STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185136	A. BUILDING _____ B. WING _____	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY MANOR NURSING CENTER	5012 EAST MANSLICK RD LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted 01/24/12 through 01/26/12. A Life Safety Code Survey was conducted on 01/25/12. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct before remedies would be imposed.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to revise the plan of care for (1) of (16) sampled residents. The care plan for Resident #6 was not	F 280	Corrective Action to be accomplished for those residents affected by the deficient practice: RAI Coordinator met with resident to discuss concerns with resident #6 refusal to turn and staying on back all the time she is in the bed. Resident #6 did say she is more comfortable on her back but was willing to try other options to change positions. During the day the resident does get up out of the bed throughout the day independently to go to the bathroom. On 2/8/12 a handrail was attached to the resident's wall so that the resident could turn herself to the left when in bed at night. When doing a follow-up with the resident on 2/28/12, the resident agreed to turn in the bed for brief periods of time during the day to relieve the pressure from her back and coccyx. She expressed understanding and the need to do so. Resident also expressed the desire to sit in her chair to read the paper in the morning but stated she gets cold. New intervention was put into place to turn the heat up in the morning in her room-assist her with getting settled in her chair with blanket and newspaper ensuring that call light is in reach. Resident was pleased with this intervention. Will follow-up with resident in one week. How the facility will identify other residents having the potential to be affected by the same deficient practice:	03-11-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Jennifer Hozanson — TITLE: X Administrator — (X6) DATE: X 2-29-12

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

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F 280	Continued From page 1 revised to reflect changes in behaviors. The findings include: The facility did not provide a policy for revision of care plans. The facility admitted Resident #6 on 11/01/11 with diagnoses of Anxiety and Depression. The admission Minimum Data Set (MDS) was completed on 11/07/11 that revealed the resident had no cognition deficit but exhibited mood symptoms. The assessment revealed the resident required limited assist with bed mobility and transfers. The resident had no pressure sores. Review of the care plan revealed an intervention (dated 11/16/11) to turn and reposition the resident every 2 hours and as needed to prevent skin breakdown. The care plan did not have any interventions regarding behaviors such as resistant to care or refusal to reposition. Observations, on 01/24/12 at 10:50 AM, confirmed the resident would not remain positioned or allow repositioning to take place as evidenced by Resident #6 lying in bed on his/her back after staff repositioned. Additional observations revealed the resident lying on his/her back at 11:30 AM and at 2:13 PM. On 01/25/12 at 10:25 AM the resident was observed to be on his/her back at 11:07 AM and at 11:35 AM after staff repositioned him/her. Observation on 01/26/12 at 10:15 AM revealed the resident lying on his/her back in the bed. Observation during a skin assessment, on	F 280	All residents in the facility are equally affected by this practice and/or the solution. Measures put in place of systematic changes made to ensure that the practice will not recur: A new resident care plan policy has been put in place. (see attached). All nurses will be required to attend a mandatory meeting conducted by the Assistant Director of Nursing and Vice President of Nursing and Client Services to review the Plan of Correction and the new Resident Care Plan Policy on one of the following dates and times: 03/06/12 @ 1:30 pm, 03/06/12 @3:30 pm, or 03/07/12 @ 3:30 pm. Nurse unable to attend one of these meetings must make arrangements to meet with the ADON before returning to work. How the facility plans to monitor its performance to ensure that solutions are sustained: The RAI Coordinator or RAI Coordinator Assistant audits all physician orders, checks them against all care plans to ensure that all care plans accurately reflects the orders. The VP of Nursing and Client Services also provides an independent audit of all orders on a weekly basis. Discrepancies are reported to the appropriate staff for follow-up. Continued problems may result in disciplinary action. A monthly report is submitted to the QA committee for review and recommendations as needed. The QA committee will establish action steps to modify the current plan/policy as needed to ensure compliance. Person(s) responsible for ensuring on-going compliance: RAI Coordinator and VP of Nursing and Client Services.	

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F 280	Continued From page 2 01/26/12 at 9:35 AM, revealed the resident had a dark red area on the resident's coccyx area. Observation revealed Licensed Practical Nurse (LPN) #1 encouraged resident to turn and reposition however, the resident refused. Interview with LPN #1, on 01/26/12 at 9:50 AM, revealed the resident did not want to turn or reposition and liked to lie on his/her back. She stated the resident's buttocks are dark red. She indicated she knew about the resident's dark red area since last week however, she failed to report this so it could be placed on the care plan. The nurse denied responsibility for revisions to the care plan and stated it was the supervisors responsibility. Interview with the MDS Coordinator, on 01/26/12 at 11:00 AM, revealed the nurse who received a physician order was to update the resident's care plan. She stated she revised the care plans as needed based upon the 24 Hour Report Sheet. If a nurse failed to document condition changes on the 24 hour report sheet, and there are no additional physician orders, then care plan changes would not be required. She revealed no staff had informed her of the resident's change in skin or refusal to turn and reposition. Interview, on 01/26/12 at 11:45 AM, with the Shift Supervisor (LPN #4) revealed each nurse was responsible for updating the care plan. The nurse who received a physician's order should also update the care plan. [Even though training was held 10/24-28/11 stating the supervisors were responsible for revision of the care plans and LPN #4 had attended.]	F 280		

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F 280	Continued From page 3 Interview, on 01/26/12 at 11:50 AM, with the Assistant Director of Nursing (ADON) revealed whenever there was a change in condition with any resident, such as skin changes, the supervisor should complete an incident report and add new interventions to the care plan. She revealed an inservice regarding updating the care plan was completed however, the inservice was for the shift supervisors only and not the floor nurses. Interview with the Treatment Nurse (LPN #3), on 01/26/12 at 12:55 PM, revealed Resident #6 was noncompliant with turning, repositioning and liked to lie on her/his back. The treatment nurse was unaware the resident had a red area on the coccyx. She stated whenever there was a change in any resident's skin the nurse completed a Resident Decline Notification form and forwarded this form to her. Review of the care plan training records revealed the "Mandatory Meeting, Care Plan Training" for all nursing supervisors was held on 10/24/11, 10/25/11, and 10/28/11. The training handouts revealed care plans must be updated at the time the change occurs by the supervisors immediately, as within 5 minutes of changing the resident's care. Also, the training handout stated if a resident had a new unwanted behavior, make a new behavior care plan. However, this could not be provided by the facility for Resident #6.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	Corrective action to be accomplished for the resident(s) affected by this deficient practice: Resident #1's order was clarified on 1/24/12 that resident may be in wheelchair with towel roll between thighs and abduction	03-11-12

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F 281	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide care and services to meet professional standards of care for one (1) of sixteen (16) sampled residents. The facility admitted Resident #1 with a pressure sore and status post a hip fracture as a result from a fall. The facility failed to develop an initial care plan for those conditions. In addition, the resident's physician ordered for the resident not to cross legs with a spacer (wedge cushion) to be placed between the resident's legs. Observation revealed the wedge cushion was not always placed between the legs as ordered. The findings include: The facility utilized the RAI (Resident Assessment Instrument) process regarding development of care plans. Review of the clinical record revealed the facility admitted Resident #1 on 01/20/12 with diagnoses of a Hip Fracture, Pneumonia, Falls, Dementia, Depression, Peripheral Vascular Disease, and Diabetes. Review of the nurses' notes, dated 01/20/12 at 11:00 PM, revealed an admission skin assessment was completed by the nurse that revealed the resident had an open area to the right buttock and the record revealed the resident sustained the hip fracture from a fall. Review of the initial care plan completed on 01/20/12 revealed a risk for skin breakdown and fracture was address; however, a care plan was	F 281	Pillow only when in bed, per PT recommendations. Care Plan and CNA assignment sheets were updated to reflect these changes. Resident #1's Care Plan has been reviewed and updated that all resident concerns are being addressed. How the facility will identify other residents who have the potential to be affected by this practice: Any residents who are post-hip fracture may be affected by this deficient practice and currently we have no other residents who meet that criteria. Any resident with new onset skin breakdown have the potential for being affected by this practice. Measures put in place or systematic changes made to ensure that the practice will not recur: New policies have been implemented regarding Risk Assessment (skin breakdown), Mechanical Off-loading, Wound Assessment, Skin Care, and resident care planning. Mandatory inservicing will be held for all C.N.A.'s and nurses on February 27 and 29, March 1 and 5. Additional inservicing regarding skin care for nurses will be held on March 6 and 7. This inservicing will also be mandatory. The Medical Director has reviewed and approved all new policies. All inserving will be presented by the Staff Development Coordinator, VP of Nursing and Client Services, and/or the Assistant Director of Nursing. How the facility plans to monitor its performance to ensure that solutions are sustained: The 24-hour report is reviewed daily by the RAI Coordinator, RAI Coordinator Assistant, and/or the Assistant Director of Nursing, for accuracy and compliance with physician orders. Skin assessment forms are	

