

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

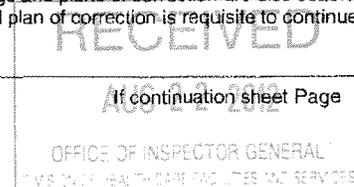
PRINTED: 08/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185466	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2012
NAME OF PROVIDER OR SUPPLIER WESTPORT PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 4247 WESTPORT ROAD LOUISVILLE, KY 40207	
(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 initiated on 07/17/12 and concluded on 07/19/12, The Life Safety Code survey was conducted on 07/19/12. The highest scope and severity was an F. The facility had the opportunity to correct before remedies would be recommended for imposition. This was a FOSS survey. An abbreviated survey was initiated on 07/17/12 and concluded on 07/19/12. The Division of Health Care substantiated the allegation of KY18746 with deficiencies cited.	F 000	The submission of this Plan of Correction does not indicate an admission by Westport Health Care Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Westport Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities for title 18/19 programs. To this end, this plan of correction shall serve as the credible allegation of compliance with all the state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	
F 203 SS=E	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more	F 203	compliance with the requirements of participation for comprehensive health care facilities for title 18/19 programs. To this end, this plan of correction shall serve as the credible allegation of compliance with all the state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. F 203 1. Residents #1 was transferred to hospital related to fluid overload and needed immediate diuresis. #4 was transferred to hospital for abnormally low blood pressure. 2. Residents transferred to hospital during July were reviewed to insure not affected by this requirement not being met. Based on audits, none were affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Stephanie Payne* TITLE: *Executive Dir.* (X6) DATE: *8/22/12*

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.

SN/RW



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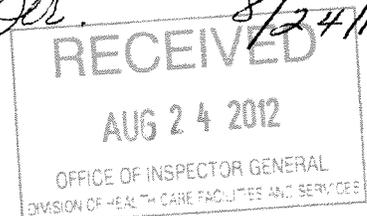
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F 203	Continued From page 1 immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide a Notice of Transfer, including the right to appeal, for two (2) of thirteen (13) sampled residents, Residents #1 and #4, prior to transfer to an acute care hospital.	F 203	F 203 1. Neither resident #1 or #4 were given transfer/discharge notices at the time of emergency transfer to the hospital. Nursing failed to give this information prior to transfer. Business office Manager contacted the responsible party for Resident #1 on 7/26/2012 and explained facility bed hold policy and responsible party chose not to hold the bed. Resident readmitted to facility on 7/28/2012 under Medicare Part A. Responsible party for Resident #4 was contacted by Business Office Manager on 6/30/2012 and again on 7/7/2012 to explain facility bed hold policy and family chose to hold the bed on both occasions. Resident #4 continues to be a resident in this facility. 2. Residents transferred to hospital during July were reviewed to insure not affected by this requirement not being met. Based on audits, none were affected. 3. Admissions persons and nurses will be educated related to Resident Rights related to Transfer/Discharge and all rights to appeal by Executive Director on 8/15-16/2012. Information will be given to residents and/or responsible party at time of admission. They will acknowledge receipt of such at this time.	

Auguste P. P. P.

Executive Dir.

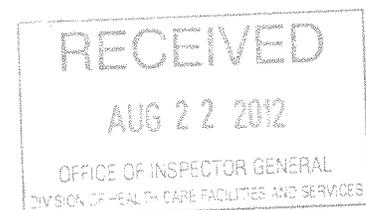
8/24/12



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F 203	<p>Continued From page 2</p> <p>The findings include:</p> <p>The facility did not have a policy regarding Notice of Transfer or the Right to Appeal.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 07/10/12 with a diagnosis of Congestive Heart Failure. The facility transferred the resident to an acute care hospital on 07/16/12.</p> <p>Review of the clinical record for Resident #4 revealed the facility admitted the resident on 03/23/12 with diagnoses of Dementia and Hypertension. The resident was transferred to an acute care hospital on 06/29/12 and again on 07/06/12. There was no evidence of a notice of transfer or the right to appeal found in either clinical record.</p> <p>Interview and record review, on 07/19/12 at 10:15 AM, with Licensed Practical Nurse (LPN) #2 revealed a Notice of Transfer with the right to appeal was not in the clinical record for Residents #1 or #4.</p> <p>On 07/19/12 at 3:30 PM, interview with the Assistant Director of Health Services (ADHS) revealed she was unsure if the facility had a Notice of Transfer with resident rights documentation provided to residents or their families. She stated the facility did not give the resident documentation of Notice of Transfer including resident rights.</p> <p>Interview with the Business Office Manager, on 07/19/12 at 3:45 PM, revealed she was not involved in the documentation for Notice of</p>	F 203		



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F 203	Continued From page 3 Transfer to residents. On 07/19/12 at 4:15 PM, interview with the Director of Health Services (DHS) revealed the resident transfer rights were discussed during the resident's admission process. The DHS stated the nursing department was not involved in providing to residents the Notice of Transfer and right to appeal. Interview, on 07/19/12 at 4:45 PM, with the Customer Service Specialist revealed the Notice of Transfer was in the resident handbook given upon initial admission. She stated she was not involved in providing residents the Notice of Transfer with right to appeal, prior to residents transfer to the hospital.	F 203			
F 205 SS=E	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy	F 205	F 205 1. Neither resident #1 or #4 were given transfer/discharge notices at the time of emergency transfer to the hospital. Nursing failed to give this information prior to transfer. Business office Manager contacted the responsible party for Resident #1 on 7/26/2012 and explained facility bed hold policy and responsible party chose not to hold the bed. Resident readmitted to facility on 7/28/2012 under Medicare Part A. Responsible party for Resident #4 was contacted by Business Office Manager on 6/30/2012 and again on 7/7/2012 to explain facility bed hold policy and family chose to hold the bed on both occasions. Resident #4 continues to be a resident in this facility. 2. Any resident transferring out of facility prior to survey had notice of bed hold policy as acknowledged during admission process and signed agreement.		

