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

PRINTED: 03/16/2010
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 _____ B. WING _____	03/03/2010

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 03/01/10 through 03/03/10 and a Life Safety Code survey was 03/04/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct before remedies would be recommended for imposition. An abbreviated survey investigating KY00014259 and KY00014244 was initiated on 03/01/10 and concluded on 03/03/10. KY00014259 and KY00014244 were unsubstantiated with no deficiencies cited.	F 000	**This plan of correction is not submitted as an admission of guilt related to the deficiencies as stated herein, but rather to comply with the regulatory process.**	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the Hydrocollator was plugged into a Ground Fault Interrupter (GFI). In addition, the facility failed to repair resident equipment; three (3) wheelchairs, and one (1) Geri-chair although replacement parts were available. The findings include: 1) Observation on 03/03/10 at 2:00pm revealed the Hydrocollator located in the Physical Therapy room was not plugged into a GFI outlet. Interview with the Physical Therapist on 03/03/10 at 1:00pm revealed he was not aware that the	F 253	<u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice-</u> The hydrocollator was immediately removed from resident care areas. A single portable GFI adapter was purchased for the hydrocollator so that the circuit will be protected no matter where the unit is used. Since the unit is portable, the GFI adapter will be attached to the hydrocollator, this will permit its use in any location. <u>How the facility will identify other residents having the potential to be affected by the same deficient practice-</u> All residents who receive PT services have potential for being affected by this practice. The use of a portable GFI adapter will protect all residents and staff who utilize the hydrocollator. <u>Measures put into place or systematic changes made to ensure that the deficient practice will not recur-</u> A sign has been placed on the hydrocollator which says that it can only be used with the GFI adapter.	03/26/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jerry C Hogansen
TITLE: Administrator
(X6) DATE: 3-26-10

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 253	Continued From page 1 Hydrocollator was not plugged into a GFI outlet. He stated it should be or it could cause a fire. Interview with The Assistant Director of Nursing on 03/03/10 at 1:10pm revealed she did not know the Hydrocollator needed to be plugged into a GFI outlet. She stated that a couple of years ago the facility had someone come in and install GFI outlets in the facility where they were needed. She stated this is not where the Physical Therapy room has always been. Interview with the Maintenance supervisor on 03/03/10 at 1:15pm revealed he had seen the Hydrocollator but did not know what it was. After he found out what it was by the surveyor and saw it had water in it, he knew it was supposed to be plugged into the GFI outlet. He stated if it's not on a GFI outlet it could potentially shock someone. 2) Observation on 03/03/10 at 9:15am revealed three (3) wheelchairs with armrests cracked, ripped or torn. The wheelchairs assigned to rooms N5-1, N5-2, and N8-1 had armrests cracked, ripped, or torn with the white material under the covering exposed with sharp edges. The Geri-chair belonging to the resident in N10-1 had splitting at the seams on the cushion above the head. The right and left side of the cushion had areas of two (2) inches in length and one (1) inch wide openings with foam exposure. The facility removed this chair and sent it to the maintenance room after surveyor intervention. Interview with the Maintenance supervisor on 03/03/10 at 9:30am revealed every nurse's station has a maintenance log, and they depend on staff to write problems down on the log. He stated he	F 253	How the facility plans to monitor its performance to ensure that solutions are sustained- The facility's director of maintenance will conduct routine, monthly, inspections of the equipment to ensure that it is being used in a safe manner. The findings will be reported to the Performance Improvement and Quality Assurance Committees for their review and recommendations; quarterly to the Quality Assessment and Assurance Committee for their review and recommendations, if any. What corrective action will be accomplished for those residents found to have been affected by the deficient practice- It is the responsibility of the housekeeping department to inspect the wheelchairs and geri-chairs during their **weekly** cleaning. If damage is noted during cleaning, the information shall be documented on the maintenance log so that the repair can be initiated. If the housekeeping staff feels that damage is a safety hazard, the chair will be immediately taken to the shift supervisor, then the chair shall be pulled from service and a replacement chair shall be provided for the resident. Also, all housekeeping, etc has received "On-the-Spot" and the policy and procedure and has been revised to reflect these changes. Reports will be made to the Quality Assurance Committee for their review and recommendations, if any.	