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F 281	Continued From page 5 not developed with interventions for the pressure sore on the resident's right buttock until four days after admission. In addition, the resident's risk for falls were not addressed. Interview with LPN #2, on 01/26/12 at 9:45 AM, revealed there was no care plan developed to address the pressure sore on the right buttock until she completed one on 01/24/12. She said the staff nurse who admitted the resident on 01/20/12 failed to develop care plans for the pressure ulcer and falls. Review of the admission orders for Resident #1, dated 01/20/12, revealed orders not to cross legs. The facility utilized a wedge cushion between the resident's legs to prevent the crossing of the legs. Review of the CNA (certified nursing assistant) care plan revealed instructions to place the wedge cushion between legs when in bed. "No crossing of legs." Observation of Resident #1, on 01/26/12 at 10:00 AM, revealed the wedge cushion was sitting in a chair beside the resident's bed. The resident had his/her legs drawn up to the stomach, one on top of the other. At 11:15 AM, observation revealed the resident remained in bed without the wedge cushion applied. The resident's legs were curled up into a fetal-like position. Interview with CNA #4, on 01/26/12 at 12:45 PM, revealed she was responsible for Resident #1's care that day. When asked why the wedge cushion was not applied, she stated LPN #2 had told her the wedge cushion was no longer placed between the legs. However, interview with LPN #2, on 01/26/12 at 1:00 PM, revealed the physical	F 281	reviewed weekly by the Assistant Director of Nursing to ensure compliance and that treatment is in place, and results will be reported monthly to the QA Committee. The QA committee will assess results and make recommendations for changes to the policy and procedure where appropriate. Person(s) responsible for ensuring on-going compliance: Assistant Director of Nursing and RAI Coordinator.	

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F 281	Continued From page 6 therapist (PT) had placed the resident in a wheelchair instead of the Geri chair when out of bed. The nurse told the PT it would be hard to have the wedge cushion between the legs while sitting in a wheelchair. The PT said to use the wedge cushion in bed only. LPN #2 said she told the CNA that the wedge cushion did not have to be applied when the resident was up in the wheelchair but still needed to be used when in bed. She indicated she would inform the CNA of the correct instructions. Observation at 1:30 PM, revealed the resident had been placed back into bed without the wedge cushion between the resident 's legs. The wedge cushion was sitting in the chair.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to implement care plan interventions for one (1) of sixteen (16) sampled residents, Resident #5. Resident #5 had care plan interventions to have a walker within reach and had a history of falls. The findings include: The facility could not provide a policy for implementation of the care plan	F 282	Corrective action to be accomplished for the resident(s) affected by this deficient practice: Resident #5's care plan and C.N.A. assignment sheet were both corrected to reflect resident's current mobility status, which is wheelchair only for all transportation. How the facility will identify other residents who have the potential to be affected by this practice: All residents care plans and C.N.A. assignment sheets will be audited to ensure that all care plan interventions are implemented. Measures put in place or systematic changes made to ensure that the practice will not recur: A new resident care plan policy has been developed. (see attached) The C.N.A. assignment sheet policy has also been reviewed and revised, addressing the way that staff receive new information.	03-11-12

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F 282	Continued From page 7 Observations made of Resident #5 on 01/24/12 at 11:06 AM, 11:36 AM, 1:33 PM, 2:14 PM, 2:49 PM and 3:24 PM, revealed no walker was present at Resident #5's side. Record Review for Resident #5 revealed the facility admitted the resident on 04/18/11 with diagnoses of Alzheimer's, Dementia and Psychosis. Record review of the Minimum Data Set (MDS) Admission Assessment dated 05/01/11 and the Quarterly Assessment dated 12/27/11 revealed Resident #5 triggered for falls, with no injuries. Cognition of a zero (0) on his/her BIMS score. Review of a fall that occurred on 01/22/12, revealed Resident #5 in the dining room, got up from the chair and started to walk toward the nurses station and fell. Review of the Falls care plan, indicated the staff were to keep the resident's walker in reach. The facility assessed Resident #5 as a falls risk secondary to history of falls, high risk medication, unsteady gait, use of walker, poor safety awareness, impaired memory, some incontinence and needs assistance with ADL's. Review of the Certified Nursing Assistant (CNA) sheet, revealed keeping the walker within reach was not identified. Interview with CNA #3, on 01/26/12 at 10:20 AM, revealed she was not aware Resident #5 was to have a walker within his/her reach. CNA #3 stated when their was a change to the CNA sheet, no one informs them, they were expected to read the CNA sheet. CNA #3 further stated Resident #5 had a history of wandering the unit. Interview with CNA #4, on 01/26/12 at 10:37 AM, revealed when CNA #4 took a look at the CNA sheet, she could not find were it was documented	F 282	Mandatory inservicing will be held for all C.N.A.'s and nurses on February 27 and 29, March 1 and 5. Additional inservicing regarding skin care for nurses will be held on March 6 and 7. This inservicing will also be mandatory. The Medical Director has reviewed and approved all new policies. All inserving will be presented by the Staff Development Coordinator, VP of Nursing and Client Services, and/or the Assistant Director of Nursing. How the facility plans to monitor its performance to ensure that solutions are sustained: Audits of residents and their care will be performed weekly to ensure 100% compliance between care and assignment sheets. This audit will be performed by the Assistant Director of Nursing. The QA committee will track and trend levels of compliance and make recommendations for changes when warranted. Person(s) responsible for ensuring on-going compliance: VP of Nursing and Client Services, and Assistant Director of Nursing.	

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F 282	Continued From page 8 for Resident #5 to have his/her walker within reach. CNA #4 stated Resident #5 was a fall risk and if the care plan was updated and the CNA sheet was not, then the CNA's would not know what type of care to provide to the residents. Interview with Licensed Practical Nurse (LPN) #6, on 01/26/12 at 10:46 AM, revealed when LPN #6 observed the CNA sheet. She could not locate information that Resident #5 needed his/her walker within reach. LPN #6 stated she was not aware Resident #5 was care planned to have his/her walker within reach. LPN #6 further stated she believed it was the charge nurses responsibility to update the CNA sheet and it was ultimately her responsibility to make sure the CNA sheet was being followed. Interview with the Registered Nurse (RN) #1 (Charge Nurse), on 01/26/12 at 12:35 PM, revealed CNA's were to keep their CNA sheet at all times. The CNA's would not know to keep Resident #5's walker within reach If it was not documented on the CNA sheet. We require CNA's to read their CNA sheet everyday. Mentors or Senior Aids were to make changes and updates and then bring to the charge nurse to revise. RN #1 stated who ever takes the order off, they were to place it on the CNA sheet. RN #1 further stated it was ultimately hers and the Director of Nursing's responsibility to update the CNA sheet, not the Minimum Data Set (MDS) Coordinator.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309	Corrective action to be accomplished for the resident(s) affected by this deficient practice: For resident #5, clip alarm order has been changed to seat alarm when in wheelchair	03-11-12