Angene Anne

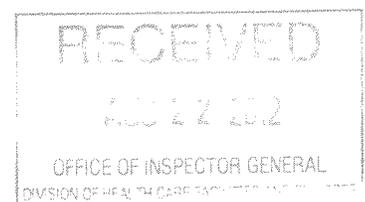
Executive Dir

8/24/12
RECEIVED
AUG 24 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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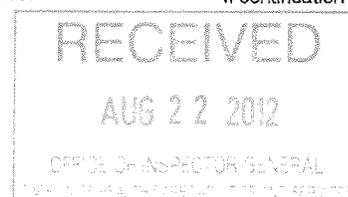
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F 205	<p>Continued From page 4 described in paragraph (b)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to provide two (2) of thirteen (13) sampled residents, Residents #1 and #4, with written notice of the facility bed hold policy at the time of transfer, or within twenty-four (24) hours for cases of emergency transfer, to an acute care hospital.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Bed Hold Agreement, not dated, revealed when a resident leaves the facility for acute care provided at a hospital the Bed Hold Agreement is sent with the resident and a letter sent to the responsible party within twenty-four (24) hours. A bed hold can also be verified by phone and documented in the resident record, with a letter to follow.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 07/10/12 with a diagnosis of Congestive Heart Failure. The resident was transferred to an acute care hospital on 07/16/12.</p> <p>Review of the clinical record for Resident #4 revealed the facility admitted the resident on 03/23/12 with diagnoses of Congestive Heart Failure and Hypertension. The resident was transferred to an acute care hospital on 06/29/12 and 07/06/12. There was no evidence of a Bed Hold Policy in either clinical record</p>	F 205	<p>F205 cont</p> <p>4. Ongoing compliance will be monitored by Medical Records audits during morning clinical meeting for those residents transferred out to acute care hospitals. Clinical meetings are held daily Monday thru Friday. Audits will also be conducted by Home Office Clinical Support Staff during Peer Review. Any noncompliance identified during Peer Review will require corrective action plan be developed and implemented by Executive Director. Any subsequent visits by Home Office staff will monitor compliance to insure system is in place. Quality Assurance will review discharges monthly.</p>	8/30/12



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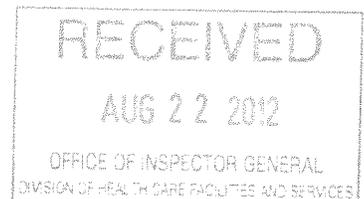
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F 205	<p>Continued From page 5</p> <p>Interview, on 07/19/12 at 9:00 AM, with Licensed Practical Nurse (LPN) #2 revealed residents were to receive a notice of bed hold if transferring to the hospital and a copy should be in the resident chart.</p> <p>Interview with the Inservice Director, on 07/19/12 at 2:25 PM, revealed residents should receive notice for bed hold when transferred to the hospital. She stated the nurses were responsible to complete the bed hold notice. The Inservice Director stated all nurses were trained to complete the bed hold notice during orientation by the new nurse's mentor.</p> <p>On 07/19/12 at 3:30 PM, interview with the Assistant Director of Health Services (ADHS) revealed the facility's business office was responsible to complete the bed hold notice with residents and families, not the nurses. The ADHS stated if a resident was transferred out on evenings and weekends, when the business office was closed, the follow up was on the next business day.</p> <p>Interview, on 07/19/12 at 3:45 PM, with the Business Office Manager revealed she called the resident's family regarding the bed hold if the resident would be out of the facility after midnight. She stated if the resident transferred out of the facility on evenings she would call the family the next business day or on Monday if the resident transferred on the weekend. The Business Office Manager stated the family would give a verbal consent or denial for the bed hold. She stated Resident #1 did not receive a bed hold as the resident was not out after midnight. She stated she was not aware if the nurses have the resident</p>	F 205		



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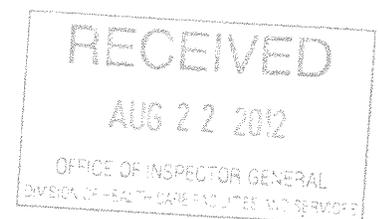
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F 205	Continued From page 6 or responsible party to sign a bed hold agreement and she did not have any copies of a bed hold notice that had been provided to any of the residents. The Business Office Manager stated residents were not given notice of bed hold for doctor appointments or therapeutic outings. The Office Manager stated she does not give written documentation to residents or responsible parties for bed hold. On 07/19/12 at 4:15 PM, interview with the Director of Health Services (DHS) revealed the Business Office Manager called the resident's responsible party about the bed hold. The DHS stated she was unaware of who informed the resident or the responsible party of the bed hold, if the resident transferred on evenings or weekends. She stated the bed hold information was given to residents during the admission process and was not a nursing responsibility. Interview, on 07/19/12 at 4:45 PM, with the Customer Service Specialist revealed residents were given the bed hold information in the resident handbook upon admission. She stated re-admissions within thirty (30) days did not receive another handbook. The Customer Service Specialist stated the Business Office Manager contacted the family for a bed hold when the resident was transferred.	F 205		
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual,	F 223	F 223 1. Skin assessment completed on Resident #5 by DHS on 7/15/2012 when notified of alleged action. No new skin issues noted. Skin tear to Left lower arm was treated per MD order and healed without infection.	



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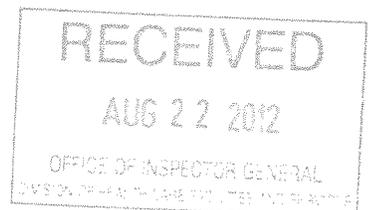
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F 223	Continued From page 7 or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of the facility's policy, it was determined the facility failed to protect one (1) of thirteen (13) residents from abuse. Resident #5. An allegation of abuse was reported to have occurred 07/14/12 by CNA #3 to the night nurse on 07/14/12. The night nurse did not report the incident until 07/15/12. The alleged perpetrator was allowed to finish working the shift and returned to work the next day. The findings include: Review of the facility's policy regarding Abuse and Neglect Procedural Guidelines, dated 09/16/11, revealed under the headings: (D) Identification, item II, any person with knowledge or suspicion of suspected abuse violations shall report immediately, without fear of reprisal; (E) Protection, item IV, the suspected employee(s) was to be suspended pending the outcome of the investigation; and (G) Reporting, item # I and II, any staff member, resident, visitor, or responsible party may report known or suspected abuse, neglect, or misappropriation to local or state agencies, and immediately, not more than 24 hours, complete an initial investigation. Review of the facility's investigation revealed on 07/14/12 at approximately 8:00 PM, CNA #3 witnessed CNA #1 squeeze Resident #5's left	F 223	F 223 Cont CNA#1 was suspended on 7/15/2012 and after investigation CNA#1's employment was terminated. CNA#3 and night nurse received written counseling on 7/23/2012 related to timely reporting of abuse or alleged abuse. 2. Social Services interviewed alert and oriented residents on Health Center to insure that no residents were affected by the cited deficiency. No concerns expressed by any residents. Other residents were observed for signs and symptoms of any distress and none were identified. A review of weekly skin assessments for the week of 7/23/2012 was completed by DHS and no new skin issues were found. 3. Staff were re-educated by the DHS and Staff Development Coordinator on 7/15/2012 and 7/16/2012 with emphasis on timely reporting. Based on policy, reports are immediate to the charge nurse, DHS, or ED. ED, DHS and Staff Development Coordinator assessed 30 staff members knowledge of abuse policy and reporting during daily rounds the week of 08/20/2012. Staff knowledgeable of reporting requirements.		