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F 253	Continued From page 2 only remembered one (1) wheelchair being put on the log and that wheelchair was repaired. He stated that his department does a Quarterly Environment check and repair things that they find broken. The Maintenance Supervisor indicated they did get a shipment of six (6) armrests for wheelchairs in February, but was not sure which wheelchairs needed them. Interview with the Housekeeping Supervisor on 03/03/10 at 10:05am revealed housekeeping washes the wheelchairs and Geri-chairs once a week. They are to inspect for damage and write any needed repairs on the maintenance log. She stated she did not think the wheelchairs or Geri-chair identified by the surveyor were listed on the maintenance log. It is everyone's responsibility to look for damage to the resident's equipment and report it on the maintenance log. Residents with chairs in disrepair have a potential for contamination, and injury. Interview with the Charge Nurse on 03/03/10 at 10:15am revealed it is everyone's responsibility to ensure that resident equipment is in good repair to ensure safety for the residents. Record review on 02/05/10 revealed the facility placed a purchase order for six (6) padded armrest for wheelchairs, and they were shipped from Direct Supply on 02/10/10. Facility policy on Maintenance Repair Request effective 02/25/02, revised, 04/06, and 09/07 revealed all request for maintenance repairs will be written either on the Maintenance Log or E-mail. Request will be written on the maintenance log by any staff member who identified a maintenance issue requiring repair.	F 253	How the facility will identify other residents having the potential to be affected by the same deficient practice- All residents in the facility who use geri-chairs or wheelchairs are equally affected by this practice. Measures put into place or systematic changes made to ensure that the deficient practice will not recur- The policy and procedure for cleaning wheelchairs and geri-chairs has been revised to include specific procedures for nursing staff and housekeeping staff to identify and report damages to equipment. An On-the-Spot in-service has been put into place to ensure that both department are aware of this policy change. How the facility plans to monitor its performance to ensure that solutions are sustained- The facility's director of maintenance will conduct routine, monthly, inspections of the equipment to ensure that the equipment does not have damaged armrests or seats. The findings will be reported to the Performance Improvement and Quality Assurance Committees for their review and recommendations; quarterly to the Quality Assessment and Assurance Committee for their review and recommendations, if any.	

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F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure the Emergency Drug Box contained medications that were not expired. One (1) Emergency Drug Box had ten (10) expired medications. The findings include: Observation on 03/02/10 at 3:30pm revealed a sticker on top of the emergency drug box that stated expired 05/2010, but the emergency box had ten (10) expired medications. The	F 425	What corrective action will be accomplished for those residents found to have been affected by the deficient practice- The emergency box that contained expired medications was immediately removed from the facility and a replacement box was delivered by the pharmacy. The new emergency box delivered was immediately checked to ensure that all medication were not expired and would not expired before the next emergency box exchange in one week. How the facility will identify other residents having the potential to be affected by the same deficient practice- All residents in the facility have the potential of being affected by this practice, since all receive medication. Measures put into place or systematic changes made to ensure that the deficient practice will not recur- D&R Pharmacy has conducted in-servicing and training with all technicians. The date on the outside of the emergency box has been removed since medications that are used during the week are replaced and the date cannot be guaranteed to correspond to the date on the emergency box. An On-the-Spot in-service has been provided to all nursing staff regarding the checking of dates of replacement medications to the emergency box.	03/26/10