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F 309	Continued From page 9 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to follow Physician orders for two (2) of sixteen (16) sampled residents, Resident #5 and #7. Resident #5 did not have a clip alarm attached as ordered and Resident #7 did not have glasses on as ordered. The findings include: No Policy was provided by the facility regarding following physician's orders. 1. Observations made of Resident #5 on 01/25/12 at 9:25 AM, 10:15 AM, 5:10 PM and 01/26/12 at 9:43 AM revealed no chair alarm attached to the chair, while the resident was sitting in his/her chair. Review of the clinical record for Resident #5 revealed an admission date of 04/18/11 with diagnoses of Alzheimer's, Dementia and Psychosis. Review of the Minimum Data Set (MDS) Admission Assessment, dated 05/01/11, and the Quarterly Assessment, dated 12/27/11, revealed Resident #5 triggered for falls, with no injuries. The facility assessed the resident as cognition of a zero (0) on his/her BIMS score. Review of a fall that occurred on 01/22/12,	F 309	and bed alarm when in bed. Both C.N.A. assignment sheet and care plan have been updated. For resident #7, glasses have been located and order continues as written on care plan. Additional information has been added to nurse team leaders' sheet to ensure compliance. How the facility will identify other residents who have the potential to be affected by this practice: All residents have the potential of being affected by not having a policy for following physician's orders. Measures put in place or systematic changes made to ensure that the practice will not recur: New policy regarding MD orders has been developed and implemented. C.N.A. assignment policy has been reviewed and revised. Mandatory inservicing will be held for all C.N.A.'s and nurses on February 27 and 29, March 1 and 5. Additional inservicing regarding skin care for nurses will be held on March 6 and 7. This inservicing will also be mandatory. The Medical Director has reviewed and approved all new policies. All inserving will be presented by the Staff Development Coordinator, VP of Nursing and Client Services, and/or the Assistant Director of Nursing. How the facility plans to monitor its performance to ensure that solutions are sustained: Audits of residents and their care will be performed weekly to ensure 100% compliance between care and assignment sheets. Routine weekly audits of resident care and assignment sheets will be performed to assess levels of compliance and reported to the Quality Assurance Committee. The QA	

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	185136	A. BUILDING _____ B. WING _____	01/26/2012

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F 309	Continued From page 10 revealed Resident #5 was in the dining room, got up from the chair and started to walk toward the nurses station and sustained a fall. Review of the Physician's Orders dated 01/22/12, revealed an order for a "clip alarm when in bed and at all times". Interview with Registered Nurse (RN) #1 (Charge Nurse), on 01/26/12 at 12:35 PM, revealed Resident #5 should have his/her clip alarm on at all times. RN #1 further stated this intervention was in place to prevent falls. Interview with Certified Nursing Assistant (CNA) #3, on 01/26/12 at 10:20 AM, revealed Resident #5 should have his/her clip alarm on at all times because he/she liked to take off and wonder a lot. Interview with CNA #4, on 01/26/12 at 10:37 AM, revealed she had gotten Resident #5 up on 01/25/12 and 01/26/12. CNA #4 realized she should have put a clip alarm on Resident #5. CNA #4 further stated when there was a change in the CNA sheet, she guessed the facility wanted them to read it to find what those changes were. 2. Observations made of Resident #7, on 01/24/12 at 11:02 AM, 11:37 AM, 2:00 PM, 2:10 PM, 2:48 PM, 3:25 PM and 4:51 PM revealed there were no glasses on his/her face. Record review of Resident #7's clinical record revealed the facility admitted the resident on 03/10/11 with diagnoses of Alzheimer's, and Dementia. Review of the MDS Admission assessment, dated 03/23/11, revealed a BIMS score of ninety-nine (99) (which meant cognitively impaired), falls did not trigger. Review of the MDS	F 309	committee will track and trend levels of compliance and make recommendations for changes when warranted. assignment sheets to ensure 100% accuracy. This audit will be done as a collaborative effort among the VP of Nursing and Client Services, the Assistant Director of Nursing, and the RAI Coordinator. The QA committee will track and trend policy compliance and make recommendations for changes when warranted. Person(s) responsible for ensuring on-going compliance: VP of Nursing and Client Services and Assistant Director of Nursing.	

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F 309	Continued From page 11 Quarterly assessment, dated 11/07/11, revealed a BIMS score of 3 (which meant cognitively impaired) and falls were triggered with no injuries. Review of Resident #7's Physician Orders, dated 12/28/11, revealed "Eye glasses to be placed in med cart, put on in the AM (morning) and take off at HS (night)". Interview with CNA #4, on 01/26/12 at 10:37 AM, revealed Resident #7 could not see well without his/her glasses. Interview with Licensed Practical Nurse (LPN) #6, on 01/26/12 at 10:46 AM, revealed Resident #7 glasses could not be found on Tuesday 01/24/12. Resident #7's glasses were suppose to be kept on the medication cart at night. If the glasses were not kept in the medication cart or in his/her room then the staff have to look for them. LPN #6 further stated Resident #7 had not fallen in a while and that she was ultimately responsible to make sure the staff were doing what they were suppose to be doing for the residents. Interview with RN #1, Charge Nurse, on 01/26/12 at 12:35 PM, revealed the nurse on the unit was responsible to make sure Resident #7's eye glasses were on. RN #1 further stated it was ultimately her and the Director of Nursing's responsibility to make sure Resident #7's glasses were on.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314	Corrective action to be accomplished for the resident(s) affected by this deficient practice: Resident #1's Care Plan has been reviewed and updated so that all resident skin care concerns are being addressed. The use of space boots, turning schedules when in	03-11-12

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F 314	Continued From page 12 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to prevent new pressure sore development and provide treatment and services to promote healing for one (1) of sixteen (16) sampled residents. The facility admitted Resident #1 to the facility with a pressure sore on the coccyx and was identified by the facility at high risk for development of additional pressure sores. The facility identified the resident developed a pressure sore on the resident's left heel; however, the facility failed to obtain treatment for the wound. In addition, the facility failed to implement interventions to promote healing (turning and repositioning) with the resident was observed lying in a Geri chair for extended periods of time. The findings include: Review of the facility's wound care guidelines (adapted from the Agency for Health Care Policy and Research Guidelines for Pressure Ulcer Treatment, no date provided) revealed...avoid uninterrupted sitting in a chair. The individual should be repositioned, shifting pressure at least every hour or be put back to bed if possible. Protocol for early intervention and prevention of skin breakdown...obtain appropriate support	F 314	Bed, daily skin inspections, a Medi-assist boot on left foot, wound care center consult, proper hydration, Foley catheter, are all interventions currently being used to maximize skin integrity. How the facility will identify other residents who have the potential to be affected by this practice: Observations of residents' skin condition during bi-weekly bathing are conducted by the C.N.A.s. Skin sheets are utilized to record and report changes in skin integrity. Nurse team leaders assess any changes reported to them by the C.N.A.s. One additional resident has been identified as being affected by this deficient practice, and interventions including turn q 2 hours when in bed, up for meals 1-1/2 hours only, gel cushion in gerichair, multivitamin added. Care plan and C.N.A. assignment sheet have been updated to reflect changes. Measures put in place or systematic changes made to ensure that the practice will not recur: New policies have been implemented regarding Risk Assessment (skin breakdown), Mechanical Off-loading, Wound Assessment, Skin Care, and resident care planning. Mandatory inservicing will be held for all C.N.A.'s and nurses on February 27 and 29, March 1 and 5. Additional inservicing regarding skin care for nurses will be held on March 6 and 7. This inservicing will also be mandatory. The Medical Director has reviewed and approved all new policies. All inserving will be presented by the Staff Development Coordinator, VP of Nursing and Client Services, and/or the Assistant Director of Nursing.	

