2)	(7)	
• HA - MDRO's (MRSA) (VRE) (C.difficile)	(1)	(0)	(0)		(1)	(0)	(0)			(4)	(4)	

4. Infection Data (Grant/Hospice/Falmouth):

	1 st QTR 2010				TOTAL 2010				TOTAL 2009			
	GRANT	HOSPICE	FALMOUTH		GRANT	HOSPICE	FALMOUTH		GRANT	HOSPICE	FALMOUTH	
	0	0	0		0	0	0		0	0	0	



	2 nd QTR 2010				TOTAL 2010				TOTAL 2009			
	EDGEWOOD	FLORENCE	FT THOMAS		EDGEWOOD	FLORENCE	FT THOMAS		EDGEWOOD	FLORENCE	FT THOMAS	
ABD HYSTERECTOMY SSI: (CLASS 2)	3.4% (2)	(0)	(0)		2.2% (3)	(0)	(0)		2.3% (7)	1.1% (1)	(0)	
C SECTION SSI: (CLASS 2)	0.4% (1)	1.6% (2)	n/a		0.4% (2)	1.2%(3)	n/a		0.8% (9)	0.9% (4)	0.5% (1)	
IMPLANTABLE CARDIAC DEVICES: Cardiac Cath Lab:	(0)	(0)	(0)		0.06% (2)	(0)	(0)		(2)	(0)	(0)	
POST PROCEDURAL:												
• Cardiac Cath Lab:	(0)	(0)	(0)		(0)	(0)	(0)		0.1% (2)	(0)	(0)	
• Interventional Radiology:	(0)	(0)	(0)		(0)	(0)	(0)		(0)	(0)	(0)	
GI - CLOSTRIDIUM DIFFICILE:	4.5/pd (16)	4.6/pd (4)	6.6/pd (4)		4.8/pd (34)	3.4/pd (7)	3.4/pd (6)		5.5/pd (78)	4.5/pd (19)	3.3/pd (14)	
UTI (CATHETER ASSOCIATED): (Critical Care)	1.8/cd (4)	(0)	1.8/cd (1)		1.6/cd (7)	(0)	1.6/cd (2)		0.7/cd (7)	0.8/cd (2)	1.3/cd (3)	
SKILLED NURSING:												
• Bloodstream		(0)	(1)			(0)	(1)			0.4/rd (2)	(0)	
• UTI (Catheter Associated)		(0)	(0)			(0)	(0)			0.2/rd (1)	0.3/rd (2)	
• HA - MDRO: MRSA VRE	n/a	(0)	(0)		n/a	(0)	(0)		n/a	(2)	(2)	
C.difficile		(0)	(0)			(0)	(1)			(7)	(5)	
		(0)	(0)			(1)	(2)			(4)	(4)	

4. Infection Data (Grant/Hospice/Falmouth):

	1 st QTR 2010				TOTAL 2010				TOTAL 2009			
	GRANT	HOSPICE	FALMOUTH		GRANT	HOSPICE	FALMOUTH		GRANT	HOSPICE	FALMOUTH	
	0	0	0		0	0	0		0	0	0	

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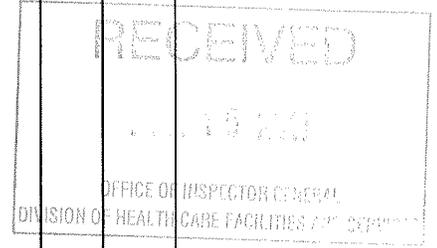
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	3 rd QTR 2010				TOTAL 2010			TOTAL 2009		
	EDGEWOOD	FLORENCE	FT THOMAS		EDGEWOOD	FLORENCE	FT THOMAS	EDGEWOOD	FLORENCE	FT THOMAS
ABD HYSTERECTOMY SSI: (CLASS 2)	3.7%(3)	(0)	(0)		2.7% (6)	(0)	(0)	2.3% (7)	1.1% (1)	(0)
C SECTION SSI: (CLASS 2)	0.8%% (2)	(0)	n/a		0.5% (4)	0.6%(2)	n/a	0.8% (9)	0.9% (4)	0.5% (1)
CARDIAC CATH LAB:										
• Sepsis:	(0)	(0)	(0)		(0)	(0)	(0)	(0)	(0)	(0)
• Surgical Site Infection (Edg):	0.1%(0)	(0)	(0)		0.08% (4)	(0)	(0)	0.1% (2)	(0)	(0)
GI - CLOSTRIDIUM DIFFICILE:	5.2/pd(17)	5.8/pd (6)	6.6/pd (6)		4.9/pd (51)	3.8/pd (10)	4.5/pd (12)	5.5/pd (78)	4.5/pd (19)	3.3/pd (14)
UTI (CATHETER ASSOCIATED): (Critical Care)	1.5/cd (3)	1.7/cd(1)	1.7/cd (1)		1.6/cd (10)	+(1)	+(3)	0.7/cd (7)	0.8/cd (2)	1.3/cd (3)
SKILLED NURSING:										
• Bloodstream							(1)		0.4/rd (2)	(0)
• Cardiovascular – VAD			(0)				(0)			0.3/rd (2)
• UTI (Catheter Associated)	n/a	(0)	(2)		n/a	(0)	(2)	n/a	0.2/rd (1)	
• HA - MDRO:		(0)	(0)			(0)	(0)		(2)	(2)
MRSA		(0)	(0)			(0)	(2)		(7)	(5)
VRE		0.8/rd(1)	(0)			0.3/rd(1)	0.4/rd(2)		(4)	
C.difficile										

* YTD Vascular rates at Flo/FTT are unavailable due to differences in coding cases prior to EPIC.
+ Denominator data are not available for calculation of rates

4. Infection Data (Grant/Hospice/Falmouth):

	3rd QTR 2010			TOTAL 2010			TOTAL 2009		
	GRANT	HOSPICE	FALMOUTH	GRANT	HOSPICE	FALMOUTH	GRANT	HOSPICE	FALMOUTH
	0	0.7%(1 uti)	0	0	0.2%(1 uti)	0	0	0	0

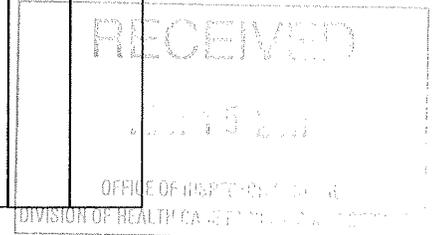


	4 th QTR 2010			TOTAL 2010			TOTAL 2009		
	EDGEWOOD	FLORENCE	FT THOMAS	EDGEWOOD	FLORENCE	FT THOMAS	EDGEWOOD	FLORENCE	FT THOMAS
ABD HYSTERECTOMY SSI: (CLASS 2)	2.4 %(1)	(0)	(0)	2.5% (7)	(0)	(0)	2.3% (7)	1.1% (1)	(0)
C SECTION SSI: (CLASS 2)	1.2 % (3)	3.0 % (3)	n/a	0.7 % (7)	1.1 % (5)	n/a	0.8% (9)	0.9% (4)	0.5% (1)
CARDIAC CATH LAB:									
• Sepsis:	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)
• Surgical Site Infection (Edg):	(0)	(0)	(0)	0.01% (4)	(0)	(0)	0.1% (2)	(0)	(0)
GI – CLOSTRIDIUM DIFFICILE:	1.6/pd (5)	7.1/pd (6)	4.6/pd (3)	4.2/pd (56)	4.0 /pd (16)	4.5 /pd (15)	5.5/pd (78)	4.5/pd (19)	3.3/pd (14)
UTI (CATHETER ASSOCIATED): (Critical Care)	3.0/cd (6)	(0)	(0)	1.9/cd (16)	0.4/cd (1)	1.3/cd (3)	0.7/cd (7)	0.8/cd (2)	1.3/cd (3)
SKILLED NURSING:									
• Bloodstream		(0)	(0)	n/a	(0)	1.6/rd (1)		0.4/rd (2)	(0)
• Cardiovascular – VAD		(0)	(0)		(0)	(0)		0.2/rd (1)	0.3/rd (2)
• UTI (Catheter Associated)		(0)	(0)		(0)	3.2/rd (2)	n/a		
• HA - MDRO: MRSA VRE		(0)	(0)		(0)	(0)		(2)	(2)
C. difficile		(0)	(0)		2.0 /rd(1)	3.2 /rd(2)		(7)	(5)

+ Denominator data are not available for calculation of rates

4. Infection Data (Grant/Hospice/Falmouth):

	4 th QTR 2010			TOTAL 2010			TOTAL 2009		
	GRANT	HOSPICE	FALMOUTH	GRANT	HOSPICE	FALMOUTH	GRANT	HOSPICE	FALMOUTH
	0	0	0	0	1 uti	0	0	0	0



ATTACHMENT 6

Weekly Cleaning Assignment – Cooks Unit

Revised 4/7/2011

ADDED:

1. Large floor mixer/bowl wiped down and sanitized
2. Complete change of fryer grease/fryers cleaned
3. Grates from stove removed and deep cleaned/oven deep cleaned
4. All refrigeration units- storage fridge, under turbo chef, drawers, cold table, freezers in back and under turbo chef, clean walls, floors, sides, inside and out.
5. Hot and cold tables, pasta cooker, and grill areas (underneath, outside, and all surrounding)/ drained and deep cleaned.

Weekly schedule

AC – Week 1 task 1., Week 2 task 2., Week 3 task 3., Week 4 task 4.

CC – week 1 task 2., Week 2 task 3., Week 3 task 4., Week 4 task 1.