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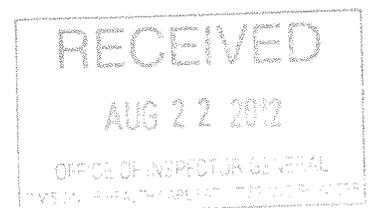
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F 223	<p>Continued From page 8</p> <p>arm and caused a skin tear and used too much pressure to wash Resident #5's bottom. CNA #3 felt this was abuse. On 07/14/12 at approximately 10:00 PM, CNA #3 wrote two statements, provided one to the night shift nurse, and placed one statement under the Director of Nurse's (DON) office door. He also reported verbally to the night shift nurse at approximately 10:00 PM that he felt CNA #1 had been rough with Resident #5. CNA #3 provided a second statement, on 07/16/12, to Social Services during the investigation. CNA #3 then indicated he was showing CNA #1 how to apply Resident #5's back brace, and that was when they noticed the blood coming from a skin tear. An interview with CNA #1 revealed Resident #5 was hitting and attempting to bite. She further stated CNA #3 and herself each took an arm to transfer Resident #5 to his/her wheelchair. CNA #1 was applying the foot rest when CNA #3 said Resident #5 had hurt himself/herself.</p> <p>Record review revealed on 07/14/12 Resident #5 was identified with a skin tear. On 07/12/12 it was documented the resident sustained a skin tear and the care plan was updated to reflect an intervention for the skin tear. Interventions were to place steri strips on the skin tear on the left forearm and to monitor the area for infection. Resident #5 had a BIMS score of 3, which indicated cognitively impaired.</p> <p>Interview with CNA #1, on 07/18/12 at 1:40 PM, revealed she and CNA #3 were sent to Resident #1's room by the nurse because his/her bed alarm kept going off. He/She was resistive to them cleaning him/her up, hit CNA #3, and was trying to bite. When they got him/her in the wheel</p>	F 223	<p>F 223 Cont</p> <p>4. During orientation all new staff are educated on the abuse policy, reporting abuse, when to report, and who to report to.</p> <p>All other staff will receive annual education related to the abuse policy and reporting alleged abuse. Random interviews will be conducted with 10 staff by the DHS or ADHS monthly times 3 months and then quarterly until substantial compliance as determined by Quality Assurance Committee. Results will be reported to QA monthly by DHS or ADHS, where compliance will be monitored and action plans required when out of compliance.</p>	8/30/12	



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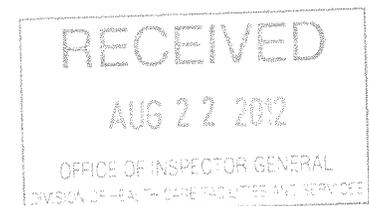
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F 223	Continued From page 9 chair they saw the skin tear. Maybe the resident bumped his/her arm, she did not know how the skin tear happened. Interview with CNA #3, on 07/17/12 at 2:55 PM, revealed CNA #1 was cleaning up the resident and the resident cried out. She told him/her to stop being so rough and CNA #1 said she thought she was burned out. CNA #3 said he went to the charge nurse at the nursing station at 10:00 PM which was at the end of his shift, and the charge nurse told him to write an incident report. The charge nurse read the report and had a second report written and turned it in to the DON. CNA #3 slid the report under the DON's door. Interview with the Director of Nursing (DON), on 07/19/12 at 2:15 PM, revealed the night shift charge nurse did not notify her when the incident was reported; however, waited and notified her by phone on 07/15/12 at approximately 4:00 PM. CNA #1 had reported to work on 07/15/12 and worked until the DON was notified and then she was sent home. She stated she suspended the CNA immediately at 4:00 PM. Further interview with the DON, on 07/19/12 at 5:20 PM, revealed the incident was not reported in a timely manner by the nurse, nor did the CNA follow the facility policy in reporting the incident.	F 223		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	F 226 1. Skin assessment completed by DHS on resident #5 on 7/15/2012 after knowledge of alleged abuse. No new skin issues were found. Order received from MD to treat skin tear. Skin tear healed without signs of infection.	



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

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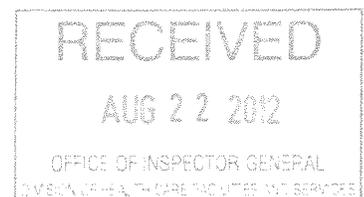
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F 226	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and policy review, it was determined the facility failed to follow their abuse policy as a staff member did not report an incident of suspected abuse immediately and thus, the alleged perpetrator was not suspended per facility policy for one (1) of thirteen (13) sampled residents. Resident #5</p> <p>The findings include:</p> <p>Review of the facility's Abuse Policy, dated 11/2010, revealed the policy contained the seven (7) components of abuse. The policy states under protection that the suspected employee will be suspended pending the outcome of the investigation. The person that identifies and if abuse is suspected the staff are to report the incident immediately.</p> <p>Review of the facility's investigation revealed on 07/14/12 at approximately 8:00 PM, CNA #3 witnessed CNA #1 squeeze Resident #5's left arm and caused a skin tear and used too much pressure to wash Resident #5's bottom. CNA #3 felt this was abuse. On 07/14/12 at approximately 10:00 PM, CNA #3 wrote two statements, provided one to the night shift nurse, and placed one statement under the Director of Nurse's (DON) office door. He also reported verbally to the night shift nurse at approximately 10:00 PM that he felt CNA #1 had been rough with Resident #5. CNA #3 provided a second statement, on 07/16/12, to Social Services during the investigation. CNA #3 then indicated he was showing CNA #1 how to apply Resident #5's back brace, and that was when they noticed the blood</p>	F 226	<p>F 226 Cont</p> <p>2. All residents have the potential to be affected. Social services interviewed alert and oriented residents on Health Center to insure no concerns expressed. A review of weekly skin assessments for the week of 7/23/2012 was completed by DHS and no new skin issues were found.</p> <p>3. All staff were re-educated by DHS and Staff Development Coordinator on 7/15/2012 7/16/2012 on the abuse policy reporting abuse or alleged abuse. How to report, when to report and to whom to report to. ED, DHS and Staff Development Coordinator assessed 30 staff members knowledge of abuse policy and reporting requirements during daily rounds the week of 08/20/2012. Staff knowledgeable.</p>	