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F 314	Continued From page 13 surfaces, initiate appropriate turning schedule, initiate measures to reduce friction and shearing, control incontinence, and inspect skin daily. Review of the clinical record revealed the facility admitted Resident #1 on 01/20/12 with diagnoses of Status Post Hip Fracture, Pneumonia, Falls, Dementia, Depression, Peripheral Vascular Disease, and Diabetes. Review of nurses' notes, dated 01/20/12 at 11:00 PM, revealed an admission skin assessment was completed and revealed the resident had an open area to the right buttock. The skin assessment further revealed the resident did not have any redness, discoloration, or open areas to the heels. The resident had incision with staples to the left hip. Review of the initial needs care plan, dated 01/20/12, revealed the facility identified the resident at risk for skin breakdown with interventions of turning and repositioning every two (2) hours to prevent sheer, friction, and pressure. However, the open area to the right buttock (present upon admission) was not care planned until 01/24/12, 4 days after admission. A comprehensive assessment had not been conducted. The facility assessed the resident to be incontinent of bowel and bladder with a cognition impairment. Review of an incident report and nurses' notes dated 01/23/12 at 3:00 AM, revealed the resident had a new dark purple area to the left heel. The incident report stated the treatment nurse was notified. On 01/26/12 at 9:15 AM, interview with LPN #1, (who had documented the new area to the	F 314	How the facility plans to monitor its performance to ensure that solutions are sustained: The 24-hour report is reviewed daily by the RAI Coordinator, RAI Coordinator Assistant, and/or the Assistant Director of Nursing, for accuracy and compliance with physician orders. Skin assessment forms are reviewed weekly by the Assistant Director of Nursing to ensure compliance and that treatment is in place, and results will be reported monthly to the QA Committee. The QA committee will assess results and make recommendations for changes to the policy and procedure where appropriate. Person(s) responsible for ensuring on-going compliance: Assistant Director of Nursing, the VP of Nursing and Client Services, and RAI Coordinator.	

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F 314	Continued From page 14 resident's left heel in the record on 01/23/12) revealed she had worked the 11 PM-7 AM shift on 01/23/12. She stated Resident #1 complained of pain of the heels. When she assessed the heels, she observed a discoloration area (purple in color) on the resident's left heel. She state she completed a "Resident Decline Notification" form and placed the form in the facility mail tray for the treatment nurse. She also informed the charge nurse. Interview with the charge nurse (RN#1) on 02/26/12 at 9:30 AM, revealed LPN#1 did report the left heel wound and she had verbally reported the change in skin to the treatment nurse on Monday, 01/23/12. Observation of Resident #1, on 01/24/12 at 11:10 AM, revealed the resident lying in bed awake. An abduction pillow was noted between the resident's legs and the resident complained of pain. At 1:10 PM, the resident was observed to be sitting up in a Geri chair eating lunch. Bilateral heel protectors were applied. At 2:30 PM, observation revealed the resident up in a Geri chair in the sitting area on the unit. Observation at 3:30 PM, 4:30 PM, and 4:50 PM revealed the resident remained in the Geri chair, reclined and sleeping. On 01/25/12 at 11:00 AM, observation of a skin assessment and wound treatment revealed the open area to the right buttock remained but a new red triangle shaped area was noted to the left buttock. The nurse's measurements were 5.9 x 4.0 cm (centimeters). In addition, the left heel had an unstageable deep purple area measuring 1.8 x 2.2 cm. The nurse was the facility's treatment	F 314		

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F 314	Continued From page 15 nurse and when asked if she had assessed the area to the left heel, she replied, "Yes". She stated she had attempted to evaluate the resident's wound on 01/23/11, but could not because the staff had not returned the resident back to bed prior to her leaving at 3:30 PM. She indicated she had conducted a skin assessment of the entire body on 01/24/12. She stated she did not see anything on the heels. However, she could not provide any evidence in the record to validate this. Continued review of the clinical record revealed the treatment nurse had documented in the nurses' notes a late entry, for 01/24/12 at 8:00 AM, that revealed a description and measurement of the right buttocks wound. Nothing was documented regarding the left heel. The nurse documented on 01/25/12 about the left heel pressure ulcer. The treatment nurse (LPN #2) was re-interviewed, on 01/26/12 at 9:45 AM,. She stated she had not had a chance to review information placed in her mail tray that week. She acknowledged RN #1 had informed her about the wound to the resident's left heel. She stated again she could not assess the wound on Monday, 01/23/12 because the resident was not laid down and was up in the Geri chair recliner until she left at 3:30 PM. Although the facility had identified the resident at high risk for additional pressure sores, the facility did not obtain treatment (mediboot) for the wound to the resident's left heel until after the skin assessment conducted with the surveyor on 01/25/11, 2 days after the pressure sore was	F 314		

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F 314	Continued From page 16 discovered.	F 314	1. Storage of hazardous materials. Corrective action to be accomplished for the resident(s) affected by this deficient practice: Plastic, locked containers have been purchased to store personal care products for all residents on the Peters Wing. (secured unit). A new hazardous material policy has been written which addresses MSDS as well. (see attached). How the facility will identify other residents who have the potential to be affected by this practice: All residents have the potential to be affected by this deficient practice. Measures put in place or systematic changes made to ensure that the practice will not recur: The use of the new storage containers will keep residents safe from consuming hazardous materials. How the facility plans to monitor its performance to ensure that solutions are sustained: Mandatory inservicing will be held for all C.N.A.'s and nurses on February 27 and 29, March 1 and 5. All inservicing will be presented by the Staff Development Coordinator, VP of Nursing and Client Services, and/or the Assistant Director of Nursing. Visual, weekly inspections will be conducted by the Assistant Director of Nursing. A report of this inspection will be made by the Assistant DON to the QA Committee for tracking and trending. Negative trends will be addressed by the QA committee and appropriate systematic changes will be recommended. Person(s) responsible for ensuring on-going compliance: Assistant Director of Nursing.	03-11-12
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide assistive devices to prevent accidents for two (2) of sixteen (16) sampled residents. In addition, the facility failed to provide an environment free from accident hazards for the secure unit (west) where residents have moderate to severe cognition impairment. Multiple hazard items (peri-wash, Listerine, denture tablets) were stored in unlocked cabinets and sitting on top of sinks and toilet tanks, accessible to the cognitively impaired residents. Many of these residents were ambulatory and capable of accessing these hazardous items. The findings include: 1. During the initial tour of the West Wing (secure Alzheimer's unit) on 01/24/12 from 8:45 AM to 9:15 AM, revealed multiple hazardous items accessible to the cognitively impaired residents. Room #4 had a bottle of Peri Fresh cleanser	F 323		