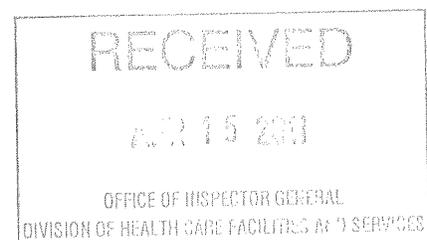
PC – week 1 task 3., Week 2 task 4., Week 3 task 1., Week 4 task 2.

Relief – week 1 task 4., Week 2 task 1., Week 3 task 2., Week 4 task 3.

Please follow the following guidelines to ensure there is enough time allotted to complete cleaning and/or prep:

At 11am the PC cook will prep from 11am-12:15pm then will assume the line cook duties. From 12:15pm till 1:30pm the AC cook will proceed with breakfast prep and clean-up before leaving.

No two cooks will ever be on break at the same time, break times may have to be adjusted to accommodate the needs of out patrons.



CODE # _____

**ST. ELIZABETH MEDICAL CENTER
ATTENDANCE RECORD**

Complete all of the following information. Then forward to Human Resources (Non-Nursing) or NSD (Nursing).

TITLE: Staff Meeting DATE: _____
 LOCATION: Ft. Thomas - Café Conf Room
 COMMITTEE CHAIR: Julie Hocker - Manager - Nutrition Services

Hocker, Julie - Manager	14169	Nutrition Service - Ft. Thomas	<i>JH</i>
Hollingsworth, Bev - Nutrition Asst.	70184	Nutrition Service - Ft. Thomas	<i>BH</i>
Hutchinson, Anne - Ambassador	70505	Nutrition Service - Ft. Thomas	<i>AH</i>
Issaacs, Abby - Ambassador	73617	Nutrition Service - Ft. Thomas	<i>AI</i>
Lambert, James - Expeditor/Lead	71648	Nutrition Service - Ft. Thomas	<i>JL</i>
Malloy, Kristina - Ambassador	77091	Nutrition Service - Ft. Thomas	<i>KMM</i>
McDonald, Benjamin - Nutrition Asst.	78452	Nutrition Service - Ft. Thomas	<i>BM</i>
Montgomery, Paul- Nutrition Asst.	78285	Nutrition Service - Ft. Thomas	<i>PM</i>
Pendery, Linda - Cashier/Server	70653	Nutrition Service - Ft. Thomas	<i>LP</i>
Perry, Nancy - Cashier/Server	5429	Nutrition Service - Ft. Thomas	<i>NP</i>
Peter, Barb- Dietitian	71374	Nutrition Service - Ft. Thomas	<i>BP</i>
Purtel, Lori - Dietitian	71500	Nutrition Service - Ft. Thomas	<i>LP</i>
Rosow, Kim - Clinical Coordinator	70232	Nutrition Service - Florence	_____
Searp, Mike - Cook	76793	Nutrition Service - Ft. Thomas	<i>MS</i>
Shell, Sheila - Expeditor/Lead	76785	Nutrition Service - Ft. Thomas	<i>SS</i>

CODE # _____

**ST. ELIZABETH MEDICAL CENTER
ATTENDANCE RECORD**

Complete all of the following information. Then forward to Human Resources (Non-Nursing) or NSD (Nursing).

TITLE: Staff Meeting

DATE:

LOCATION: Ft. Thomas - Café Conf Room

COMMITTEE CHAIR: Julie Hocker - Manager - Nutrition Services

Stephens, Gina - Nutrition Asst.	70848	Nutrition Service - Ft. Thomas	G.S.
Tackett, Marilyn - Cook	70447	Nutrition Service - Ft. Thomas	M.T.
Valz, Pam - Cook	73470	Nutrition Service - Ft. Thomas	ON
Veal-Bennett, Brendal - Expeditor/Lead	71495	Nutrition Service - Ft. Thomas	BWB
Walton, Sivanja - Nutrition Asst.	79824	Nutrition Service - Ft. Thomas	SMO
Webb, Janet - Nutrition Asst.	73537	Nutrition Service - Ft. Thomas	J.W.
Wisher, John - Nutrition Asst.	70146	Nutrition Service - Ft. Thomas	J.W.

Acceptable AOC
04/06/11

Please accept this Plan of Correction as the St. Luke Hospital Skilled Nursing Facility East's credible allegation of substantial compliance effective March 25, 2011 for the deficiencies noted from survey completed March 24, 2011. It is our intent that that se have substantially corrected our deficiencies per requirements in 42 CFR Part 483 Subpart B.

All direct staff – nurses and CNAs – as well as RNs in other clinical roles is trained on infection control protocols during the new hire orientation and annually during the mandatory in-service days. All non-direct care staff – Administrator, Social Services, Activities, and Therapists - is trained on infection control protocols during new hire orientation and annually through a mandatory computer based education program. In addition direct care staff receives training on the proper use, cleaning and storage of Glucometers. Lab conducts a competency and recertifies staff three [3] times a year.

On March 15, 2011 the State survey noted that a CNA performing a blood glucose check entered an isolation room with the meter and case and placed the monitor on the bed while performing the test. When she was finished she removed her gown and placed it in the drawer with clean gowns and then returned the monitor to the cabinet without cleaning it.

The unit was not notified of the breach in infection control protocol until 3/16/11 at approximately 11am; ending at approximately 11:20am, coinciding with the scheduled blood glucose monitoring prior to lunch. At that time the Administrator suspended any further testing and ordered an immediate in-servicing of staff currently on the unit. The Assistant Nurse Manage developed a "key point" in-service. **Attachment A: Blood Glucose Monitoring and Isolation Precautions. Also, please, see attached in-service attendance sheets.**

The Assistant Nurse Manager and Administrator presented the in-service to the staff on duty @ approximately 11:30 am. Float pool staff working the unit on 3/16/11 were included in the in-service. At the conclusion of the in-service the Administrator and Assistant Nurse Manager began the observation process with the CNAs with the remaining noon accuchecks. Priority was given to the CNAs as they are responsible for routinely performing the test.

The Administrator informed the staff working day shift on 3/16/11 that no staff would be permitted to perform blood glucose monitoring until they had completed the in-service. The Administrator also informed the staff that the Administrator and Assistant Nurse Manager would observe them performing the test on a resident in isolation after they had completed the in-service to ensure understanding and compliance with process.

The Administrator with the assistance of the Assistant Nurse Manager continued to in-service staff at the beginning of each shift to ensure that trained staff would be available for the shift. This process would continue until all staff had been in-serviced and observed and would ensure that adequate staff would be trained to perform the scheduled tests without any interruption in the testing process. **This process would be completed, including in-service and observation, by March 19, 2011. Attachment B: SNF: In-service and Observation of Blood Glucose and Isolation Precautions Tracking Record.** There would be one outlier - a CNA was on vacation who would not be returning until 3/21/11. She would be in-serviced and an observation completed at the beginning of her scheduled shift on 3/21/11.

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The Administrator determined that the process would need to continue beyond March 19, 2011 as float staff is assigned to the unit periodically. Float staff assigned to the unit during the survey and through the initial in-servicing were in-serviced by the Administrator and observed by either the Administrator or Assistant Nurse Manager. **Please see attendance sheets.** The charge nurse for each shift will review procedure with float staff, not previously in-serviced, prior to starting the shift and will observe when performing the test to ensure understanding and compliance. This information will be entered into **Attachment B: SNF: In-service and Observation of Blood Glucose and Isolation Precautions Tracking Record.**

In addition, the Administrator directed the Charge Nurse to remove all contents from the two [2] Glucometer cases, thoroughly clean the cases using the SaniWipes and restock the cases with necessary supplies – lancets, gauze, bandaids, test solutions and strips. This was immediately done by the Charge Nurse. The meters were also thoroughly cleaned by the Charge Nurse and replaced in the charger.

On 3/16/11 the Administrator and Assistant Nurse Manager conducted an investigation, based on information provided by the surveyor, and identified the staff involved in the incident. The CNA was not working on 3/16/11 and was not scheduled to return until 3/17/11. It was determined that on her return on 3/17/11, following the in-service, that the Assistant Nurse Manager would work directly with her on all assigned accuchecks to ensure her understanding of the use and cleaning of the glucometer and standards for contact isolation. The Assistant Nurse Manager after four 4 tests determined that the CNA did not understand and required extensive cueing to maintain compliance. At that time her accuchecks were reassigned to another CNA. The Administrator and Assistant Nurse Manager met with her and discussed the issue. It was determined that the Assistant Nurse Manager would provide support for her for the remainder of the day to complete routine work, but no accuchecks. At that time she would be taken off the schedule to allow Staff Development to work with her. She was scheduled for an eight hour [8 hr.] class on infection control procedures on March 21, 2011. There would be no loss of pay and she should view this as an opportunity to help her in her practice. She has to this date performed well based on observations by the Assistant Nurse Manager, Charge Nurses and nurse she has been assigned to. She has received numerous compliments on her care from residents and families. The Administrator will, on her return to duty on 3/22/11 observe both with the accucheck testing and compliance with isolation procedures.

General Infection Control principles are taught to all staff during new hire orientation. The Nursing Division provides additional training on infection control and use of glucometers as part of the new hire orientation. **Attachment F: Example of Classroom Orientation Checklist for CNA.** Annually all staff are re-serviced on Infection Control principles through CB training for non-clinical staff and mandatory in-service days for clinical staff. This process was outlined for the surveyors in a meeting with Infection Control and Staff Development.