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F 226	<p>Continued From page 11</p> <p>coming from a skin tear. A facility interview with CNA #1 revealed Resident #5 was hitting and attempting to bite. She reported CNA #3 and herself each took an arm to transfer Resident #5 to his/her wheelchair. CNA #1 was applying the foot rest when CNA #3 said Resident #5 had hurt himself/herself. However, the incident was not reported to the state agency or Adult Protective Services as required.</p> <p>Record review revealed on 07/14/12 Resident #5 was identified with a skin tear. On 07/12/12 it was documented the resident sustained a skin tear and the care plan was updated to reflect an intervention for the skin tear. Interventions were to place steri strips on the skin tear on the left forearm and to monitor the area for infection. Resident #5 had a BIMS score of 3, which indicated a cognition deficit.</p> <p>Interview, on 07/17/12 at 2:35 PM, with CNA #3 revealed he stated on Saturday he was working a split hallway. About 8:00 PM, CNA #1 asked him to help get Resident #5 up. He stated the resident needed toileting and CNA #1 was rubbing him/her too hard. Resident #5 hit CNA #3 when they were getting the resident to the chair. CNA #3 stated he saw blood on Resident #5's left arm and he felt CNA #1 caused it. CNA #3 further stated, he did not report his concern until 10:00 PM to the night nurse.</p> <p>Interview, on 07/19/12 at 1:40 PM, with CNA #1 revealed she asked CNA #3 for help to get Resident #5 up to his/her wheelchair. The resident had become restless and was setting the bed alarm off. She stated she and CNA #3 had to toilet the resident before getting the resident up</p>	F 226	<p>F 226 Cont</p> <p>4. All new staff are educated on the abuse policy during orientation. All other staff receive annual education related to abuse policy and reporting alleged abuse or abuse. Random interviews with 10 staff will be conducted by the DHS or ADHS monthly times 3 months and then quarterly times 2. Results will be reported by DHS or ADHS to the monthly QA meeting, where compliance will be monitored and action plans required when out of compliance. Compliance will also be monitored by Home Office Support staff. Noncompliance will be addressed by requiring corrective action plans which is implemented and monitored by Executive Director.</p>	8/30/2012



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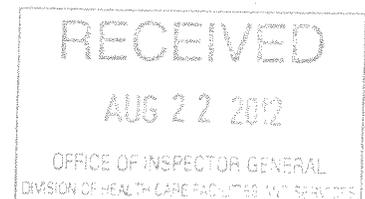
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F 226	Continued From page 12 and she was struggling the whole time and hit CNA #3 in the groin. While she adjusted the foot rest CNA #3 stated that Resident #5's arm was bleeding. The resident was taken to the night nurse who dressed the arm. Interview with the Director of Nursing (DON), on 07/19/12 at 2:15 PM, revealed she was not notified of a suspected incident of abuse until 07/15/12 at approximately 4:00 PM. At that time CNA #1 was suspended pending the investigation outcome and the investigation was initiated. The State Agency and Adult Protective Services were notified. The DON stated per the facility policy, CNA #3 should have reported the suspected incident to the nurse immediately, and the nurse should have immediately reported the incident to the DON.	F 226			
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 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, record review, and review of the facility's policy, it was determined the facility failed to follow Doctor's (MD) orders regarding oxygen for one (1) of thirteen (13) sampled residents, Resident #4.	F 309	1. Resident #4 was assessed and no harm occurred. O2 saturation 97% on room air. Order obtained to discontinue oxygen on 7/19/2012. All other MD orders for resident being followed as written. 2. All residents have the potential to be affected. A review of MD orders for all residents were reviewed on 7/20/2012 by DHS, ADHS and Medical Records to insure orders being followed as written. No other issues identified.		



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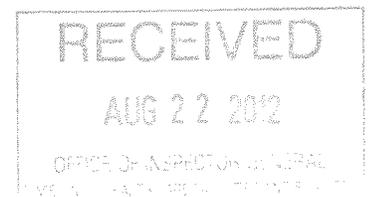
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F 309	<p>Continued From page 13</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Guidelines for Medication Orders, not dated, revealed a current list of orders would be maintained in each resident's clinical record. The admitting nurse should review the standing orders with the physician when verifying admission orders. Additionally, an order should not be "dropped" and should have an order to discontinue.</p> <p>Review of the clinical record for Resident #4 revealed the facility re-admitted the resident on 07/09/12 with diagnoses of Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE), Hypertension, and Dementia. Admission orders included continuous oxygen (O2) at 1.5L per minute.</p> <p>Review of the Twenty-four (24) Hour Nursing Report, dated 07/09/12, revealed the facility re-admitted Resident #4 with continuous O2 at 1.5L</p> <p>Observation, on 07/17/12 at 8:15 AM, revealed Resident #4 had an O2 concentrator in the bedroom by the resident's bed. The resident was not using the oxygen.</p> <p>Observation, on 07/17/12 at 11:19 AM, 12:00 PM, 12:35 PM, 2:30 PM, 3:05 PM, on 07/18/12 at 8:15 AM, 9:30 AM, 11:30 AM and on 07/19/12 at 8:00 AM, 9:30 AM, 10:15 AM, 1:45 PM, revealed Resident #4 was not using oxygen and did not have oxygen in the room.</p> <p>Interview, on 07/19/12 at 9:00 AM, with Licensed</p>	F 309	<p>F 309 cont</p> <p>3. Nurses will be educated on transcribing and following MD orders by DHS 8/15-16/2012. Admitting nurse will verify orders with second nurse, and both will sign off. Admitting nurse will then verify with MD.</p> <p>4. Admission orders and any new orders will be reviewed in the morning CQI meeting by Medical Records to determine accuracy. MD orders are also reviewed for implementation and follow up. Random Audits of 5 charts will be conducted by Nurse Management team focusing on new orders from previous 24 hours, as well as orders for new admissions monthly X 3 months and then quarterly X 6 months. Results on the audits will be followed by the monthly QA meeting as presented by Medical Records, where compliance will be monitored and corrective action plans required when out of compliance. Executive Director will be responsible for overall implementation and monitoring of corrective plans.</p>	8/30/12	