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F 323	Continued From page 17 sitting on top of the toilet tank in the residents' bathroom. Review of the warning label revealed, "May cause eye irritation ." "Avoid contact with eyes." "Keep out of the reach of children." Room #10 contained a bottle of Peri Fresh, tube of Peri Guard with additional instructions, "If accidentally ingested, contact the poison control center right away." In addition, there was a box of denture tablets with instruction to not put in mouth. Room #7 had a box of denture tablets, tube of Peri Guard, 1 liter bottle of Listerine, can of shaving cream, and bottle of Peri Fresh cleanser in an unlocked medicine cabinet. Room #5 had one bottle of Peri Fresh sitting on top of the toilet tank and two bottles and a box of denture tablets in an unlocked cabinet. Room #2 had a bottle of Peri Fresh and a Listerine bottle sitting on the back of the toilet. Interview with LPN #6, on 01/26/12 at 12:40 PM, revealed the Peri Fresh and other items are supposed to be stored in the medicine cabinet located in the residents' bathroom. She acknowledged the cabinets are not locked and residents could open them. She said during the daytime, most residents are in the unit's dining room/activity room but at night the resident are sleeping in their rooms. Most residents on the secure unit are ambulatory and wander about the unit. Interview with the Director of Nursing, on 01/26/12 at 2:15 PM, revealed there had been no incident where a resident had ingested a personal hygiene product or chemical. She stated all residents on the secure unit are cognitively impaired and wander about the unit.	F 323	2. Assistive Devices Within Reach. Corrective action to be accomplished for the resident(s) affected by this deficient practice: For resident #5, clip alarm order has been changed to seat alarm when in wheelchair and bed alarm when in bed, and walker has been discontinued. Resident is unable to walk without assistance. Both C.N.A. assignment sheet and care plan have been updated. How the facility will identify other residents who have the potential to be affected by this practice: Upon investigation, it was determined that the cause of the problem was that the care plan and assignment sheet had not been updated according to the resident's needs. An audit being performed by the Assistant RAI Coordinator will identify any other instances where the assignment sheets are not accurate.with the care plan and the care provided. Measures put in place or systematic changes made to ensure that the practice will not recur: The Resident Care Planning Policy has been developed and the C.N.A. Assignment Sheet Policy has been reviewed and revised. Mandatory inservicing will be held for all C.N.A.'s and nurses on February 27 and 29, March 1 and 5. The Medical Director has reviewed and approved all new policies. All inservicing will be presented by the Staff Development Coordinator, VP of Nursing and Client Services, and/or the Assistant Director of Nursing. How the facility plans to monitor its performance to ensure that solutions are sustained: Audits of residents and their care will be performed weekly to ensure 100% compliance between care and assignment	

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F 323	Continued From page 18 Review of the census revealed there were eighteen (18) residents on the secure unit during the survey. All eighteen resident were identified to be ambulatory with a cognition deficit. 2. Observations made of Resident #5 on the secured unit on 01/25/12 at 9:25 AM, 10:15 AM, 5:10 PM and 01/26/12 at 9:43 AM revealed no chair alarm attached to the chair, while sitting in his/her chair. Observations of Resident #5 on 01/24/12 at 11:06 AM, 11:36 AM, 1:33 PM, 2:14 PM, 2:49 PM and 3:24 PM, revealed no walker was present at Resident #5's side. Review of Resident #5 clinical record revealed the facility admitted the resident on 04/18/11 with diagnoses of Alzheimer's, Dementia and Psychosis. Review of the Minimum Data Set (MDS) Admission Assessment, dated 05/01/11, and the Quarterly Assessment, dated 12/27/11, revealed Resident #5 triggered for falls and no injuries. The facility assessed the resident with a cognition of a zero (0) on his/her BIMS score. Review of a fall that occurred on 01/22/12, revealed Resident #5 was in the dining room, got up from the chair and started to walk toward the nurses station and fell. Review of the Physician's Orders, dated 01/22/12, revealed an order for a "clip alarm when in bed and at all times". Review of the Falls care plan, revealed the staff were to keep the walker in reach of the resident. Review of the Certified Nursing Assistant (CNA) sheet, revealed the walker being kept within reach was not identified. Interview with CNA #3, on 01/26/12 at 10:20 AM, revealed Resident #5 should of had a clip alarm on at all times and she was not aware Resident	F 323	sheets. Routine weekly audits of resident care and assignment sheets will be performed to assess levels of compliance and reported to the Quality Assurance Committee. The QA committee will track and trend levels of compliance and make recommendations for changes when warranted. Person(s) responsible for ensuring on-going compliance: Assistant Director of Nursing and the VP of Nursing and Client Services.	

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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 323	Continued From page 19 #5 was to have a walker within his/her reach. CNA #3 stated when their was a change to the CNA sheet, no one informed them, they were expected to read the CNA sheet. CNA #3 further stated Resident #5 had a history of wandering the unit. Interview with CNA #4, on 01/26/12 at 10:37 AM, revealed she was not aware Resident #5 was to wear a clip alarm. When CNA #4 reviewed the CNA sheet, she could not find were it was documented for Resident #5 to have his/her walker within reach. CNA #4 stated Resident #5 was a fall risk and if the care plan was updated and the CNA sheet was not, then the CNA's would not know what type of care to provide to the Residents. Interview with the Registered Nurse (RN) #1 (Charge Nurse), on 01/26/12 at 12:35 PM, revealed Resident #5 should have on his/her clip alarm at all times. She stated the aids would not know to keep Resident #5's walker within reach if it was not documented on the CNA sheet. RN #1 further stated this intervention was in place to prevent falls. 3. Observations of Resident #7, on 01/24/12 at 11:02 AM, 11:37 AM, 2:00 PM, 2:10 PM, 2:48 PM, 3:25 PM and 4:51 PM revealed no glasses on his/her face. Review of Resident #7's clinical record revealed the facility admitted the resident on 03/10/11 with diagnoses of Alzheimer's, and Dementia. Review of the MDS Admission assessment, dated 03/23/11, revealed a BIMS score of ninety-nine (99) (which meant cognitively impaired), falls was	F 323	3. Eyeglasses, etc. Corrective action to be accomplished for the resident(s) affected by this deficient practice: For resident #7, glasses have been located and order continues as written on care plan. Additional information has been added to nurse team leaders' sheet to ensure compliance. How the facility will identify other residents who have the potential to be affected by this practice: Residents will be randomly audited by the nurse team leader on a weekly basis to ensure that C.N.A. assignment sheets match the care provided. Measures put in place or systematic changes made to ensure that the practice will not recur: The Resident Care Planning Policy has been developed and the C.N.A. Assignment Sheet Policy has been reviewed and revised. Mandatory inservicing will be held for all C.N.A.'s and nurses on February 27 and 29, March 1 and 5. The Medical Director has reviewed and approved all new policies. All inservicing will be presented by the Staff Development Coordinator, VP of Nursing and Client Services, and/or the Assistant Director of Nursing. How the facility plans to monitor its performance to ensure that solutions are sustained: Audits of residents and their care will be performed weekly to ensure 100% compliance between care and assignment Sheets, to be completed by the nurse team leader. Routine weekly audits of resident care and assignment sheets will be performed to assess levels of compliance and reported to the Quality Assurance Committee. The QA	

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185136	A. BUILDING _____ B. WING _____	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY MANOR NURSING CENTER	5012 EAST MANSLICK RD LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 20 not triggered. Review of Resident #7's MDS Quarterly assessment, dated 11/07/11, revealed a BIMS score of 3 (which meant cognitively impaired) and falls was triggered with no injuries. Review of Resident #7's Physician Orders, dated 12/28/11, revealed "Eye glasses were to be placed in the med cart, put on in the AM (morning) and take off at HS (night)". Interview with CNA #4, on 01/26/12 at 10:37 AM, revealed Resident #7 could not see well without his/her glasses. Interview with Licensed Practical Nurse (LPN) #6, revealed Resident #7 glasses could not be found on Tuesday 01/24/12. Resident #7's glasses were suppose to be kept on the medication cart at night. If the glasses were not kept in the medication cart or in his/her room then the staff have to look for them. LPN #6 further stated Resident #7 had not fallen in a while and that she was ultimately responsible to make sure the staff were doing what they were suppose to be doing for the residents. Interview with the RN #1, Charge Nurse, on 01/26/12 at 12:35 PM, revealed the nurse on the unit was responsible to make sure Resident #7's eye glasses were on. RN #1 further stated it was ultimately her and the Director of Nursing's responsibility to make sure Resident #7's glasses were on.	F 323	committee will track and trend levels of compliance and make recommendations for changes when warranted. Person(s) responsible for ensuring on-going compliance: VP of Nursing and Client Services and the Assistant Director of Nursing.	
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	F 371		

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	185136	A. BUILDING _____ B. WING _____	01/26/2012