The unit provides skilled care for Contact Isolation residents only. The unit is not equipped to handle Respiratory Isolation. To ensure that all staff were confident in their understanding of these precautions Jerry Abramis, Infection Preventionist, presented an in-service on Contact Precautions to the SNF staff

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on 3/18/11 at 3 pm. **Attachment D: Contact Isolation. Please see attendance sheet.** The in-service included:

- Requirement that all staff wears gloves when entering the room
- Gowns are required when direct care is being provided
- Discussion of what constitutes direct care
- What equipment can and cannot be taken into an isolation room
- How to clean equipment before removing from an isolation room
 - Saniwipes
 - Bleach
 - Alcohol

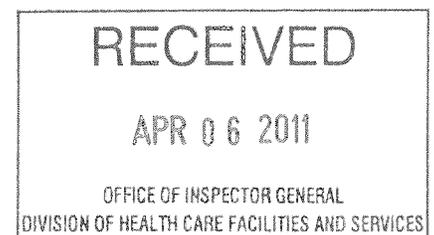
The hospital policy based Infection Control guidelines allowed for the reuse of the isolation gown if not grossly soiled and a hook was available to hang it in the patient's room. The staff was instructed that is portion of the policy would not be followed – gowns were to be used only once and then be properly disposed in accordance with infection control procedures.

On March 21, 2011 the Administrator met with the Social Worker, Activity Coordinator, MDS Coordinator and therapists to review contact isolation precautions and change in the procedure for the isolation gowns.

Random daily observation rounds have been made. **Attachment E: SNF: Observation of Blood Glucose and Isolation Precautions.** During these rounds the Administrator, Assistant Nurse Manager or Charge Nurse have monitored staff for compliance with both the use of glucometer [with and without isolation] and contact isolation [the unit has maintained 4-5 isolation residents since the survey]. If cueing to avoid a breach in the precautions is given it has been noted on the monitoring tool and a second observation done with that staff member. This has also been noted on the monitoring tool.

On March 24, 2011 a gown was noted by a surveyor hanging in a resident room on a hook. When it was brought to the attention of the Administrator, who had been working most of the day with the surveyors, the Administrator brought the staff together and reviewed the new process for isolation gowns. Paul Siffel, CNA, had already noted the gown and removed it. The administrator then made rounds throughout the isolation rooms and determined that no gowns were hanging. The Administrator was able to identify that the gown was left by a therapist. Therapy was gone for the day. On 3/25/11 the Administrator directed Gloria Guilfoile, charge nurse to address this issue with therapy in the morning meeting. The morning meeting takes prior to any care being provided. This review was noted on the monitoring tool. Random observations are continuing with all staff, particularly looking for compliance with isolation gowns. Any breach or potential breach will be handled in the same manner.

- Identify the breach or potential breach
- Ensure the safety of the resident
- Counsel staff involved
- Review procedures with all staff



- Monitor for compliance

Staff has knowledge of any admission involving isolation precautions prior to admission of the resident. When notified by Admission Coordinator of the admission the Charge Nurse or Clerical Coordinator download data from Epic. Isolation precautions are noted. In addition, the Admission Coordinator always advises unit of an admission involving isolation so that a private room can be assigned. The unit then:

- Notifies Central Supply that an isolation cart is needed
- On delivery ensures that the care is properly stocked
- Posts the "Contact Isolation" sign on the door **Attachment C: Contact Precautions**

These signs were present at the time of the survey. This was confirmed by Jerri Abramis, Infection Preventionist, when she met with the surveyors on 3/15/11. The signs directing the staff as to the appropriate precautions and PPE required.

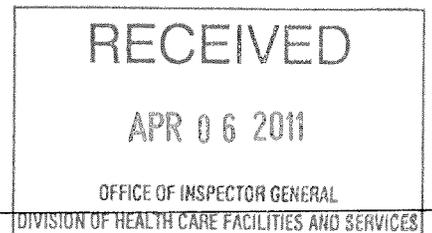
- Ensure that the room is ready for the admission
- The nurse assigned the residents receives report from the sending unit/facility
- The nurse provides report to assigned CNA; including the information regarding the isolation.
- The nurse ensures that family members understand that the resident is in isolation
 - Recommend that gloves and gowns are worn
 - Provide reminder that hand hygiene is to be performed prior to leaving the room

Upon admission isolation precautions are implemented and followed.

On March 17, 2011 the Administrator and Assistant Nurse Manger conducted a follow-up on resident #12. An accucheck was performed on this resident on March 15, 2011 immediately follow the incident with resident #11 – outlined above. He physician was notified on March 17, 2011 that an accucheck had been performed on his patient with a meter that was potentially contaminated. The Physician ordered a CBC for 3/18/11 and the results of the CBC were negative. In addition, the documentation in Epic, computer based documentation program, indicated that full assessments had been done each shift with vital signs. The staff was instructed by the Assistant Nurse Manager on March 17, 2011 to monitor for any of the following signs: fever, chills, diarrhea, and any change in status that would indicated onset of an infections. The staff was further instructed to notify the Assistant Director of Nursing or Administrator if any signs were noted.

The Administrator and Assistant Nurse Manager will continue to monitor compliance with blood glucose testing and compliance with contact precautions daily for 4 weeks and then weekly for 4 weeks. Monitoring to begin on March 19 after the training and observation is complete. In addition, a PDSA Performance Improvement plan will be developed at the end of the eight weeks that will continue the monitoring 6 additional months. **Attachment E: SNF: Observation of Blood Glucose and Isolation Precautions.** Observations will not be limited to unit staff of nursing float staff but anyone entering an isolation room. To date that has included: housekeeping, lab and pastoral care. Again, any breach or potential breach in isolation precautions will be handled as outlined above.

Wendy Bauer, NHA
4/7/11



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NAME OF PROVIDER OR SUPPLIER ST LUKE HOSPITAL EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 85 NORTH GRAND AVENUE FORT THOMAS, KY 41075		
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{F 000}	INITIAL COMMENTS On 04/11/11, an onsite revisit to the standard survey (03/24/11) was conducted which determined Immediate Jeopardy (IJ) had been removed at F441 and F490 on 03/25/11 as alleged in the Acceptable Allegation of Compliance (AOC) dated 04/06/11. While the IJ was removed at F441 and F490, continued non-compliance remained at a S/S of "E". The facility had not completed all staff in-servicing and the Quality Assessment and Assurance (QAA) Program had not completed the staff monitoring, analysis of information, nor the development and implementation of a plan to ensure correction of the deficient practice to prevent non-compliance recurrence. The non-IJ deficiency, F371, cited during the standard survey was not reviewed for compliance as the facility had not submitted a Plan of Correction (POC). Therefore, the deficiencies detailed on this statement of deficiencies for the revisit on 04/11/11 include the F371 deficiency identified on the standard survey dated 03/15/11.	{F 000}	Please accept this Plan of Correction as the St. Luke Hospital East Skilled Nursing Facility's credible allegation of substantial compliance effective <u>April 15, 2011</u> noted from the survey Completed March 24, 2011. It is our intent that we have substantially corrected our deficiencies per requirements in 42 CR Part 483 subpart B. F371 The facility ensures the safe procurement/storing/preparation/serving of food through its procedures, and training and monitoring of staff.		
{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 This REQUIREMENT is not met as evidenced	{F 371}		4/15/11	

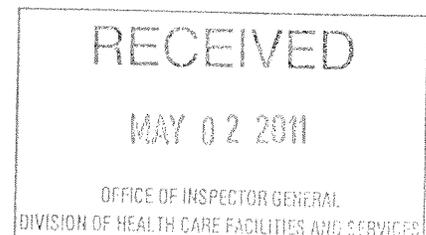
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: W. Rudy Jones, NHA TITLE: Adm. Dir. (X8) DATE: 4/29/11

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

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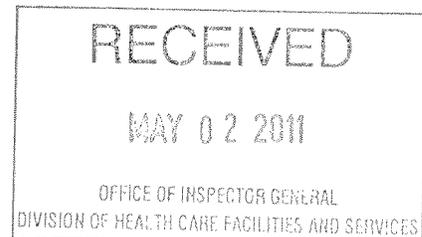
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{F 371}	Continued From page 1 by: Based on observations, interview, and record review, it was determined the facility failed to ensure food was stored, prepared, and distributed under sanitary conditions. The facility failed to follow their Floor Care, Infection Control Guidelines for Nutrition Services, Storage of Foodstuffs and Maintenance of Equipment for Nutrition Services policies. The Kitchen floors were observed unclean and with standing water. Appliances (i.e. mixers, bowls) were soiled with dried sticky substances. Employees were not wearing required full hair covering. Frozen food items were stored on the floor in the freezer. Dry goods items were not sealed and covered and stored in a manner in accordance with infection control. The walk in refrigerators and freezers had peeling paint on the ceilings. The findings include: 1. Policy review of the Floor Care policy with revision date of 11/09 revealed all spills (food, liquids, grease) are immediately cleaned up by appropriate staff person. Floor care policy states mop heads are placed in soiled laundry and mop equipment is stored in the appropriate area, and wet floor signs are placed on wet floors until dry, with all associates responsible to report wet or slippery floors to Supervisors. Observation, on 03/15/11 at 10:00am, during a tour of the kitchen revealed the kitchen floor had standing water near large boilers directly under the hood where condensation dripped constantly on the floor. Two (2) large boilers had continuous boiling water. Puddles of water were contained by using multiple mop heads placed on the floor to absorb the water. Lettuce salad was spilled on	{F 371}	Area was immediately cleaned during survey. 3/15/11. Policy regarding floor care was reviewed with all staff at department meeting on 3/31/11. Cooks were instructed to remove excess water immediately when it occurs while kettles are in use by using a dry mop bucket and dry mop kept in the area. Each day when the kettles are no longer in use the cooks were instructed to discard bucket/water in proper area and discard mop heads in the soiled mop container. At no time will the use of only mop heads to soak up excess water be permitted. Attachment 1: Nutrition Service Department Meeting, 1.1. Long range plan: Maintenance performed preventive maintenance on hood with the cleaning of traps and exhaust filters to ensure adequate exhaust and contracted with Peck Mechanical to verify the current CFM of the system and make recommendations – process started on 4/22/11. Attachment 8: Email Spills regarding lettuce and flour were cleaned immediately from floor on 3/15/11 and floor care reviewed with staff working on 3/15/11. Staff was inserviced on policy at the department staff meeting on 3/31/11 Attachment 1: Nutrition Service Department Meeting, 1.1. Daily monitoring excess to be done by supervisor/team leader for 3 months. Attachment 2: Daily Monitoring Checklist.	