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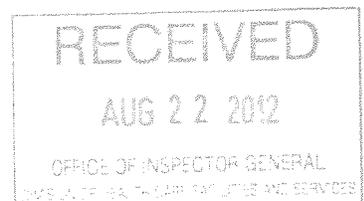
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F 309	<p>Continued From page 14</p> <p>practical Nurse (LPN) #2 revealed Resident #4 had a current MD order for O2 at 1.5L continuously and had not been discontinued by the MD. She stated the O2 order was also written on the Twenty-four (24) Hour Nursing Report which was reviewed by the management team on weekdays. The LPN stated the resident had not been receiving oxygen and could become hypoxic.</p> <p>On 07/19/12 at 10:30 AM, interview with Certified Nursing Assistant (CNA) #5 revealed Resident #4 had returned from the hospital with O2 but the resident refused to wear the oxygen. The CNA stated everyone was responsible to check the resident to make sure he/she was wearing the oxygen and the nurses were responsible to adjust it.</p> <p>Interview, on 07/19/12 at 2:25 PM, with the Inservice Director revealed new nurses were trained by mentors in the administration of oxygen and care of equipment as well as following MD orders. She stated new admission orders were reviewed in the administration morning meeting. She stated to discontinue an order the MD must be called.</p> <p>Interview, on 07/19/12 at 3:30 PM, with the Assistant Director of Health Services (ADHS) revealed the nurses received initial MD orders for new admissions. The resident's orders were reviewed on the next business day after admission in the morning meeting. The ADHS stated she had been told Resident #4's O2 had been discontinued by the physician.</p> <p>Interview with the Director of Health Services</p>	F 309			



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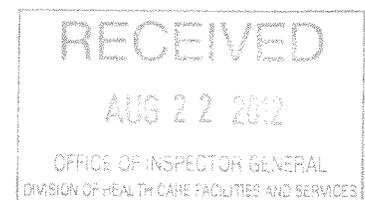
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F 309	Continued From page 15 (DHS), on 07/19/12 at 4:15 PM, revealed the nurses implement new admission orders per the MD, based upon the resident's orders from the hospital. The DHS stated the orders were reviewed in the morning meeting. She stated the nurses were responsible to administer O2 to the resident per the MD order. The DHS stated she was not sure why Resident #4's O2 was missed and without the oxygen the resident could become hypoxic.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined the facility failed to follow their high risk nutritional guidelines to meet the nutritional needs for one (1) of thirteen (13) sampled residents. Resident #5. The findings include: Review of the High Risk Nutrition Procedure Guidelines, dated 12/07, revealed the intent of the	F 325	F 325 1. Resident #5 was assessed and placed on weekly weights, a supplement of her choice and fortified foods. Order obtained to remove front of brace during mealtime. 2. All residents have the potential to be affected. Review of monthly weights completed 8/8/2012. Any resident with a weight loss of 5% or more, or a BMI of less than 18.5% have been placed on weekly weights. 3. New admissions or any resident placed on supplements, or have a BMI of less than 18.5% will be placed on Clinically at Risk (CAR) program by the ADHS and weekly weights as well as being reviewed by the Dietitian weekly.	



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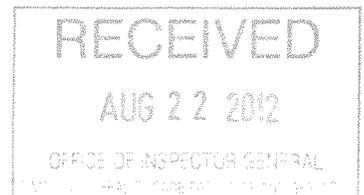
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F 325	<p>Continued From page 16</p> <p>program was to maintain the resident's nutritional status to prevent weight loss. One of the clinical conditions identified was refusal to eat or decreased caloric intake. Another guideline was for the resident's weight to be monitored. Residents with weight loss were to be assessed to determine the possible cause.</p> <p>Observations of Resident #5, on 07/17/12, for the lunch meal revealed he/she wore a body/chin brace when out of bed. The brace hyper-extends the neck. Observation of the resident attempting to eat a small peice of turkey revealed it was difficult for him/her to chew. The resident drank the liquids and ate the mashed potatoes, eating approxiately 30% of the lunch meal.</p> <p>Observation of Resident #5, on 07/18/12, at breakfast revealed he/she ate almost all of his/her breakfast which consisted of, oatmeal, orange juice, a scrambled egg, and a fortified shake. The resident consumed 85% of the meal.</p> <p>Review of Resident #5's clinical record revealed he/she was admitted to the facility on 06/28/12. A baseline weight at the time of admission was 100.4 lbs. On 07/12/12 at the clinical meeting the dietitian ordered fortified shakes for thr resident. The weight for the resident was ordered monthly.</p> <p>Review of the July monthly weights revealed the July weight was obtained on 07/02/12 at which time the resident weighed 100.0 lbs.</p> <p>A weight was obtained on 07/19/12, at which time, the resident's weight was 94.4 lbs. > 5% weight loss in sixteen (16) days.</p>	F 325	F 325 Cont	8/30/2012	



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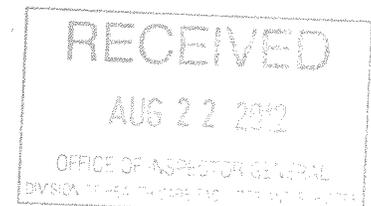
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F 325	Continued From page 17 Interview with the Dietitian, on 07/18/12 at 3:34 PM, revealed the weight schedule had not been adjusted to monitor the resident's weight. She further explained, since the resident was on a 2600 calorie diet, the resident would receive 1300 calories, if the resident ate half her diet. The Dietitian calculated a BMI of 17.8 for the resident. The Dietitian confirmed the procedure had not been followed and the resident had not received adjustments to account for the difficulty in chewing due to the neck brace. In addition, the Dietitian stated nursing could also have adjusted the resident's weight schedule. Interview with the Director of Nursing (DON), on 07/19/12 at 8:10 AM, revealed the protocol was to get an admission weight and then weigh every month. When the resident was placed on a fortified shake it would have been reasonable for the resident to have been placed on a more frequent weight. The facility contacted the physician's office on 07/17/12 to see if the upper part of the brace could be removed during the meal and they have not responded to the facility yet. However, they (the facility) had not tried to make contact again with the physician.	F 325			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	1. All foods not sealed, labeled or dated in one freezer and refrigerator were removed and disposed of immediately. The stove/oven and deep fryer were cleaned following notification by the surveyor that day. Male staff were instructed to wear proper beard cover at all times.		