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F 371	Continued From page 21 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review it was determined the facility failed to store, distribute, prepare and serve food under sanitary conditions, as evidence by the cook touching multiple items during the tray line service such as food, tables, utensils, etc., with no use of hand sanitizer or changing gloves. The stove, prep tables, and the deep fryer had a heavy build up of grease and dirt. Also, the facility failed to date and label seven (7) large bags of food items, such as corn, pancakes, and French toast that had been opened. The findings include: Review of the facility's policy on Handwashing Procedures, revised 04/11, revealed hands were to be frequently and thoroughly washed to prevent the transmission of bacteria. 1. Observation of tray line, on 01/25/12 at 12:30 PM through 1:17 PM, revealed Dietary Worker #5 served spaghetti and garlic bread by scooping extra spaghetti noodles onto plates with her gloved hands, thirteen (13) times, touched garlic bread thirty-seven (37) times, and scooped mixed vegetables onto a plate one (1) time, while wearing the same gloves the dietary worker had	F 371	1. Hand washing/Gloves Corrective action to be accomplished for the resident(s) affected by this deficient practice: A counseling was conducted by the Dietary Manager with the employees who were involved in the deficient practice on 01-25-12 and 01-27-12. They were reminded how to properly utilize gloves, discussed cross-contamination, and policies and procedures related to hand washing. How the facility will identify other residents who have the potential to be affected by this practice: An audit tool is being developed for assessing staff using gloves properly. Measures put in place or systematic changes made to ensure that the practice will not recur: An inservice was conducted on hand washing, sanitation, and infection control, for all dietary staff on 2-27-12. Three staff persons did not receive training on that date, and they will be educated on an individual basis. How the facility plans to monitor its performance to ensure that solutions are sustained: The dietary manager will conduct spot , weekly audits to ensure compliance with these policies. Reports of the audits will be provided to regular meetings of the QA Committee. The QA committee will track and trend these reports and make appropriate recommendations for modification where warranted. Person(s) responsible for ensuring on-going compliance: Dietary manager.	03-11-12

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	185136	A. BUILDING _____ B. WING _____	01/26/2012

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F 371	Continued From page 22 touched plates, spoons, and an apron two (2) times. Interview with Dietary Worker #5, on 01/25/12 at 1:25 PM, revealed she worked at the facility for two (2) years and was not aware the kitchen was cited on hand sanitation the year before. Dietary Worker #5 stated she wears gloves for sanitary reasons, so the residents don't get germs. She further stated she should probably not touch objects and then touch food and that she was not aware she touched her apron and food. Interview with Dietary Worker #2, on 01/26/12 at 11:55 PM, revealed they have to wear gloves at all times. The Dietary Worker #2 further stated it was not okay to touch clothing and then touch food. She stated she used tongs when serving bread and dinner roles. They were to wear gloves for the prevention of germs, infection and disease. Interview with the Dietary Manager, on 01/26/12 at 12:10 PM, revealed she witnessed Dietary Worker #5 touching items at the last minute and touching food with hands was not appropriate. 2. Review of the facility's policy on Sanitation, effective 05/08, revealed it was the facility's policy to maintain equipment and work surfaces in a sanitary condition through daily, ongoing procedures. Observation of the main kitchen, on 01/26/12 at 11:30 AM, revealed stoves had dark brown grime on outer surfaces. The outside fryer was observed to have a yellow, white and brown grimy substance and prep tables were observed with a	F 371	2. Sanitation/Equipment Corrective action to be accomplished for the resident(s) affected by this deficient practice: One dietary aide is responsible for special cleaning of the kitchen and equipment. He has been counseled by the dietary manager on 01-27-12 regarding his need to clean the equipment and surfaces, and his cleaning schedule has been modified. How the facility will identify other residents who have the potential to be affected by this practice: An immediate audit was conducted by the dietary manager to determine if other surfaces needed cleaning. Measures put in place or systematic changes made to ensure that the practice will not recur: The updating of the cleaning schedule will ensure that the kitchen is sanitary and clean. How the facility plans to monitor its performance to ensure that solutions are sustained: Weekly routine audits will be performed by the cook and submitted to the dietary manager for review. The dietary manager will take appropriate action to correct any deficient practices. Reports of the audits will be provided to the QA committee for tracking and trending, and the committee will make recommendations for necessary adjustments to the policies and cleaning schedule. Person(s) responsible for ensuring on-going compliance: Dietary Manager.	

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F 371	Continued From page 23 brown grimy substance on the outside surfaces. Interview with the Dietary Manager, on 01/26/12 at 11:30 AM, revealed the stoves were cleaned on Mondays and Tuesdays. The Dietary Manager stated that everything should be cleaned under and over surfaces and she never noticed the machines were not cleaned. Continued interview at 12:10 PM, revealed she had to physically monitor the cleaning. The outside stove and fryer machine was not cleaned appropriately and she was unable to monitor the cleaning this week. 3. Review of the facility's policy on Refrigerated Storage, effective 05/08, revealed it was there policy to store, prepare and serve food in accordance with federal, state and local sanitary codes. All foods will be properly wrapped and/or stored in sealed containers and dated and labeled. Food will be discarded within appropriate shelf life. Observation of the Freezer, on 01/26/12 at 11:30 AM, revealed three (3) bags of pancakes, two (2) bags of french toast sticks and two (2) bags french toast, were not dated and labeled. Interview with Dietary Worker #4, on 01/26/12 at 11:30 AM, revealed he took items out of the box and did not date and label items. He further stated, he did not know how the other staff would know to use it if there was no date. Interview with Dietary Worker #2, on 01/26/12 at 11:55 AM, revealed she was not aware there were items in the freezer that were not dated and labeled. Dietary Worker #2 further stated all items should be dated and labeled when opened.	F 371	3. Food Storage Corrective action to be accomplished for the resident(s) affected by this deficient practice: The employees involved in the deficient practice were counseled on 01-26-12 by the Dietary Manager regarding the need to properly label and date all stored food items. How the facility will identify other residents who have the potential to be affected by this practice: An immediate inspection of the food storage areas was conducted by the Dietary Manager, and no other labeling deficiencies were noted. Measures put in place or systematic changes made to ensure that the practice will not recur: The Dietary Manager conducted an inservice with all dietary employees on 02-27-12 regarding food storage and labeling. How the facility plans to monitor its performance to ensure that solutions are sustained: The cook will audit cold storage areas 2 x weekly and dry storage weekly to ensure that all food is properly labeled and dated. These audits will be provded to the dietary manager and regular reports will be provided to the QA Committee. The QA committee will make recommendations for appropriate changes when needed. Person(s) responsible for ensuring on-going compliance: Dietary Manager.	

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DIVISION OF HEALTH CARE FACILITY SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185136	A. BUILDING _____ B. WING _____	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY MANOR NURSING CENTER	5012 EAST MANSLICK RD LOUISVILLE, KY 40219

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F 371	Continued From page 24 Interview with Dietary Worker #3, on 01/26/12 at 12:00 PM, revealed everything should have a date and say what the items is.	F 371		
F 431 SS=E	483.60(b); (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	Corrective action to be accomplished for the resident(s) affected by this deficient practice: The unidentified tubes of medicine have been discarded. How the facility will identify other residents who have the potential to be affected by this practice: All residents have the potential for being affected by this deficient practice. Measures put in place or systematic changes made to ensure that the practice will not recur: A new policy for the storage and labeling of medication has been written. (see attached policy). All nurses will be re-educated regarding proper storage and labeling of medications. The mandatory inservicing will be conducted on March 6 and 7 by the VP of Nursing and Client Services and the Assistant DON. The medical director has reviewed and approved the new policy. How the facility plans to monitor its performance to ensure that solutions are sustained: The treatment cart will be inspected by the Assistant DON on a weekly basis. Unidentified medication will be immediately removed and disciplinary action will occur promptly with the skin care nurse. Reports of findings of this audit will be reported to the QA Committee, and appropriate recommendations made for change will occur. Person(s) responsible for ensuring on-going compliance: Assistant Director of Nursing.	03-11-12