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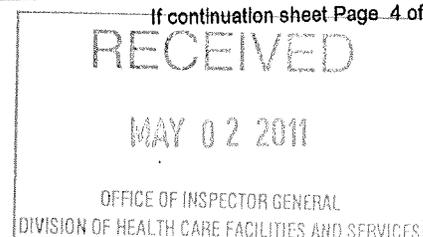
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{F 371}	<p>Continued From page 2</p> <p>the floor near the cold prep area. In the dry goods storage area, flour was spilled on the floor.</p> <p>Interview, on 03/15/11 at 10:00am, with the Manager of Food Service (FSM) revealed that condensation drips from the range hood where new boilers and equipment were installed during 2010 in order to provide a new meal delivery format. The FSM said, the staff used mop heads to absorb the condensation from the range hood, which pools on the floor. The FSM acknowledged the spills should be cleaned when they occur, and the lettuce salad and flour should have been cleaned off the floor immediately.</p> <p>2. Policy review of Infection Control Guidelines for Nutrition Services, with revision date 11/09 reveal all equipment shall be disassembled, cleaned, sanitized, dried, and reassembled after each use, and states 'clean' means free of visible soil. The Infection Control Guidelines also stated that kitchen personnel shall keep clean hair covered with a hairnet, all foods that have been prepared for service shall be covered, dated, and discarded after three days, and food shall be served with clean tongs, scoops, forks, spoons, spatulas or other suitable implements to avoid manual contact whenever possible.</p> <p>Observation on 03/16/11 at 11:45am during tray line preparation found the Cook wearing a checked cap with hair outside of the cap. The Prep-cook and Server/Cashier both wore a bouffant head cover on the back part of the head with the front of the head/hair exposed. The staff at the Starter Station wore a bouffant head cover in a manner which left hair exposed at the forehead and back of the neck.</p>	{F 371}	<p>Infection Control</p> <p>The facility requires that all dietary personnel wear hair nets and hair is to be fully covered. Action was immediately taken on 3/15/11, during the survey to ensure that all hair nets were on and covering hair. Hair control policy reviewed with staff in department meeting on 3/31/11. Attachment 1: Nutrition Service Department Meeting, 1.2.</p> <p>Daily monitoring by supervisor/team leader will be done to ensure for 3 months to ensure compliance with policy. Attachment 2: Daily Monitoring Checklist.</p> <p>The facility designates equipment that is to be cleaned daily/weekly. Equipment cleaning reviewed with staff in department meeting 3/31/11. Attachment 1: Nutrition Service Department Meeting, 1.3.</p> <p>Equipment cleaned on 3/15/11, during survey. Action taken to ensure no reoccurrence: Mixers added to current weekly cleaning checklist. Attachment 6: Weekly Cleaning Checklist. Cleaning of can opener added to daily monitoring sheet. Attachment 2: Daily Monitoring Checklist.</p> <p>Daily monitoring by supervisor/team leader will be done to ensure for 3 months to ensure compliance with policy Attachment 2: Daily Monitoring Checklist.</p>	



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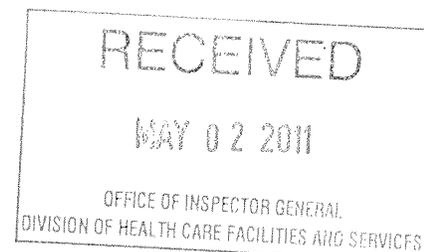
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{F 371}	<p>Continued From page 3</p> <p>Observation on 03/17/11 at 9:10am, during the sanitation tour, revealed the Kitchen Aide counter mixer, can opener, and Hobart stand mixer were not clean and ready for use, as there were dried particles on the equipment.</p> <p>Continued interview with the FSM revealed the FSM said the Kitchen Aide mixer, the Hobart stand mixer, and the can opener were not cleaned properly and should have been cleaned after use. The FSM did not have a cleaning log for the cleaning of appliances and the kitchen work area. The FSM said she was not aware that kitchen staff were not wearing complete head coverings, and said that no hair should be exposed when the head covering was worn properly.</p> <p>3. Policy review of Storage of Foodstuffs, with a revision date of 11/09, revealed food items are to be stored six inches off the floor, and all leftovers will be placed in shallow pans, covered, labeled, and dated before refrigeration, with mandatory prompt cooling of leftovers.</p> <p>Continued observation during the kitchen tour revealed the Walk-in refrigerator #2 had a container of tomato soup, artichoke strips, and blueberry muffin batter in baking tins uncovered on a cart. The tomato soup and artichoke strips were stored in open containers on the top shelf of a second cart, within three (3) feet of cracked and peeling paint on the ceiling. The third cart had a tray of scalloped potatoes which were too hot to touch and directly placed under a covered tray with tomatoes, sauce, and cheese. The prep walk-in refrigerator revealed containers of carrots, corn, green beans, and asparagus, which were stored on the top shelf of a rolling cart, unsealed</p>	{F 371}	<p>Storage of Foodstuffs The facility stores food in accordance with HACCP. During the survey, 3/15/11, all deficiencies noted by the surveyor were immediately corrected. The food storage policy/HCCAP were reviewed with staff at department meeting on 3/31/11. Attachment 1: Nutrition Service Department Meeting, 1.4. Storage bin was ordered/received for bread crumbs. Attachment 3: Purchase Requisition.</p> <p>Proper storage of food in coolers and in walk-ins will be monitored daily by supervisor/team leader for 3 months. Attachment 2: Daily Monitoring Checklist.</p> <p>Immediate action taken regarding proper chilling of food items: Blast Chiller in-service given to all cook staff. Attachment 4: Blast Cool Instructions/ In-service.</p>	



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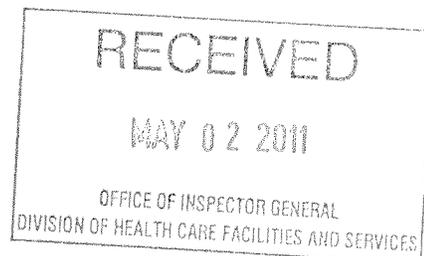
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{F 371}	Continued From page 4 and open to air. Observation of Walk-In freezer #3 revealed three (3) boxes of frozen mashed potatoes were stacked and stored directly on the floor. Continued interview the FSM was unaware of the open dry goods and said she would identify a container in which to seal and store the breadcrumbs and lentils. The FSM said staff have been trained during orientation to review kitchen policies, and not to leave scoops in a container/bins. The FSM acknowledged that all refrigerated containers of prepared foods should be covered and the items on the top of the rolling cart were in close proximity to the cracked and peeling paint, which created a risk of food contamination. The FSM stated, the storage of a tray of hot scalloped potatoes on a cart within the walk-in refrigerator was acceptable because the food was stored in a large flat tray which would cool quickly. He/she said hot food would not affect the tray of prepared cold food directly above it or raise the temperature of the refrigerator. The FSM acknowledged boxes of frozen food should not be stored on the freezer floor. 4. Policy review of Maintenance of Equipment for Nutrition Services, with revision date 11/09, stated all corrective maintenance is conducted consistent with procedures outlined by Plant Engineering. Both walk-in refrigerator #1 and #2 were found to have cracked and peeling paint from the ceilings and walls. Walk-in freezer #3 revealed ice droplets on the ceiling and ice on the freezer vent; ice was heavy on the upper right side.	{F 371}	Maintenance of Equipment Cracked and peeling paint in cooler: immediate action taken for resolution: peeling paint was scraped and sealed by Plant Engineering. Attachment 5: Before and After Pictures. Long term resolution to issue will be for the walk-in boxes to be stripped of paint. This will require a refrigerated box truck for transfer of cold food items. Truck has been scheduled for the week of May 16, 2011 and will be completed by May 20, 2011.		



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{F 371}	Continued From page 5 Continued interview revealed the FSM was not aware of the cracked and peeling paint in walk-in refrigerators #1 and #2, but said the peeling paint, "needs to be taken care of." The FSM further stated the ice on the ceiling and vent of walk-in freezer #3 was not unusual. This freezer was out of service in January, 2011. The FSM said the freezer was old and required service frequently by facility Plant Engineering. Interview on 03/17/11 at 9:10am with the FSM revealed that she initiated a work order to report the cracked and peeling paint in walk-in refrigerators #1 and #2, as well as the collection of ice droplets on the ceiling and vent of walk-in freezer #3. The FSM said she addressed concerns with the hospital's Project Manager about the condensation of the floor since the new equipment was installed in October, 2010, and said he/she sent an e-mail on the date of the survey, 03/17/11, requesting assistance. Interview on 03/17/11 at 10:00am with the Supervisor of Plant Engineering (SPE) revealed that the frozen condensation in walk-in freezer #3 was not an unusual occurrence because it was a very old appliance. The SPE said the defrost mode is automatically activated three (3) times daily and runs for thirty (30) minutes to defrost the buildup. The SPE had no response to explain if the defrost mode was functioning properly, or why the frozen condensation remained in place as observed consecutively for two days. The SPE stated when the request was received to paint the inside of walk-in refrigerators #1 and #2, he objected and explained that the interior surface of both units was aluminum, which should not be painted. The SPE said last year the engineering staff scraped the paint off of the interior of walk-in	{F 371}	Frozen condensation on condenser: TEMP TRAK, automated monitoring system, takes daily readings. Reports show that adequate temperatures were maintained for freezer unit. Attachment 7: Temp Trak Report. Staff was instructed to limit the amount time the freezer door remained open to allow defrost cycle to work and remove condensation. Staff was instructed to stack supplies outside the freezer; then take stacked supplies into freezer and close door while putting supplies in appropriate place, thereby reducing the amount of time the door was open and the amount of condensation. Daily monitoring of temperature to be done. Attachment 7: Temp Trak. Long term resolution: Kent Electricians inspected condenser on 4/13/11 and made recommendation that were implemented by Plant Operations. Attachment 9: Email.		