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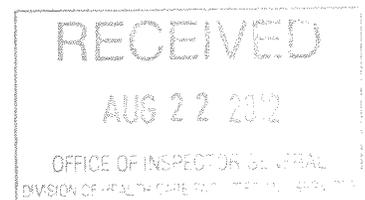
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F 371	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to ensure open foods were sealed, labeled, and/or dated in one (1) of one (1) freezer and one (1) of one (1) refrigerator. The facility failed to ensure kitchen appliances were clean for two (2) of two (2) appliances (stove/oven and deep fryer). The facility failed to ensure the ice scoop in one (1) of two (2) dining rooms was not stored in the ice. In addition, the facility failed to ensure the kitchen staff wore beard covers for one male staff. The findings include: Tour of the kitchen, on 07/17/12 at 8:15 AM, revealed two (2) open packages of green beans on the shelf in the refrigerator, four (4) opened gallon containers of salad dressings without dates to indicate when they were opened, and an outdated container of tuna salad. The tuna salad was prepared on 07/02/12 and had expired on 07/09/12. The freezer had an opened box of pork patties. There was no date on the box and the patties were loose in the box, and unwrapped. Continued observation, at this time, revealed a brownish/black substance on the side of the fryer, inside the convection oven doors and a clear, shiny substance on the lid of the fryer. In addition, one (1) male kitchen staff did not have his beard covered and a contaminated ice scoop was sitting in the ice bowl in the dining room.	F 371	F 371 cont 2. No residents were found to be affected as evidenced by no acute illnesses reported or noted. 3. Dietary staff will be re-educated by Home Office Dining Services Support person on policies related to Proper Food Storage, Safe food handling, required cleaning of all equipment, and proper hair restraints to be worn at all times in kitchen. Re-education will be completed by 8/15/2012. 4. Completion of daily sanitation checklist will be done by AM and PM Cooks and will be reviewed weekly X3 months by Director of Food Service to maintain compliance with all policies and procedures. Director of Food Services will complete monthly audits X3 months of all sanitation policies and procedures. Dinning Service Support and Dietitian will each complete one kitchen sanitation audit quarterly.		



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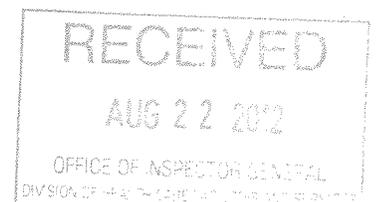
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185466	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2012
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F 371	Continued From page 19 Review of the kitchen's daily cleaning schedule revealed all scheduled cleaning had been initiated as completed; however, the stove, fryer, and oven have a brownish/black substance on them. There was also a shiny, clear substance on the lid and sides of the fryer. Interview with the Assistant Director of the kitchen, on 07/18/12 at 11:40 AM, revealed some of the area's on the cleaning schedule (the fryer, stove, and oven) needed further cleaning. Interview with Cook #1, on 07/18/12 at 11:45 AM, revealed he wiped the fryer and oven with a damp rag and disinfectant daily. He could not confirm when these items had last been treated with a cleaning agent. Interview with Cook #2, on 07/18/12 at 11:50 AM, revealed he cleaned the oven and stove top weekly with an oven cleaner. Residue of the spray cleaner, a white substance, was seen on the side of the grill. He had no explanation for why the residue of the cleaner had not been removed.	F 371	F 371 Cont Results will be followed in the monthly QA meeting as presented by Food Service Director. Compliance will be monitored and corrective action plans required when out of compliance. The Executive Director will be responsible for monitoring plans to insure compliance is maintained.	8/30/2012
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441	F 441 1. Residents A and B were assessed to insure no negative outcomes (infections) as a result of improper handling of glucometer. 2. All residents receiving accuchecks have the potential to be affected. No evidence of infection was found. All residents receiving accuchecks will be assessed for signs of infection by DHS, ADHS on or before 8/11/2012.	



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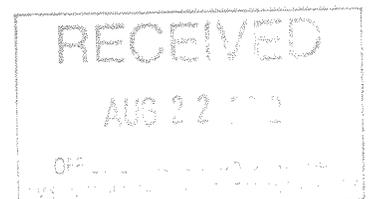
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F 441	Continued From page 20 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, Guidelines for Accuchecks/Glucometer Maintenance, it was determined the facility failed to ensure a glucometer was handled and cleaned in a manner to prevent contamination and to prevent disease for two (2) of two (2) unsampled	F 441	F 441 cont 3. DHS and ADHS re-educated Nurses on proper cleaning of glucometer before and after accuchecks on 08/15-16/2012. Nurses were also re-education on the proper storage of glucometer and the proper use of gloves during this procedure. Nurses were required to complete return demonstration on cleaning and storage of glucometer with proper use of gloves. 4. All employees are trained on the infection control policy upon hire and then annually as required by regulation. Nurses will participate in annual competency check off on proper cleaning, storage of the glucometer and the proper use of gloves. DHS or ADHS will randomly audit 5 nurses on the use of glucometer monthly X3 months and then quarterly for 2 quarters. Results of the audits will be reported by DHS or ADHS to the monthly QA meeting, where compliance will be monitored and action plans required when out of compliance.	8/30/12



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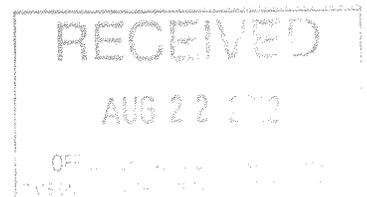
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F 441	<p>Continued From page 21 residents observed during blood glucose testing. Unsamped Residents A and B.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Guidelines for Accuchecks/Glucometer Maintenance, not dated, revealed: number 7, Glucometer machines shall be cleaned between residents; and number 8, Glucometer machines and testing supplies shall be stored according to manufacture's recommendations. Review of the manufacture's recommendations for the storage of glucometer machines revealed the machines should be stored in the container in which they were received. Review of a skills checklist regarding the glucometer machine for nurses revealed the nurse cleans the Glucometer surface after each use with a Sani wipe and properly stores the glucometer.</p> <p>Observation of Unsamped Resident A's blood glucose testing during a medication pass, on 07/18/12 at 11:35 AM, revealed LPN #1 cleaned the glucometer with a Sani wipe after use and then dropped the glucometer into her scrub top pocket which contained an ink pen, a tissue, and the vial of blood glucose testing strips. LPN #1 also dropped a pair of gloves she had used during the blood glucose testing procedure with Unsamped Resident A into the same pocket with the glucometer. Further observation, on 07/18/12 at 11:45 AM, revealed LPN #1 did not clean the glucometer which she removed from her pocket with a Sani wipe prior to using the machine for the blood glucose testing on Unsamped Resident B.</p>	F 441			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 22</p> <p>Interview with LPN #1, on 07/19/12 at 2:30 PM, revealed the glucometer machines were stored in a drawer in the medication carts. She stated the machines were cleaned at the beginning of each shift by a nurse but she knew they were to be cleaned prior to use with each individual resident. LPN #1 further stated she was unaware she had dropped the glucometer machine in her scrub top pocket as it was just a habit and she did not realize she was contaminating the machine prior to use with the second unsampled resident. She stated she was trained on cleaning the glucometer machines after use with a resident but did not remember being trained on cleaning the machines prior to use with each resident. LPN #1 stated the use of a contaminated glucometer machine could be a potential cause for the spread of infection.</p> <p>Interview with the Director of Nursing, on 07/19/12 at 5:35 PM, revealed it was her expectation that the nurses cleaned the glucometer machines prior to use with all residents and they were not to place the machines in their clothing pockets at any time. She indicated the effect of using a contaminated glucometer machine on a resident for blood glucose testing would include the potential spread of infection.</p>	F 441			