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F 425	Continued From page 4 medications included: Diphenhydramine injection 50mg vial expired 02/2010, Furosemide injection 20mg vial expired 03/01/2010, Hydroxyzine 25mg tablets expired 01/2010, Promethazine injection 25mg expired 03/01/2010, Solumedrol injection 40mg expired 01/2010, Haloperidol injection 5mg/ml expired 01/2010, Chlorpromazine 25mg expired 01/2010, Erythromycin tablets 250mg expired 02/2010, Phenytoin sodium tablets 100mg expire 02/2010, and Penicillin VK tablets 250mg expired 03/01/2010. There were twelve (12) receipts of medications signed out from 02/25/10 through 03/02/10 from the emergency box creating twelve (12) opportunities for error. Interview with the Assistant Director of Nursing (ADON) on 03/02/10 at 4:00pm revealed the emergency box is switched every week. She continued to say she did not know why the medications were expired but she would call the pharmacy to get a replacement. She stated it is the responsibility of the nurse who removed medication from the emergency box to check the expiration date, and the staff had not reported any drugs from the emergency box as being expired. A phone interview with the Operations Manager from the contract Pharmacy on 03/02/10 at 4:15pm revealed the emergency box is suppose to be changed every week. He continued to say it was the Pharmacies responsibility to ensure the medications supplied were not expired. He stated that they had a new Technician, who had only been there three (3) weeks and she did not understand that she was suppose to check for expired drugs every time the box was returned. Interview with the Operations Manager from the contract pharmacy at the facility on 03/03/10 at	F 425	How the facility plans to monitor its performance to ensure that solutions are sustained- A weekly audit shall be performed by the night shift staff when the new emergency box arrives to ensure all medication are in date. All medications found out of date shall be immediately removed from the emergency box and sent back to pharmacy for replacement. A copy of the audit shall be sent to the Assistant Director of Nursing for immediate follow-up with the pharmacy. The findings will be reported to the Performance Improvement and Quality Assurance Committees for their review and recommendations; quarterly to the Quality Assessment and Assurance Committee for their review and recommendations, if any.	

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F 425	Continued From page 5 1:30pm revealed the pharmacy is responsible to ensure that the medication sent to the facility are not expired. He explained that the system was to have a quality technician to supply the medication correctly in the emergency box. He stated that the pharmacy does not have a routine second check of the box to ensure there are no expired medications. He stated that he and a Pharmacist do Quality Checks periodically, but had not found any problem. He stated that the potential for the resident who received expired medications was "not great". The facility policy 6.2.1.2.3 for Pharmacy Services effective 12/01/07 states that upon exchange, facility staff should review each drawer for appropriate expiration dating. The facility policy 5.4 for Pharmacy Services effective 12/01/07 states that facility staff should review the interim/stat/emergency supply for correct quantity and expiration.	F 425		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	<u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice-</u> All Nursing staff have participated in "on-the Spot Inservices" regarding feeding residents and proper handling of food with tray set-up. In addition Nursing Management is providing daily observation in the dining and individual staff in-servicing as concerns are identified. A sink for hand washing is being installed in the main dining room.	04/05/10

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F 441	Continued From page 6 (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 and record review it was determined the facility failed to ensure the staff practiced safe food handling. Observations of the breakfast meal on 03/02/10 at 8:00am, 03/03/10 at 8:00am and observation of the lunch meal on 03/02/10 revealed four (4) State Registered Nursing Assistants (SRNA) touching the resident's food with their bare hands for nine (9) of the twenty one (21) sampled residents (#1, #3, #8, #11, #17, #18, #19, #20 and #21). In addition, there was no hand sanitizing before or after handling the resident's food. The findings include:	F 441	How the facility will identify other residents having the potential to be affected by the same deficient practice- All residents in the facility have the potential of being affected by this practice. Measures put into place or systematic changes made to ensure that the deficient practice will not recur- The policy for Feeding resident in the Dependent Dining Room and Independent Dining Room has been updated to address infection control concerns. All staff have been in-serviced on the policy changes. Measures put into place or systematic changes made to ensure that the deficient practice will not recur- An audit has been developed and shall be performed monthly. The findings will be reported to the Performance Improvement and Quality Assurance Committees for their review and recommendations; quarterly to the Quality Assessment and Assurance Committee for their review and recommendations, if any.	