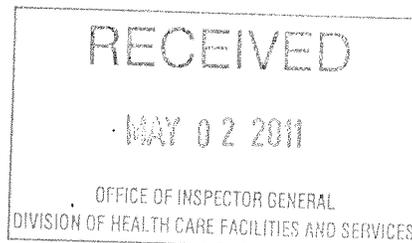
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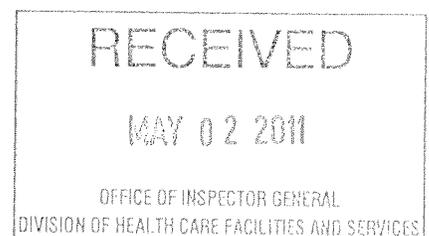
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 371}	Continued From page 6 freezer #3 which also aluminum, had been painted earlier and the paint was cracking and peeling. The SPE said, "I guess we will have to scrape the other refrigerators now."	{F 371}		
{F 441} SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	{F 441}	F441 The facility ensures the safety of its residents through its policies and practices related to infection control. All direct care staff was in-serviced on both cleaning/use of glucometers in and out of isolation, which included a review of isolation precautions. This was completed on 3/19/11. Attachment A: Blood Glucose Monitoring and Isolation Precaution In-service and Attachment B: SNF: In-service and Observation of Blood Glucose and Isolation Precautions Tracking Record. Additional in-servicing on Contact Isolation began on 3/18/11, 3-11pm shift and concluded on 3/22/11. All direct care staff attended in-service, except Katie Utz CNA, who was on a LOA from the unit. Attachment D-1: Timecard. The timecard shows that she came in from her LOA for the first in-service on 3/18/11 but did not return to the unit after that date. She transferred to Critical Care and began working there on 3/28/11. Linda Chandler, CNA attended the the additional Contact Isolation In-service,	4/15/11



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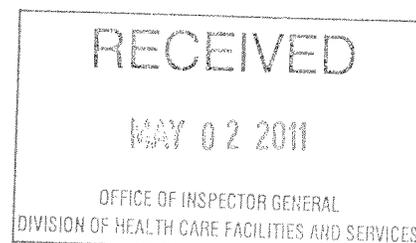
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185328	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/11/2011
NAME OF PROVIDER OR SUPPLIER ST LUKE HOSPITAL EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 85 NORTH GRAND AVENUE FORT THOMAS, KY 41075	
(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 441}	<p>Continued From page 7</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that Immediate Jeopardy identified during the standard survey (03/24/11) had been removed; however, non-compliance continued to exist as the facility had not completed Contact Isolation Precautions in-servicing for two (2) certified nursing assistants (CNA). Additionally, the facility had not completed the Quality Assessment and Assurance (QAA) initiative related to staff monitoring, analysis of monitoring results, and the development and implementation of the Performance Improvement Plan.</p> <p>The findings include:</p> <p>Record review of the Contact isolation Precautions Tracking Record revealed two (2) Direct Care Staff (CNA) had not completed the training.</p> <p>Interview, on 04/11/11 at 12:45pm, with the Administrator and Associate Nurse Manager revealed the facility had not implemented all aspects of their plan to correct the deficient practice. She stated the facility needed to continue to monitor contact isolation procedures for up to eight (8) weeks. Once the monitoring is complete, the Quality Assessment and Assurance Program will coordinate an analysis of the information in order to develop a Performance Improvement Plan with specific objectives to</p>	{F 441}	<p>on 3/19/11. Attachment D: Contact Isolation. This in-service was conducted by the Administrator with Linda in attendance. She confirmed that she attended the in-service, however, she failed to sign the attendance sheet and it was not noted on the tracking record. Attachment D: Contact Isolation [tracking record]. This was an unintentional oversight by Administration.</p> <p>On 4/5/11 the in-service was repeated to review and re-enforce isolation precautions. Attachment D: Contact Isolation Linda Chandler attended this in-service. Attachment D-2: Sign In.</p> <p>The facility monitored compliance daily with glucometer use with isolation residents and non-isolation residents, and with contact isolation residents [with and without glucometer testing]. The daily monitoring concluded on 4/15/11. The facility is currently conducting weekly monitoring for maintenance of long term compliance. Attachment E: Observation of Blood Glucose Monitoring and Isolation Precautions. Beginning 4/1/11 data collected from these observations is recorded in PDSA format, including an analysis of the data and action plan for any deficiency noted. This process will continue for no less than 6 months [per facility practice with new PI projects]. Attachment K: 2011 Performance Improvement.</p>	



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NAME OF PROVIDER OR SUPPLIER ST LUKE HOSPITAL EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 85 NORTH GRAND AVENUE FORT THOMAS, KY 41075		
(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 441}	Continued From page 8	{F 441}			
{F 490}	meet the needs of the skilled unit.	{F 490}			
SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that Immediate Jeopardy (IJ), identified during the standard survey (03/24/11) had been removed; however, non-compliance continued to exist related to administration regarding the infection control process. The facility had not completed staff in-servicing regarding contact isolation precautions nor had the facility's Quality Assessment and Assurance Program completed the monitoring, analysis of information in order to develop and implement the Performance Improvement Plan to ensure the deficient practice had been corrected and to prevent recurrence. The findings include: Record review of the Contact Isolation Precautions Tracking Record revealed the facility had not completed training for two (2) Direct Care Staff (CNA). Interview, on 04/11/11 at 12:45pm, with the Administrator and Associate Nurse Manager revealed that while observations of staff demonstrating proper glucometer use and	F490 The facility ensures the safety of its residents through its policies and practices related to infection control. All direct care staff was in-serviced on both cleaning/use of glucometers in and out of isolation, which included a review of isolation precautions. This was completed on 3/19/11. Attachment A: Blood Glucose Monitoring and Isolation Precaution In-service and Attachment B: SNF: In-service and Observation of Blood Glucose and Isolation Precautions Tracking Record. Additional in-servicing on Contact Isolation began on 3/18/11, 3-11pm shift and concluded on 3/22/11. All direct care staff attended in-service, except Katie Utz CNA, who was on a LOA from the unit. Attachment D-1: Timecard. The timecard shows that she came in from her LOA for the first in-service on 3/18/11 but did not return to the unit after that date. She transferred to Critical Care and began working there on 3/28/11. Linda Chandler, CNA attended the the additional Contact Isolation In-service.	4/15/11		



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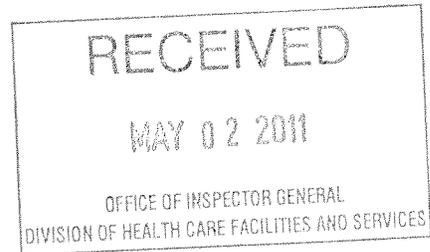
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NAME OF PROVIDER OR SUPPLIER ST LUKE HOSPITAL EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 85 NORTH GRAND AVENUE FORT THOMAS, KY 41075
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{F 490}	Continued From page 9 cleaning, and isolation precautions had been completed daily the facility had not implemented all aspects of their plan to correct the deficient practice. The facility needed to continue to monitor for eight (8) weeks the contact isolation procedures. At which time the Quality Assessment and Assurance Program will develop a Performance Improvement Plan (PIP) based on the analysis of the data from the observation logs. The PIP will be developed with specific objectives to meet the needs of the skilled unit.	{F 490}	<p>on 3/19/11. Attachment D: Contact Isolation. This in-service was conducted by the Administrator with Linda in attendance. She confirmed that she attended the in-service, however, she failed to sign the attendance sheet and it was not noted on the tracking record. Attachment D: Contact Isolation [tracking record]. This was an unintentional oversight by Administration.</p> <p>On 4/5/11 the in-service was repeated to review and re-enforce isolation precautions. Attachment D: Contact Isolation Linda Chandler attended this in-service. Attachment D-2: Sign In.</p> <p>The facility monitored compliance daily with glucometer use with isolation residents and non-isolation residents, and with contact isolation residents [with and without glucometer testing]. The daily monitoring concluded on 4/15/11. The facility is currently conducting weekly monitoring for maintenance of long term compliance. Attachment E: Observation of Blood Glucose Monitoring and Isolation Precautions. Beginning 4/1/11 data collected from these observations is recorded in PDSA format, including an analysis of the data and action plan for any deficiency noted. This process will continue for no less than 6 months [per facility practice with new PI projects]. Attachment K: 2011 Performance Improvement.</p>	
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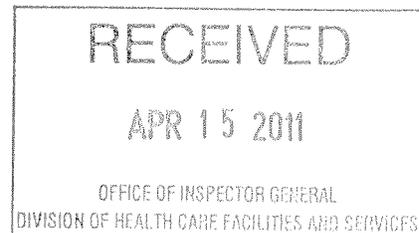


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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185328	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2011
NAME OF PROVIDER OR SUPPLIER ST LUKE HOSPITAL EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 85 NORTH GRAND AVENUE FORT THOMAS, KY 41075	