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	185136	A. BUILDING _____ B. WING _____	01/26/2012

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F 431	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to store drugs and biologicals for one (1) of one (1) treatment cart. The facility failed to ensure 10 tubes of cream on the treatment cart were labeled with a resident's name to identify whom the cream was intended for use. The findings include: Review of the facility's policy Storage of Medications, effective date 02/01/10, revealed section F... Medications labeled for Individual residents are stored separately from floor stock medications. Observations, on 01/24/12 at 3:15 PM and on 01/26/12 at 9:15 AM, revealed the treatment cart for the facility had 10 containers of creams (3 tubes of Aloe Vesta, 2 tubes of Vitamin A&D Ointment, 4 tubes of Peri-guard, and 1 bottle of Peri- lotion) that were not labeled with any resident names. Interview with Registered Nurse (RN #3) on 01/24/12 at 3:45 PM, revealed these creams came from the facility stock supply, not pharmacy and were not labeled to identify which resident the creams were intended for use. Interview, on 01/26/12 at 9:15 AM, with Licensed Practical Nurse (LPN #3) revealed the creams in the treatment cart are intended for individual	F 431		

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	185136	A. BUILDING _____ B. WING _____	01/26/2012

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F 431	Continued From page 26 resident use and are not to be shared. She stated the creams should be labeled with each resident's name and without a label there was no way to know who the cream belongs to. LPN #3 also stated if a resident used someone else's cream, there was a potential for the resident to have an allergic reaction or contamination. Interview with RN #1, on 01/26/12 at 11:35 AM, revealed each resident should have their name on each tube of cream and the medication should not be shared. problems with not having labeled creams was contamination of other residents. Interview, on 01/26/12 at 11:50 AM, with the Assistant Director of Nursing (ADON) revealed the tubes of cream are supplied by the facility not the pharmacy, therefore the creams do not have a label with the resident's name. She stated the problem of unlabeled creams could be multiple residents sharing the same medication with the potential to spread infection.	F 431		

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DHHS - CENTERS FOR MEDICARE & MEDICAID SERVICES

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

PRINTED: 01/31/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185136	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY MANOR NURSING CENTER	5012 EAST MANSLICK RD LOUISVILLE, KY 40219

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1976 SURVEY UNDER: 2000 Existing FACILITY TYPE: S/NF TYPE OF STRUCTURE: One (1) story, Type V Protected. SMOKE COMPARTMENTS: Five (5) smoke compartments. FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system. GENERATOR: Type II generator. Fuel source is natural gas. Upgraded in 2009. A standard Life Safety Code survey was conducted on 01/25/12. Wesley Manor was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for sixty-eight (68) beds and the census was sixty-four (64) on the day of the survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
X Jerry L Hoganson	X Administrator	X 2-29-12

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

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K 000	Continued From page 1 The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) Deficiencies were cited with the highest deficiency identified at F level.	K 000		
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit signage according to NFPA standards. The deficiency had the potential to affect two (2) of the five (5) smoke compartments, residents, staff and visitors. The facility is licensed for sixty-eight (68) beds and the census was sixty-four (64) on the day of the survey. The findings include: Observation, on 01/25/12 at 10:25 AM, with the Administrator and the Maintenance Director revealed the two (2) doors required for exiting the	K 022	Corrective action to be accomplished for those residents affected by the deficient practice: New exit signs have been installed in the dining room. This was completed on February 21, 2012. How the facility will identify other residents having the potential to be affected by the same deficient practice: All exit doors have been audited by the maintenance director to ensure that they are all in compliance. This was completed on 01-31-12 by the administrator. Measures put into place or systematic changes made to ensure that the practice will not recur: Since the affected doors do not exit to outside of the building, it was assumed that exit signs were not needed. The Fire Marshall educated the maintenance director during the survey on the interpretation of this regulation, and the administrator and the maintenance director reviewed this specific requirement of NFPA 101 7.10.14. This was done on January 25, 2012. How the facility will monitor its performance to ensure that solutions are sustained: Exit door are inspected weekly by the administrator for compliance. Any issues with the doors reported immediately to the maintenance director.	03-11-12

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K 022	Continued From page 2 Dining area were not identified by approved, readily visible signage. The door exiting to the exterior of the building was identified with an approved, readily visible sign; however, the door leading to the exit access corridor did not have the required proper signage. Interview, on 01/25/12 at 10:25 AM, with the Administrator and the Maintenance Director revealed they were informed by the local Fire Department that the existing conditions were acceptable. NFPA 101 (2000 Edition) 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.	K 022	Any light bulbs in exit signs that burn out are reported on the maintenance log and replaced as needed by the maintenance staff. How the facility plans to monitor its performance to ensure that solutions are sustained: The Director of Maintenance visually inspects (audits) the building on a daily basis. Any bulbs not functioning are replaced immediately. Unusual occurrences, such as malfunctioning exit signs, will be reported to the maintenance director by staff who notice the problem via the maintenance logs. Trends will be reported to the QA committee on a monthly basis by the Director of Maintenance. The QA committee will make recommendations for changes in policy or equipment based on these audit reports. Person(s) responsible for on-going compliance: Director of Maintenance.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or	K 029	Corrective action to be accomplished for those residents affected by the deficient practice: Self-closing devices have been installed on the two affected doors. This was completed on 02-23-12. How the facility will identify other residents having the potential to be affected by the same deficient practice: All doors in the facility have been inspected by the director of maintenance On 01-25-12	03-11-12

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	185136	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/25/2012

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K 029	Continued From page 3 field-applied protective plates that do not exceed 48 Inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards, per NFPA Standards. The deficiency had the potential to affect two (2) of the five (5) smoke compartments, residents, staff and visitors. The facility is licensed for sixty-eight (68) beds and the census was sixty-four (64) on the day of the survey. The findings include: Observations, on 01/25/12 between 9:00 AM and 10:20 AM, with the Administrator and the Maintenance Director revealed the door to the Stock Room located in the North Hall and the door to the Dry Storage Room located in the Kitchen, did not have self closing devices installed on the doors. Interviews, on 01/25/12 between 9:00 AM and 10:20 AM, with the Administrator and the Maintenance Director revealed they were not aware the Stock Room and the Dry Storage Room were considered hazardous storage areas and the doors were required to be equipped with self closing devices.	K 029	and were found to be in compliance. Measures put into place or systematic changes made to ensure that the practice will not recur: The director of maintenance and the administrator were informed of the specific requirements of NFPA 101 19.3.2.1 by the state fire marshal during the inspection. The director of maintenance and the administrator discussed the application of the requirements as they relate to Wesley Manor, and which doors are affected. Exit doors are inspected on a weekly basis by the administrator and the vice president of administration. Any issues are noted and reported to the director of maintenance for repair. How the facility will monitor its performance to ensure that solutions are sustained: The director of maintenance will conduct monthly inspections of all doors to ensure that automatic closures are functioning. A report of his findings will be made to the QA committee, and recommendations by the committee will be addressed. Person(s) responsible for on-going compliance: Director of Maintenance.	