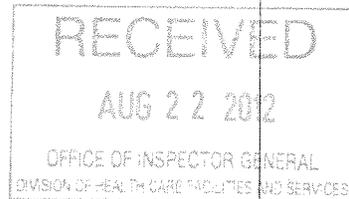
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 2010</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet and dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 07/17/12. Westport Place Health Campus was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has fifty (50) certified beds with a census of forty three (43) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		
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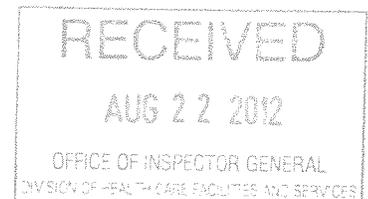
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Dir* (X6) DATE *8/21/12*

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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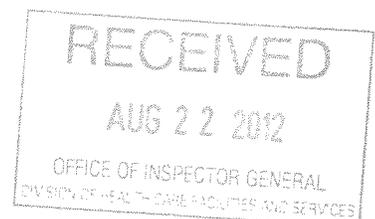
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K 000	Continued From page 1	K 000		
K 011 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire/smoke barrier walls were capable of resisting the passage of smoke in a common wall with a nonconforming building in the event of a fire. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff, and visitors. The facility has fifty (50) certified beds with a census of forty three (43) the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/17/12 at 10:07 AM, with the Director of Plant Operations revealed the fire barrier wall separating the Skilled Nursing Facility from the Assisted Living Facility, had penetrations by pipes that were not sealed with a rated material equal to the wall.</p>	K 011	<p>K 011</p> <ol style="list-style-type: none"> 1. No residents affected by cited deficiency. 2. Director of Plant Operations (DPO) performed maintenance on all smoke barriers including the common wall shared with nonconforming building. DPO applied intumescent firestop sealant that has been tested in accordance with ASTM E814 (UL149) to all smoke barrier penetrations. 3. Work completed on 07/18/2012. 4. DPO is to make monthly inspections on all smoke barriers and repair any penetrations with UL rated firestop sealant. DPO will report findings of inspections monthly in QA meeting. Executive Director will be responsible for monitoring audits to insure compliance is maintained. 	8/30/2012



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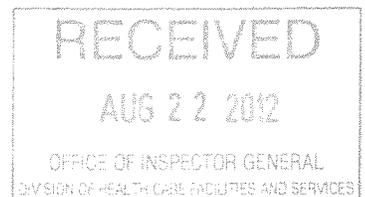
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K 011	Continued From page 2 Interview, on 07/17/12 at 10:07 AM, with the Director of Plant Operations revealed he was unaware of the penetrations and confirmed the observation. Reference: NFPA 101 2000 edition 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that	K 011		



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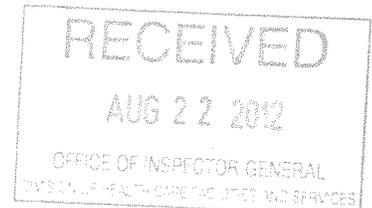
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K 011 K 018 SS=F	Continued From page 3 is designed for the specific purpose. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors protecting corridor openings were constructed to resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility has fifty (50) certified beds with a census of forty three (43) on the day of the survey. The findings include: Observation, on 07/17/12 between 1:00 PM and 2:45 PM, with the Director of Plant Operations revealed the corridor doors to room numbers; 101, 103, 108, 109, 111, 113, 116, 201, 205, 206, 212, 303, 304, 306, 309, 311, 312, 313, 314, and 315 had a gap too large around the jamb and would not resist the passage of smoke.	K 011 K 018	K 018 1. No residents affected by cited deficiency. 2. Director of Plant Operations to install weather striping on corridor doors to rooms 101, 103, 108, 109, 111, 113, 116, 201, 205, 206, 212, 303, 304, 306, 309, 311, 312, 313, 314, and 315 to ensure smoke resistant seal. 3. Work completed on 08/09/2012. 4. DPO to conduct monthly inspections. DPO will present findings as part of monthly QA meeting in which Executive Director will be responsible for insuring compliance is maintained. Non compliance will result in corrective action plan being developed.	8/30/2012	



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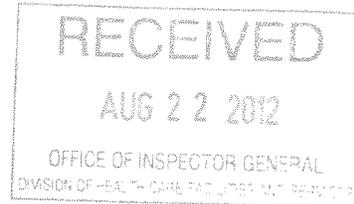
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K 018	<p>Continued From page 4</p> <p>Interview, on 07/17/12 between 1:00 PM and 2:45 PM, with the Director of Plant Operations revealed he was not aware of the doors having a gap that would not resist the passage of smoke.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction.</p>	K 018		



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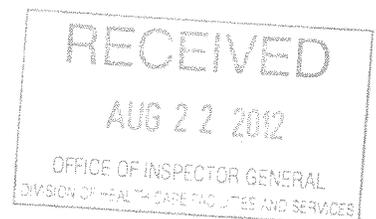
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K 018	Continued From page 5 The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 This STANDARD is not met as evidenced by: Based on staff interview and observation, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility has fifty (50) certified beds with a census of forty three (43) on the day of the survey. The findings include: Observation and record review, on 07/17/12 at 11:00 AM, with the Director of Plant Operations revealed the emergency lights with battery backup located throughout the facility were not tested for 1-1/2 hours within the last year. Interview, on 07/17/12 at 11:00 AM, with the Director of Plant Operations revealed he was not aware the emergency battery lighting had to be tested annually for 1-1/2 hours.	K 046	K 046 1. No residents affected by cited deficiency. 2. Most recent 1.5 hour test performed on 8/7/12. 3. DPO reeducated by Divisional DPO related to performing testing of emergency backup lighting for 1.5 hours test annually. Education completed on 8/16/12. 4. Monthly and annual testing will be recorded on Plant Operations monthly Life Safety check list and will be reviewed at monthly QA meeting.	8/30/2012



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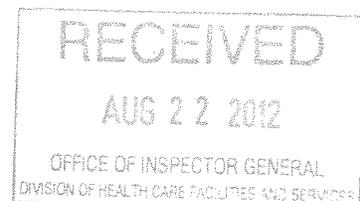
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K 046	Continued From page 6 Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		