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K 025	<p>Continued From page 1</p> <p>Security revealed a hole, approximately 1 " inch in diameter, located in the smoke barrier for the Cardiac Wing.</p> <p>Interview on 03/16/2011 at 9:30 AM, with the Director of Security, revealed the fire alarm company was working in the facility two (2) days ago and the hole maybe from the fire alarm company.</p> <p>Observation on 03/16/2011 at 9:32 AM, with the Director of Plant Operations and Director of Security revealed a hole, approximately 1 " inch in diameter, located in the smoke barrier near the Therapy Gym.</p> <p>Interview on 03/16/2011 at 9:32 AM, with the Director of Security, revealed the fire alarm company was working in the facility two (2) days ago and the hole maybe from the fire alarm company.</p> <p>Reference: NFPA 101 (2000 edition) Refer to NFPA 101 (2000 Edition).</p> <p>8.2.3.2.4.2*</p> <p>Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p>	K 025	<p>implementation of the proper fire stop assembly as evident in attached documentation, specifically WO #101685 completed on 3/16/11 by Maintenance Tech, Paul Payne. Attachment K2: WO#101685</p> <p>Additionally, the semi-annual inspection and rectification of any Deficiencies for all smoke and fire Barriers on the second floor was Completed as evident in attached Documentation, specifically WO #98687 completed on 3/28/11 by Maintenance Tech, Marvin Sands. Attachment K3: WO#98687</p> <p>Fire Dampers Life safety items deemed deficient under Section 8.2.3.2.4.3a&b, specifically, unable to provide documentation of completion of smoke and fire damper testing performed in 2010. Honeywell Service Technicians Performed inspections of all smoke And fire dampers again throughout the Following dates: 3/29/11, 3/30/11, 4/4/11 4/5/11, 4/6/11 and 4/7/11. See attached copy of inspection report verifying that all dampers were inspected. Attachment K4: Honeywell Inspection, Fire/Smoke Dampers.</p>	



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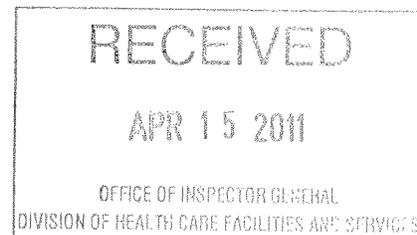
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NAME OF PROVIDER OR SUPPLIER ST LUKE HOSPITAL EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 85 NORTH GRAND AVENUE FORT THOMAS, KY 41075
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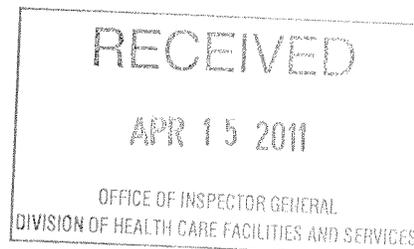
K 025	<p>Continued From page 2</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(3) *Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met:</p> <p>a. The material shall be capable of maintaining the fire resistance of the fire barrier.</p> <p>b. The material shall be protected by an approved device that is designed for the specific purpose.</p> <p>(4) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions:</p> <p>a. It shall be made on either side of the fire barrier.</p> <p>b. It shall be made by an approved device that is designed for the specific purpose.</p> <p>2. Based on record review and interview, it was determined the facility failed to ensure smoke/fire dampers were maintained according to National Fire Protection Association (NFPA). The</p>	K 025		
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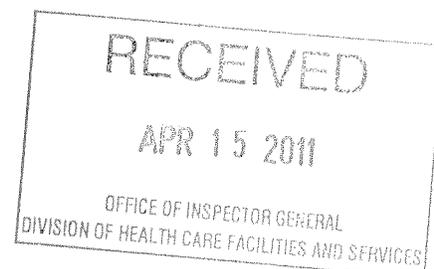
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K 025	Continued From page 3 deficiency had the potential to affect three (3) smoke compartments, twenty six (26) residents, staff and visitors. The census the day of the survey was nineteen (19) residents. The findings include: Record review of the fire/smoke dampers maintenance records on 03/16/2011 at 10:25 AM, with the Director of Security, revealed the facility had documentation for maintenance conducted on the fire/smoke dampers in 2004. Interview on 03/16/2011 at 10:25 AM, with the Director of Plant Operations, revealed the facility had maintenance performed in 2010 on the fire/smoke dampers, but the facility was unable to produce documentation for the maintenance. Reference: NFPA 90a (1999 Edition). 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. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 025			
K 062 SS=F		K 062	K062 The facility ensures the safety of its patients through its policies and practices related to the maintenance, inspection and testing of sprinkler systems	4/16/11	



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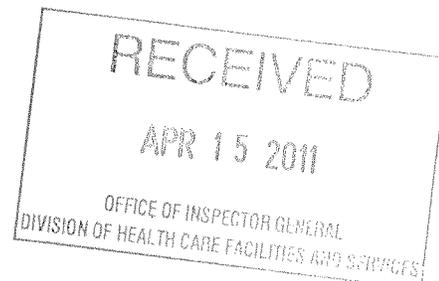
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K 062	Continued From page 4 Based on record review and interview, it was determined the facility failed to ensure valves located in the sprinkler system were maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) smoke compartments, twenty six (26) residents, staff and visitors. The census the day of the survey was nineteen (19) residents. The findings include: Record review of the sprinkler maintenance records on 03/16/2011 at 10:30 AM, with the Director of Security and the Director of Plant Operations, revealed the facility had no documentation gauges located in the sprinkler system had been inspected monthly. Interview on 03/16/2011 at 10:30 AM, with the Director of Plant Operations, revealed the facility does not inspect the gauges in the sprinkler system monthly. Reference: NFPA 25 (1998 edition) 9-3.3.1 All valves shall be inspected weekly. Exception No. 1: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Exception No. 2: After any alterations or repairs, an inspection shall be made by the owner to ensure that the system is in service and all valves are in the normal position and properly sealed, locked, or electrically supervised. 9-3.3.2* The valve inspection shall verify that the	K 062	Life safety items deemed deficient under NPFA 25 Section 9.3.3.2 (1998 edition), specifically, valves secured with locks or supervised in accordance with NFPA standards shall be permitted to inspection monthly. Monthly Preventive Maintenance Work Orders have Been generated and are being Completed monthly to inspect all Sprinkler valves in accordance with NPFA standards as evident in Attached documentation, specifically WO#102064 and WO#102067. Both completed on 3/30/11 by Carpenter, Terry Wilson and Maintenance Technician, Paul Payne. Attachment K5: WO102064; Attachment K6: WO#102067	



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K 062	Continued From page 5 valves are in the following condition: (a) In the normal open or closed position (b) *Properly sealed, locked, or supervised (c) Accessible (d) Provided with appropriate wrenches (e) Free from external leaks (f) Provided with appropriate identification	K 062			



of 1 100%

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St. Elizabeth Healthcare -

Work Order #: **101682 (ROUTINE)**

Control # **NONE** Equipment Type **NONE** Model # **NONE**

Issue Date / Time **3/16/2011 12:04 PM** Priority **HIGH** Est Hrs **0.00** Status **CLOSED**
 Status Date / Time **3/16/2011 1:19 PM**

Assigned Engineer **Terry Wilson (3W)** Department **NONE** Location **TCU**
 Specialty **Carpenter Shop** Cost Center # **NONE** Dpt Phone # **000-000-0000** Campus **FT THOMAS**
 Subcode **NONE** Requester **Elmer Norton (elmern)** Req Phone # Building **BEDTOWER**
 Room **NONE** Space

REQUEST

fire wall repair

Procedure Name **NONE** Procedure **0**

Control # **NONE** Serial # **00000000000000000000** EQ Type **NONE** Model # **NONE** Department **NONE** Location **NONE**

Initials	StartDate/Time	Time	OT	WO Code	Con #

Part #	Qty	Used On	Wo Code

4/7/2011 8:09:25 AM

Work Order: **101682**

RECEIVED
APR 15 2011
 OFFICE OF INSPECTOR GENERAL
 DIVISION OF HEALTH CARE FACILITIES AND SERVICES

Work Order #: 101682 (ROUTINE)

Control #(s): NONE

Issue Date / Time	Priority	Est Hrs	Assigned Engineer	Sp
3/16/2011 12:04 PM	HIGH	0.00	Terry Wilson (3W)	Ca
Department	Cost Center #	Dpt Phone #	Requester	Re
NONE	NONE	000-000-0000	Elmer Norton (elmern)	
Location	Campus	Building	Wing	Flc
TCU	FT THOMAS	BEDTOWER	NONE	TC
Request	fire wall repair			
Action				

Procedure Name

NONE

Control #	EQ Type	Model #	Group Name
NONE	NONE	NONE	

						Total
Labor	Start Date	End Date	Total Time	Over Time	Lump Sum	Work Co
3W	3/16/2011 12:04 PM	3/16/2011 1:19 PM	1.25	1.00	\$0.00	NONE

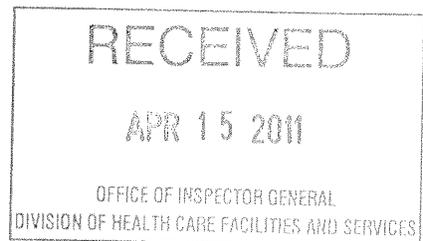
Part #	Quantity	Unit	On Date	Unit Cost	Lump Sum	Part Cost	Work Co
NONE	0.00	NONE	3/16/2011 12:04 PM	\$0.00	\$0.00	\$0.00	NONE

WO Labor Total Cost		Wo Part Total Cost		WO Total Cost	WO Total Hours
\$0.00	+	\$0.00	=	\$0.00	1.25



4/7/2011 8:04:44 AM

* - Inactive
HEMS Enterprise.