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K 029	Continued From page 4 Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than	K 029		

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K 029	Continued From page 5 48 in. (122 cm) above the bottom of the door.	K 029		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiencies had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for sixty-eight (68) beds with a census of sixty-four (64) on the day of the survey. The findings include: Observations, on 01/25/12 between 9:07 AM and 9:55 AM, with the Administrator and the Maintenance Director revealed the delayed egress doors located at the exits from the North and South Resident Halls, did not have the required signage stating the door was equipped with a fifteen (15) second delay before opening. Interviews, on 01/25/12 between 9:07 AM and 9:55 AM, with the Administrator and the Maintenance Director revealed they were not	K 038	Corrective action to be accomplished for those residents affected by the deficient practice: The affected egress doors now have proper signs installed adjacent to the 15-second-delay button. This was completed on 02-24-12. How the facility will identify other residents having the potential to be affected by the same deficient practice: All egress doors having 15-second-delay buttons were inspected by the administrator to ensure that they are labeled with the proper signage. This was completed on 02-24-12. Measures put into place or systematic changes made to ensure that the practice will not recur: All doors have been inspected and they currently have proper signage. How the facility will monitor its performance to ensure that solutions are sustained: Since all egress doors are inspected weekly by the administrator, the presence of these signs will also be audited to ensure compliance. (see attachment). Person(s) responsible for on-going compliance: Administrator	03-11-12

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K 038	Continued From page 6 aware the delayed egress signage was not posted on the exit doors. Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30	K 038		

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K 038	Continued From page 7 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 038		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, according to NFPA standards. The deficiency had the potential to affect each of the five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty-eight (68) beds and the census was sixty-four (64) on the day of the survey. The findings include:	K 050	Corrective action to be accomplished for those residents affected by the deficient practice: Fire drills are to be conducted on a monthly basis so that each shift has a drill each quarter. How the facility will identify other residents having the potential to be affected by the same deficient practice: A fire drill was conducted on 02-29-12 during the day shift by the director of maintenance. The administrator also instructed the director of maintenance regarding this requirement. Measures put into place or systematic changes made to ensure that the practice will not recur: The administrator or the VP of administration will audit time and dates of fire drills to ensure they are being conducted per regulation. How the facility will monitor its performance to ensure that solutions are sustained: Reports of fire drill dates and times are reported to the QA Committee. Any issues of non-compliance are addressed by the committee. Person(s) responsible for on-going compliance: Director of Maintenance and the Administrator	03-11-12

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K 050	Continued From page 8 Record review, on 01/25/12 at 12:30 PM, with the Maintenance Director revealed the fire drills were not being conducted quarterly, on each shift at random times. There was no record of fire drills being conducted during the third shift, in the first and third quarters of 2011. Interview, on 01/25/12 at 12:30 PM, with the Maintenance Director revealed he was not aware of the two (2) fire drills not being conducted during the third shift. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure smoke detectors were inspected and tested according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the (5) smoke compartments, residents, staff and visitors. The facility is licensed for sixty-eight (68) beds and the census was sixty-four (64) on the day of the survey.	K 054	Corrective action to be accomplished for those residents affected by the deficient practice: The Director of Maintenance Contacted the Fire Protection Contractor on 01-31-12. How the facility will identify other residents having the potential to be affected by the same deficient practice: All facility smoke detectors were tested for sensitivity and completed on 2-24-12. Measures put into place or systematic changes made to ensure that the practice will not recur: The fires protection contractor has been instructed to test smoke detectors for sensitivity according to regulation on an annual basis when warranted. The director of maintenance receives this report annually, stores it, and gives a copy to the administrator.	03-11-12

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K 054	Continued From page 9 The findings include: Record review of the fire alarm inspection reports, on 01/25/12 at 12:20 PM, with the Maintenance Director revealed no documentation of a Smoke Detector Sensitivity Test being performed on the fire alarm smoke detectors within the required time frame required by Code. Smoke detectors must be tested according to NFPA 72 (1999 edition) to ensure their reliability. Interview, on 01/25/12 at 12:20 PM, with the Maintenance Director, revealed he was unaware the facility did not have a current sensitivity test on the fire alarm smoke detectors. Reference: NFPA 72 (1999 edition) 7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency	K 054	How the facility will monitor its performance to ensure that solutions are sustained: Reports from the Fire Protection Contractor will be provided to the QA Committee for evaluation and recommendation to administration Person(s) responsible for on-going compliance: Director of Maintenance and the Administrator	

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K 054	Continued From page 10 is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced.	K 054		

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K 054	Continued From page 11 Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.	K 054		
K 062 SS=F	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: Based on observation and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect each of the five (5) smoke compartments, residents, staff and visitors. The facility is licensed for sixty-eight (68) beds and the census was sixty-four (64) on the day of the survey. The findings include: Observation, on 01/25/12 at 9:20 AM, with the Maintenance Director revealed the escutcheon plate (trim piece) was missing from the sprinkler head located in the alcove between Resident Rooms N-5 and N-7. The escutcheon plate is	K 062	Corrective action to be accomplished for those residents affected by the deficient practice: The escutcheon plate was installed on the affected sprinkler head on 01/31/12. How the facility will identify other residents having the potential to be affected by the same deficient practice: All sprinkler heads were inspected on 01/31/112 by the director of maintenance to ensure that remaining plates were in place. Measures put into place or systematic changes made to ensure that the practice will not recur: The director of maintenance will inspect the fire suppression system quarterly and report any issues to the fire protection agency. The agency will also inspect the system quarterly and report and/or repair any issues. How the facility will monitor its performance to ensure that solutions are sustained: Any issues with the fire suppression system will be reported to the QA Committee. The Committee will make recommendations to administration for any needed corrections to policies or repairs to the system.	03-11-12

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K 062	Continued From page 12 required for the ceiling assembly to resist the passage of smoke in the event of a fire. Interview, on 01/25/12 at 9:20 AM, with the Maintenance Director revealed he was not aware of the missing escutcheon plate. Record review, on 01/25/12 at 12:40 PM, with the Maintenance Director revealed the required Quarterly Inspection Reports for the Sprinkler System had not been conducted during the third and fourth quarters of 2011. A Quarterly Inspection was performed on 01/24/12 and the Quarterly Inspection prior to that was performed on 05/27/11. Interview, on 01/25/12 at 12:40 PM, with the Maintenance Director revealed a confirmation of the Quarterly Inspections not being performed because of a misunderstanding between the facility and the sprinkler contractor. Reference: NFPA 101 (2000 edition) 4.6.12.1. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 9.7.5 Maintenance and Testing.	K 062	Person(s) responsible for on-going compliance: Director of Maintenance and the Administrator	

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K 062	Continued From page 13 All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Reference: NFPA 25 (1998 Edition). 1-8 Records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to, valve inspections; flow, drain, and pump tests; and trip tests of dry pipe, deluge, and preaction valves. 1-8.1 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY MANOR NURSING CENTER	5012 EAST MANSLICK RD LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 14 9-1* General. This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of valves, valve components, and trim. Table 9-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.	K 062		
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress, per NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty-eight (68) beds and the census was sixty-four (64) on the day of the survey. The findings include: Observations, on 01/25/12 between 9:40 AM and 10:37 AM, with the Administrator and the Maintenance Director revealed unapproved locks (slide bolt type) were installed on two (2) doors within the facility. 1. A slide bolt on the door to the Dining Area from the Office Area / Nursing Station. 2. A slide bolt on the doors separating the clean and soiled areas of the Laundry.	K 130	Corrective action to be accomplished for those residents affected by the deficient practice: Slide bolts have been removed from the affected double doors so that regular door hardware can be utilized. This was completed on 02-24-12. How the facility will identify other residents having the potential to be affected by the same deficient practice: All doors were inspected on 01-27-12 by the director of maintenance and the administrator to ensure that they were in compliance. Measures put into place or systematic changes made to ensure that the practice will not recur: The administrator instructed the director of maintenance that the facility is not to utilize any slide bolts to secure doors in the facility. How the facility will monitor its performance to ensure that solutions are sustained: The director of maintenance will inspect the facility on a monthly basis to ensure that doors meet regulations. Monthly reports will be submitted to the QA committee, and the committee will make recommendations for needed adjustment to physical plant changes to the administrator.	03-11-12

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	185136	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/25/2012

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K 130	Continued From page 15 Interviews, on 01/25/12 between 9:40 AM and 10:37 AM, with the Administrator and the Maintenance Director revealed they were aware of the locks installed on the doors; however they were not aware that slide bolt locks were prohibited. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130	Person(s) responsible for on-going compliance: Director of Maintenance and the Administrator.	

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