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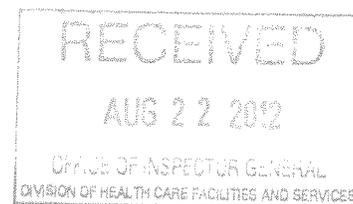
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K 050 SS=F	Continued From page 7 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for 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. 18.7.1.2 This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility has fifty (50) certified beds with a census of forty three (43) on the day of the survey. The findings include: Fire Drill record review, on 07/17/12 at 11:18 AM, with the Director of Plant Operations revealed the fire drills were not being conducted at unexpected times under varied conditions. First shift fire drills were being conducted predictably between 10:47 AM and 11:17 AM, second shift was being conducted between 2:40 PM and 3:30 PM, and third shift was being conducted between 10:45 PM and 11:03 PM. Interview, on 07/17/12 at 11:18 AM, with the	K 050	K 050 1. No residents affected by cited deficiency. 2. The next fire drill will be held according to regulations on 08/14/2012 at 10:00 am. (first shift) 3. Director of Plant Operations will conduct fire drills quarterly on each shift at random times. 4. Fire Drill reports will be discussed monthly in QA meeting by DPO. Any non compliance will require corrective action plan be developed. Executive Director will monitor compliance.	8/30/2012	



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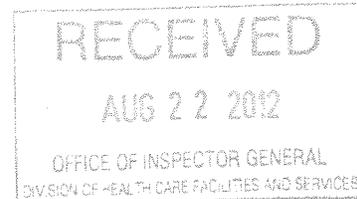
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K 050	Continued From page 8 Director of Plant Operations revealed they were unaware the fire drills were not being conducted as required. Reference: NFPA 101 Life Safety Code (2000 Edition). 18.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050			
K 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. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3)	K 062			



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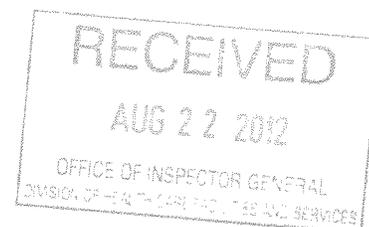
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K 062	<p>Continued From page 9</p> <p>smoke compartments, residents, staff and visitors. The facility has fifty (50) certified beds with a census of forty three (43) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 7/17/12 at 10:26 AM, with the Director of Plant Operations revealed insulation on sprinkler heads located sporadically throughout attic. The attic was insulated with blow in type insulation which can blow around the attic during high wind weather conditions and attach itself to the sprinkler heads causing an obstruction to the spray pattern. Further observation revealed two sprinkler heads in the attic to have the original orange plastic shipping block still attached to them to prevent damage during installation. The shipping blocks had the phrase remove after installation molded into the plastic. The shipping blocks were found on a sprinkler head located in the attic above the Therapy Room, also above the staff lounge.</p> <p>Interview, on 7/17/12 at 10:26 AM, with the Director of Plant Operations revealed he was not aware the insulation had blown around and attached itself to some of the sprinkler heads, and he was also not aware of the shipping blocks that were not removed after the sprinklers were installed.</p> <p>Observation, on 7/17/12 at 2:45 PM, with the Director of Plant Operations revealed the sprinkler head located in the 100 Hall Med Room was missing the escutcheon (trim ring), and paint</p>	K 062	<p>K 062</p> <ol style="list-style-type: none"> 1. No residents affected by cited deficiency. 2. Bullitt County Sprinklers inspected all attic areas for sprinkler head shipping blocks on 7/19/12. 3. Director of Plant Operations conducted inspection of attic for the purpose of cleaning all sprinkler heads of insulation and other obstructions on 7/19/12. 4. Director of Plant Operations to conduct quarterly inspections of all sprinkler heads located in attic to insure they are free of all obstructions. Director of Plant Operations to conduct Monthly inspections of all escutcheon rings in common areas, resident rooms and work areas. All inspection reports will be presented by DPO to QA committee monthly. compliance will be monitored by Executive Director and Home Office Divisional DPO support. 	8/30/2012	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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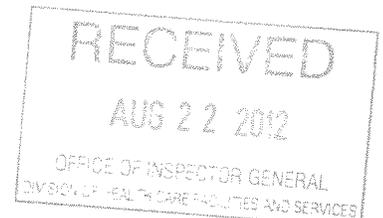
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K 062	<p>Continued From page 10 was on the sprinkler head.</p> <p>Interview, 7/17/12 at 2:45 PM, with the Director of Plant Operations revealed he was not aware of the missing escutcheon, or the paint on the sprinkler head.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.</p> <p>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. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy</p>	K 062		



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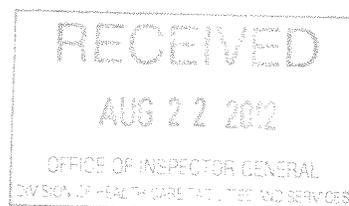
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K 062	Continued From page 11 (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 062		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility has fifty (50) certified beds with a census of forty three (43) on the day of the	K 144	K 144 1.No residents affected by the cited deficiency. 2. Vanguard Sales and service inspected generator for correct operation. Generator battery was cleaned and anti-corrosion material applied to battery terminals on 7/30/12. 3. Director of Plant Operations will visually inspect battery terminals during weekly inspections. Results of these inspections will be presented by DPO during monthly QA meetings. 4. Executive Director will monitor compliance and require corrective action plans for non compliance.	8/30/2012



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K 144	<p>Continued From page 12 survey.</p> <p>The findings include:</p> <p>Observation, on 7/17/12 at 1:48 PM, with the Director of Plant Operations revealed the generator battery had a buildup of corrosion on the positive terminal.</p> <p>Interview, on 7/17/12 at 1:48 PM, with the Director of Plant Operations revealed he had not noticed the corrosion on the battery during his weekly inspections.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established</p> <p>6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p> <p>6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the</p>	K 144			



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K 144	Continued From page 13 transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff, and visitors. The facility has fifty (50) certified beds with a census of forty three (43) on the day of the survey. The findings include: Observation, on 07/17/12 at 2:20 PM, with the Director of Plant Operations revealed a microwave plugged into a power strip that was plugged into another power strip located in the Director of Health Services Office. Interview, on 07/17/12 at 2:20 PM, with the Director of Plant Operations revealed he was not aware of the misuse of power strips. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the	K 147	K 147 1. No resident affected by cited deficiency. 2. Director of Plant Operations removed microwave and 1 power strip 7/17/12. DHS in-serviced on proper use of power strips. 3. DPO to in-service all management staff on proper use of equipment and power strips 8/14/2012. 4. Director of Plant Operations will make monthly facility audits for proper use of power strips and appliances x3 months, and then continue quarterly audits, those will be reported to safety committee for monitoring and compliance.	8/30/2012



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K 147	Continued From page 14 intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147			