of 1 100%

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Work Order #: 101685 (RO - Repair Ord)

Control #(s): NONE

Issue Date / Time
3/16/2011 1:25 PM

Department
NONE

Location
2NDFLOOR

Request

Requester Name : Matt
Did fire stop on 2nd floor for Matt

Action

Procedure Name

NONE

Priority
STANDARD
Est Hrs
0.00
Cost Center #
NONE
Dpt Phone #
000-000-0000
Campus
FT THOMAS

Assigned Engineer
Paul Payne (3K)
Requester
Patricia Smith (patty)

Building Wing
FT THOMAS NONE

Sp
NC
Re
Flc
2N

Control #	EQ Type	Model #	Group Name
NONE	NONE	NONE	

Labor	Start Date	End Date	Total Time	Over Time	Lump Sum	Work Co	Total
3K	3/16/2011 12:00 AM	3/16/2011 1:00 AM	1.00	1.00	\$0.00	NONE	

Part #	Quantity	Unit	On Date	Unit Cost	Lump Sum	Part Cost	Work Co
NONE	0.00	NONE	3/16/2011 1:25 PM	\$0.00	\$0.00	\$0.00	NONE

WO Labor Total Cost	Wo Part Total Cost	WO Total Cost	WO Total Hours
\$0.00	\$0.00	\$0.00	1.00

* - Inactive



4/7/2011 8:07:57 AM

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Work Order #: 98687 (SCHEDULED)

St. Elizabeth Healthcare -

Control #	2 FL.FIRE WALLS	Equipment Type	ABOVE CEILING PENETRATIONS	Model #	NONE
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Issue Date / Time	Priority	Est Hrs	Status	CLOSED
1/1/2011 12:00 AM	HIGH	0.00	Status Date / Time	3/28/2011 2:30 AM

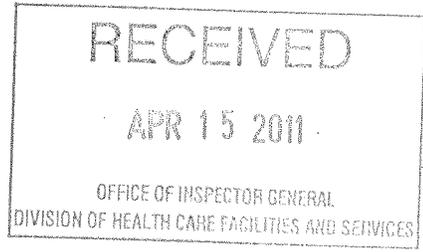
Assigned Engineer	Department	Location	2NDFLOOR
Marvin Sands (3R)	NONE	Campus	FT THOMAS
Specialty	Cost Center #	Dpt Phone #	Building
NONE	NONE	000-000-0000	FT THOMAS
Subcode	Requester	Req Phone #	Wing
NONE	NONE	0000000000	NONE
			Floor
			2NDFLOOR
			Room
			NONE
			Space

Request - This work order must be completed no later than *** 1/28/2011 *****

PROCEDURE: ABOVE CEILING PENETRATIONS 2ND FLR (464) (SEMI-ANNUALLY) (Next Date: Jul 1 2011 - SEMI-ANNUALLY)

- 1. ABOVE CEILING PENETRATIONS 2nd Flr (462)
- 1. ABOVE CEILING PENETRATIONS (4)
- CHECK ALL SMOKE BARRIER WALLS FOR PENETRATIONS
- SEAL ALL PENETRATIONS WITH HOSPITAL APPROVED SEALANT ON BOTH SIDES OF PENETRATION
- NOTE ALL OPEN PENETRATIONS

- Label Location
- 5LHL3 door by elev 1,2
 - 5LH7K north stairwell
 - 5LH7L near elev 1,2 and Family Waiting
 - 5LH83 Laundry chute
 - 5LHL4 Laundry door
 - 5LHL9 Telephone equipment door
 - 5LH7M back stairwell of L&D by OR#1
 - 5LH7N double doors to BC across from 2209
 - 5LH7G door to west stairwell across from 2205
 - 5LH7F double doors to BC hall
 - 5LHL5 door to kitchen
 - 5LHL6 door going into PFW medical records area
 - 5LHL7 electrical closet by double doors by elev 4,5
 - 5LH7H double doors going to east hallway
 - 5LH7J east stairwell
 - 5LH7B double doors on 2C by ultrasound
 - 5LH79 door to stairwell by rm 9 Hospice
 - 5LHLB door to mech rm
 - 5LH81 double doors by rm 3 Hospice Bedtower
 - 5LH77 double doors going into bedtower by elev 6,7
 - 5LH5K smoke tower outside exit door
 - 5LH80 smoke tower inside exit door
 - 5LH7Z Laundry chute
 - 5LHLC mech equipment
 - 5LHLD double door by rm 2723 2SW
 - 5LH5G double door by rm 2721 2SW
 - 5LHLF door to classroom across from rm 2721
 - 5LH5H stairwell door at end of 2SW hall
 - 5LH5D Cardiology Center double doors



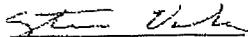
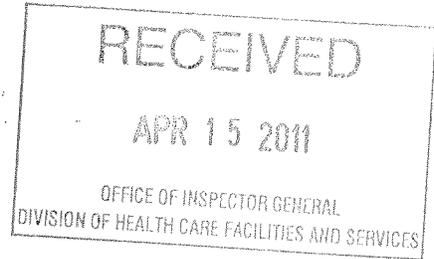
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Site Name/Address : St. Elizabeth Hospital 85 N. Grand Ave. Ft Thomas, Ky

Inspection Type : Fire / Smoke dampers

Inspection Co. : Honeywell 1280 Kemper Meadow Cincinnati, Ohio 45240

Inspection date : 3-29-11, 3-30-11, 4-4-11, 4-5-11, 4-6-11, 4-7-11
Inspected by : Steve Vehr
Email address : steve.vehr@honeywell.com

Floor	Damper	Location	Test	Type
B	0	at Smoke Tower Xfan0	Visual / operational	Gravity
B	B1	Generator Rm	Visual	Thermal Link
B	B2	Generator Rm	Visual	Thermal Link
B	B3	Generator Rm	Visual	Thermal Link
B	B4	Elevator Lobby	Visual	Thermal Link
B	B5	Electric Rm	Visual	Thermal Link
B	B6	Electric Rm	Visual	Thermal Link
A	ST-1	at Smoke Tower Xfan1	Visual / operational	Pneumatic
A	ST-2	at Smoke Tower XFan2	Visual / operational	Pneumatic
A	1	Sewing Room	note 1	Pneumatic
A	2	Sewing Room	note 1	Pneumatic
A	3	Central Supply	note 1	Pneumatic
A	4	Sewing Room bathroom	note 1	Pneumatic
A	5	Linen Room	note 1	Pneumatic
A	6	Housekeeping closet	note 1	Pneumatic
A	PT-1A	Physical Therapy exercise room	Visual	Thermal Link
A	PT-1B	Physical Therapy exercise room	Visual	Thermal Link
A	PT-2A	Physical Therapy exercise room	Visual	Thermal Link
A	PT-2B	Physical Therapy exercise room	Visual	Thermal Link
A	CTC-1	CTC Mechanical Room	Visual	Thermal Link
A	CTC-2	CTC Mechanical Room	Visual	Thermal Link
A	CTC-3	CTC Mechanical Room	Visual	Thermal Link
A	CTC-4	CTC Mechanical Room	Visual	Thermal Link
A	CTC-5	CTC Mechanical Room	Visual	Thermal Link
A	CTC-6	CTC Mechanical Room	Visual	Thermal Link
A	CTC-7	CTC Mechanical Room	Visual	Thermal Link
A	CTC-8	CTC Mechanical Room	Visual	Thermal Link
A	CTC-9	Behind Tumor Registration	Visual	Thermal Link
A	CTC-10	Behind Tumor Registration	Visual	Thermal Link
A	CTC-11	CTC Pharmacy	note 2	Thermal Link
A	ER-A1	Bsmnt ER ME Rm	note 1	Pneumatic
A	ER-A2	Bsmnt ER ME Rm	note 1	Pneumatic

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A	ER-A3	Bsmnt ER ME Rm	note 1	Pneumatic
A	ER-A4	Bsmnt ER ME Rm	note 1	Pneumatic
A	ER-A5	Bsmnt ER Electric Rm	Visual	Thermal Link
A	ER-A6	Bsmnt ER ME Rm	Visual	Thermal Link
A	ER-A7	Bsmnt Er	Visual	Thermal Link
1	1S1	ICU	Visual	Thermal Link
1	OP-1	Outpatient	Visual	Thermal Link
1	OP-2	Outpatient	Visual	Thermal Link
1	ST-3	at Smoke Tower Sup Fan 3	Visual / operational	Pneumatic
1	ST-4	at Smoke Tower Sup Fan 4	Visual / operational	Pneumatic
1	51	Outpatient hallway	note 1	Pneumatic
1	52	Outpatient hallway	note 1	Pneumatic
1	54	Nurses locker room	note 1	Pneumatic
1	55	Nurses locker room	note 1	Pneumatic
1	11	Front surgery hall by elevators	note 1	Pneumatic
1	14	Front surgery hallway	note 1	Pneumatic
1	16	Front surgery hallway	note 1	Pneumatic
1	13	Front surgery hallway	note 1	Pneumatic
1	17	Front surgery hallway	note 1	Pneumatic
1	26	Surgery electric room	note 1	Electric
1	35	Surgery recovery room	note 1	Pneumatic
1	36	Surgery recovery room	note 1	Pneumatic
1	39	Surgery recovery room	note 1	Pneumatic
1	33	Surgery outer core by recovery	note 1	Pneumatic
1	34	Surgery outer core by recovery	note 1	Pneumatic
1	25	OR 1	note 1	Pneumatic
1	20	OR 1	note 1	Pneumatic
1	32	Alcove outside OR 1	note 1	Pneumatic
1	40	Alcove outside OR 1	note 1	Pneumatic
1	24	OR 1 closet	note 1	Pneumatic
1	15	OR 1 waiting room	note 1	Pneumatic
1	23	OR 1 waiting room bathroom	note 1	Pneumatic
1	21	Surgery holding area	note 1	Pneumatic
1	59	Surgery outpatient doorway	note 1	Pneumatic
1	37	OR storage room	note 1	Pneumatic
1	38	OR storage room	note 1	Pneumatic
1	58	OR head nurses office	note 1	Pneumatic
1	57	Surgery electric room	note 1	Pneumatic
1	ER-1	ENDO rear hallway	Visual / operational	Pneumatic
1	ER-2	ENDO rear hallway	Visual / operational	Pneumatic
1	ER-3	ENDO rear hallway	Visual / operational	Pneumatic
1	ER-4	ENDO rear hallway	Visual / operational	Pneumatic
1	ER-5A	ER	note 2	Pneumatic
1	ER-5B	ER	note 2	Pneumatic
1	ER-6	ER	note 5	Pneumatic
1	ER-7	ER	note 5	Pneumatic
1	ER-8	ER	Visual / operational	Pneumatic
1	ER-9	ER	Visual / operational	Pneumatic
1	ER-10	ER	note 2	Pneumatic
2	2C-1	2nd Floor Core	Visual	Thermal Link