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F 441	Continued From page 7 Observation of the breakfast meal on 03/02/10 at 8:00am revealed SRNA #1 holding one strip of bacon in her bare hands and feeding it to Resident #17. No hand sanitizing was observed. The SRNA then picked up the utensils of the other residents and continued to assist feeding them breakfast. Observation of the breakfast meal on 03/03/10 at 8:00am revealed SRNA #1 holding Resident #19's toast in her bare hands while applying butter. She then laid the toast on the resident's plate for consumption. No hand sanitizing was observed. She continued to assist the other residents with their meal as well as intermittently feeding Resident #19 their toast with bare hands. Interview with SRNA #1 on 03/03/10 at 9:45am revealed the SRNA had worked at the facility for approximately three (3) weeks. She was unaware that touching a resident's food with her bare hands was a problem. Further interview with the SRNA revealed how touching food with her bare hands, and feeding it to a resident could transfer germs into their mouth, and cause them to become ill. Interview with the Restorative Nurse on 03/03/10 at 12:35pm revealed all staff are educated upon hire and in-serviced throughout the year on infection control. She also stated that germs can easily be transmitted to the residents when food handling contamination occurs. When the food is then ingested by the resident an illness can occur. Observation of the breakfast meal on 03/03/10 at 8:15am revealed SRNA #2 feeding Resident #16.	F 441		

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F 441	Continued From page 8 The SRNA dropped the resident's toast onto the resident's breakfast tray from the resident's plate. SRNA#2 then picked up the toast with her bare hands and handed it to the resident for consumption. She continued to assist the other residents with feeding, no hand washing or hand sanitation observed. Interview with SRNA #2 on 03/03/10 at 10:25am revealed she was not to touch the resident's food with her bare hands because the germs on her hands could be transmitted to the resident. She had been in-serviced many times both at the facility and through her agency on infection control and food handling. Observation of the lunch meal on 03/02/10 at 12:30pm revealed SRNA #4 served a food tray to Resident #19 for consumption. She handled inanimate objects and opened packages, then proceeded to pick up a peanut butter sandwich with bare hands and handed the peanut butter sandwich to Resident #19 who then proceeded to eat the peanut butter sandwich. The SRNA did not use hand sanitizer during food service to the residents. She continued to assist the other residents at the table with their meal, as well as intermittently feed Resident #19. The SRNA picked up a cookie bare handed and placed the cookie to Resident #20's mouth for consumption. She continued to touch the food of Resident #19 and Resident #20 without regards to handwashing or hand sanitizing. Interview with SRNA #4 on 03/03/10 at 2:26pm revealed that she was aware she was not to touch the resident's food with her bare hands because the germs on her hands could be transmitted to the resident. She stated that she	F 441		

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F 441	Continued From page 9 had been in-serviced many times at the facility on infection control and food handling. Observation of the breakfast meal on 03/03/10 at 8:27am revealed SRNA #1 holding Resident #18's toast in her bare hands while applying butter. She then laid the toast on the resident's plate for consumption. The SRNA did not use hand sanitizer during food service to the residents. She continued to assist the other residents with their meal, as well as intermittently holding food with bare hands and feeding Resident #18. Observations of Resident #1 and Resident #8 on 03/03/10 at 8:10am revealed an SRNA to butter toast using bare hands. The SRNA then repositioned Resident #1, placed her bare hand in the pocket of her uniform and continued to feed Residents #1 and #18. The SRNA tore the slices of toast into pieces on each plate and proceeded to place these pieces of toast in the mouths of Resident #1 and #8 without the SRNA sanitizing or washing their hands. Observation of the lunch meal on 03/02/10 at 12:40pm revealed SRNA #3 served the tray for Resident #3 and Resident #21. She handled inanimate objects, opened condiments, and commented the food appeared hot. She placed the 5th digit of her left hand into the mashed potatoes and gravy of Resident #21, and stated, "that's too hot". She wiped the food substance from her finger with the resident's napkin, and returned the napkin to the tray for the resident's use. SRNA #3 stirred the food and continued to feed Resident #21 from the food plate that she tested with her 5th digit (little finger). The SRNA did not use hand sanitizer during the meal assist.	F 441		