2	2C-2	2nd Floor Core	Visual	Thermal Link
2	2C-3	2nd Floor Core	Visual	Thermal Link
2	2C-4	2nd Floor Core	Visual	Thermal Link
2	2C-5	2nd Floor Core	Visual	Thermal Link
2	2C-6	2nd Floor Core	note 2	Thermal Link
2	2C-7	2nd Floor Core	Visual	Thermal Link
2	2C-8	2nd Floor Core	Visual	Thermal Link
2	2C-9	2nd Floor Core	note 2	Thermal Link
2	2C-10	2nd Floor Core	Visual	Thermal Link
2	2C-11	2nd Floor Core	Visual	Thermal Link
2 S	76	Cardiology center	note 1	Pneumatic
2 S	71	Cardiology center	note 1	Pneumatic
2 S	77	Cardiology center	note 1	Pneumatic
2 S	72	Cardiology soiled utility room	note 1	Pneumatic
2 S	78	Cardiology soiled utility room	note 1	Pneumatic
2 S	73	Cardiology outside CCU door	note 1	Pneumatic
2 S	79	CCU backdoor	note 1	Pneumatic
2 S	80	CCU backdoor	note 1	Pneumatic
2 SW	65	Classroom	note 1	Pneumatic
2 SW	66	Room 2701	note 1	Pneumatic
2 SW	67	Room 2701	note 1	Pneumatic
2 SW	68	Classroom	note 1	Pneumatic
2 SW	64	Room 2701 bathroom	note 1	Pneumatic
2 SW	63	Hallway by room 2721	note 1	Pneumatic
2 SW	61	Room 2721	note 1	Pneumatic
2 SW	62	Room 2721	note 1	Pneumatic
2 SP	SP-1	Surgery penthouse	Visual	Thermal Link
2 SP	SP-2	Surgery penthouse	Visual	Thermal Link
2 SP	SP-3	Surgery penthouse	Visual	Thermal Link
2 SP	SP-4	Surgery penthouse	Visual	Thermal Link
2 SP	SP-5	Surgery penthouse	Visual	Thermal Link
2 SP	SP-6	Surgery penthouse	Visual	Thermal Link
2 SP	SP-7	Surgery penthouse	Visual	Thermal Link
2 SP	SP-8	Surgery penthouse	Visual	Thermal Link
2	2 WC-1	Womens Center	Visual	Thermal Link
2	2 WC-2	Womens Center	Visual	Thermal Link
2	2 WC-3	Womens Center	Visual	Thermal Link
2	2 WC-4	Womens Center	Visual	Thermal Link
2	2A-1	Womens Center	note 3	
2	2A-2	Womens Center	note 3	
2	2A-3	Womens Center	note 3	
2	2A-4	Womens Center	note 3	
2	2A-5	Womens Center	note 3	
2	2A-6	Womens Center	note 3	
2	2A-7	Womens Center	note 3	
2	2A-8	Womens Center	note 3	
2	2A-9	Womens Center	note 3	
2	2A-10	Womens Center	note 3	
2	2A-11	Womens Center	note 3	
2	2A-12	Womens Center	note 3	
2	2A-13	Womens Center	note 3	
2	2A-14	Womens Center	note 3	
2	2A-15	Womens Center	note 3	

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4	4C-3	4th Floor Core	Visual	Thermal Link
4	4C-4	4th Floor Core	Visual	Thermal Link
4	4C-5	4th Floor Core	Visual	Thermal Link
4	4C-6	4th Floor Core	Visual	Thermal Link
4	4C-7	4th Floor Core	Visual	Thermal Link
4	4C-8	4th Floor Core	Visual	Thermal Link
4	4C-9	4th Floor Core	note 2	Thermal Link
4	4C-10	4th Floor Core	Visual	Thermal Link
4	4C-11	4th Floor Core	Visual	Thermal Link
4 S	121	4th Floor South	note 1	Pneumatic
4 S	122	4th Floor South	note 1	Pneumatic
4 S	123	4th Floor South	note 1	Pneumatic
4 S	124	4th Floor South	note 1	Pneumatic
4 S	125	4th Floor South	note 1	Pneumatic
4 S	126	Rm 4601	note 1	Pneumatic
4 S	127	Rm 4601	note 1	Pneumatic
4 S	128	Rm 4601	note 1	Pneumatic
4 SW	111	4th Floor SouthWest	note 1	Pneumatic
4 SW	112	4th Floor SouthWest	note 1	Pneumatic
4 SW	113	Classroom	note 1	Pneumatic
4 SW	114	Classroom	note 1	Pneumatic
4 SW	115	Classroom	note 1	Pneumatic
4 SW	116	Classroom	note 1	Pneumatic
4 SW	117	Classroom	note 1	Pneumatic

- 1-Smoke damper disconnected from control
- 2- no access
- 3- Smoke damper actuator deleted in recent construction.
- 4- ETL activated, damper propped open
- 5- Damper closed

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ATTACHMENT K5

Work Order #: 102064 (ROUTINE) St. Elizabeth Healthcare - Ft. Thomas
 Control # NONE Equipment Type NONE Model # NONE

Issue Date / Time	3/30/2011 1:27 PM	Priority	HIGH	Assigned Engineer	Terry Wilson (3W)	Specialty	Carpenter Shop	Status Date / Time	3/30/2011 6:42 PM	Status	CLOSED
Department	NONE	Cost Center #	NONE	Requester	Elmer Norton (elmem)	Req Phone #	NONE	Subcode	NONE		
Location	NONE	Campus	NONE	Building	NONE	Floor	NONE	Room	NONE	Space	NONE

Request
 work with alpha fire protection checking sprinkler valves.

Action

Procedure Name
 NONE Procedure #
 0

Control #	NONE	Serial #	000000000000	EQ Type	NONE	Model #	NONE	Department	NONE	Location	NONE	EQ Labor	\$0.00	EQ Parts	\$0.00	EQ Hours	5.25
-----------	------	----------	--------------	---------	------	---------	------	------------	------	----------	------	----------	--------	----------	--------	----------	------

Labor	3W	Start Date	3/30/2011 1:27 PM	End Date	3/30/2011 6:42 PM	Total Time	5.25	Over Time	1.00	Lump Sum	\$0.00	Work Code	NONE	PO	NONE	Control #	NONE
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Part #	NONE	Quantity	0.00	Unit	NONE	On Date	3/30/2011 1:27 PM	Unit Cost	\$0.00	Lump Sum	\$0.00	Work Code	NONE	PO	NONE	Control #	NONE
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WO Labor Total Cost	\$0.00	+	WO Part Total Cost	\$0.00	=	WO Total Cost	\$0.00	WO Total Hours	5.25	-	Estimate Hours	0.00	=	Difference	5.25
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ATTACHMENT K6

Work Order #: 102067 (ROUTINE) Equipment Type: NONE Model #: NONE
 Control #: NONE

St. Elizabeth Healthcare - Ft. Thomas

Issue Date / Time: 3/30/2011 2:02 PM Priority: STANDARD Est Hrs: 0.00 Assigned Engineer: Paul Payne (3K) Status Date / Time: 3/30/2011 8:02 PM Status: CLOSED
 Department: Maintenance Cost Center #: 409002 Dpt Phone #: Requester: Elmer Norton (elmer) Subcode: NONE
 Location: SLE Campus: FT THOMAS Building: NONE Wing: NONE Floor: NONE Room: NONE Space: NONE
 Req Phone #: Speciality: NONE

Request: fire inspection
 Action:

Procedure Name: NONE Procedure #: 0

Control #	Serial #	EQ Type	Model #	Department	Location	EQ Labor	EQ Parts	EQ Hours
NONE	000000000000	NONE	NONE	NONE	NONE	\$0.00	\$0.00	6.00

Labor	Start Date	End Date	Total Time	Over Time	Lump Sum	Work Code	PO	Control #
3K	3/30/2011 2:02 PM	3/30/2011 8:02 PM	6.00	1.00	\$0.00	NONE	NONE	NONE
			Total		\$0.00			

Part #	Quantity	Unit	On Date	Unit Cost	Lump Sum	Part Cost	Work Code	PO	Control #
NONE	0.00	NONE	3/30/2011 2:02 PM	\$0.00	\$0.00	\$0.00	NONE	NONE	NONE

WO Labor Total Cost	+	Wo Part Total Cost	=	WO Total Cost	WO Total Hours	Estimate Hours	=	Difference
\$0.00		\$0.00		\$0.00	6.00	0.00		6.00