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F 441	Continued From page 10 SRNA #3 checked the temperature of Resident #3's food as she placed the 5th digit (little finger) of her left hand into the ground meat served on the resident's plate. The SRNA wiped her finger off with the resident's napkin, placed the napkin back on the tray for future use, and continued to feed Resident #3. Interview with SRNA #3 on 03/03/10 at 2:20pm revealed she was not to touch the resident's food with her bare hands because the germs on her hands could be transmitted to the resident. She had been in-serviced many times at the facility on infection control and food handling, and should have not touched the resident's food with her bare hands. Record review of the Hand Washing Policy revealed hands shall be washed before and after each resident contact (even if gloves are worn). Personnel shall always wash their hands between all resident contacts and after contact with a source that is likely to be contaminated with virulent microorganisms or pathogen such an object or device contaminated with secretions or excretions from residents.	F 441		

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

Wesley Manor Health Care Center F253

On The Spot In-service

All Nursing Staff

Date: March 16, 2010

Topic: Repairs of Wheelchairs and Geri-chairs

Discussion: State Survey Plan of Correction 2010. It was noticed during our state survey that we had multiple wheelchairs and geri-chairs with foam exposed and in need of repair (This creates an infection control risk for the staff and the residents). When doing your daily resident care monitor for chair repairs and place repairs on the maintenance log. The maintenance staff will determine what parts to order and will do immediate repairs to ensure the chair is safe for use.
If at any time you feel that any chair is unsafe for resident use, if there is a large cut in the fabric exposing the foam causing a infection control issue, a risk for resident injury, or other mechanical error please take the chair out of service and notify the shift supervisor immediately so that a replacement chair can be found to provide proper care for the resident,

Thanks Deanna Young RN

Attendance Signatures: Please initial by typed name

Shepherds (South) Wing	Peters (West) Wing	Slider (North) Wing	Shift Supervisor/Ancillaries

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

Wesley Manor Health Care Center F441

On The Spot In-service

All Nursing Staff

Date: March 16, 2010

Topic: Feeding residents and proper handling of food with tray set-up
2010 Plan of Correction

Discussion: Please see the changes in the policy related to feeding residents. It is critical that when feeding residents and setting up the resident's tray that food is not handled with our bare hands. Gloves must be worn when setting up the residents tray and then your hands shall be washed or hand sanitizer used between each tray set-up.
We are having a sink installed in the main dining room, there is a sink in the Peters Wing dining area and there is a sink outside of the independent dining room. There will be extra glove stations installed in all dining areas to ensure that everyone has plenty of access to gloves. You are responsible for keeping hand sanitizer on you at all times.

This is an infection control issue when we go from one resident's tray to another and are not wearing gloves or practicing hand washing between trays.

This was a State Survey Deficiency and part of the plan of correction. This will be part of the ongoing quality assurance process that we will be auditing to ensure that staff are practicing safe handling of food when setting up resident trays.

See Deanna or Amy if you have questions or concerns.
Thanks Deanna Young RN

Attendance Signatures: Please initial by typed name

Shepherds (South) Wing	Peters (West) Wing	Slider (North) Wing	Shift Supervisor/Ancillaries

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DIVISION OF HEALTH CARE FACILITIES CARE SERVICES

Wheelchair and Geri-chair Audit

F253

Resident	Was W/C or g-chair in need of repair		If yes, was replacement parts ordered		Was chair able to have temporary repair until parts arrive		If, no was a suitable replace chair found for resident.	
	Yes	No	Yes	No	Yes	No	Yes	No

Comments:

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HEALTH & HUMAN SERVICES AND SERVICES

Completed by:_____ Date: _____

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OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS

F252

ATTENTION

Hydrocollator can only be used with the GFI adapater

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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE

SUBJECT: F441 FEEDING RESIDENTS IN THE DEPENDENT DINING ROOM AND INDEPENDENT DINING ROOM	REFERENCE #
DEPARTMENT: WESLEY MANOR HEALTH CARE CENTER	PAGE: 1 OF: 4
	EFFECTIVE:
APPROVED BY: Resident Care Policies Committee	REVISED: 1/06, 10/07, 9/09, 3/10

POLICY:

To ensure that all residents are assisted with meals or fed properly in a timely manner.

PROCEDURE FOR DEPENDENT DINING ROOM:

1. South Hall Nurse is in charge of the Dependent Dining Room, and any emergency that might occur, ensuring the dining room is operating properly.
2. Tray set up shall be as follows:
    a. Staff shall ensure that gloves are worn when setting up the tray and handling, or having direct contact with resident food (ei buttering toast or bread). Gloves shall be changed between setting up each resident's tray and hands washed or hand sanitizer used.
    b. Before adding items such as salt, pepper, sugar, jelly etc ask the resident for preferences when possible or try to obtain information from family.
    c. Remove all trash from tray before presenting the tray to the resident.
3. All staff shall feed all residents at the table at the same time, going from one resident to another alternating between food and fluids.
4. All staff shall attempt to engage the resident into conversation that is appropriate for the resident regarding their past life or old world events to help stimulate the resident during meal time.
5. All U-shape tables shall have 4 residents, 2 that require total feeding and 2 that require assistance with feeding, however, this ratio may change depending on the needs of the residents to up to 4 resident that require total feeding.
6. A staff person shall be assigned to each U-shape table for each meal, or may sit in the middle of two U-shaped tables (to form a circle). Attempts are made to have the same staff person feed at the same table(s) daily to increase continuity and to increase staff's knowledge about how to feed a particular resident and maintain intake.
7. All residents at each table shall receive their trays at the same time.
8. All residents shall be fed at each table at the same time by the staff person sitting inside the U of the table. Each staff person sitting inside the U of the table. Each staff person shall rotate around the table giving each resident a bite. ***Remember to alternate bites of food with drinks of fluids.***
9. Some tables may have all residents that require cueing ***only.*** All staff are responsible for monitoring these tables for intake and cueing as necessary.

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SUBJECT: F441 FEEDING RESIDENTS IN THE DEPENDENT DINING ROOM AND INDEPENDENT DINING ROOM	REFERENCE #
	PAGE: 2 OF: 4
DEPARTMENT: WESLEY MANOR HEALTH CARE CENTER	EFFECTIVE:
APPROVED BY: Resident Care Policies Committee	REVISED: 1/06, 10/07, 9/09, 3/10

10. Proper technique shall be used for set of and feeding of residents:
    - Hands shall be washed or alcohol gel used between each tray set up when staff touch the food on the residents tray
    - Tray set up using utensils and not touching food with your hands.
    - Hands shall be washed or alcohol gel used between feeding each resident if their food is touch during feeding.
11. All staff are responsible for documenting percentage of intake of the meal for the residents at the tables you are serving:
    - Intake sheets are separated by halls and are located in folders in the hanging racks on the back wall of the dining room.
    - The shift supervisor is responsible for updating and maintaining the intake sheets for North and South halls.
    - Intakes are recorded in percentages: 0%, 25%, 50%, 75% or 100%. Review the intake poster if needed to assist you in determining the percentage to chart for each resident.
    - Report to the hall nurse for residents that have intake of less than 25% for any meal.
    - Record fluid intake by adding up the amount of fluid taken for each meal. Keep in mind to encourage fluids during and between meals, the average resident needs between 1200-1500cc of fluid a day to maintain adequate hydration:
        - Drinking glasses=240cc
        - Juice glasses=120cc
        - Carton of milk= 240cc
        - Health shake=120cc
    - Breakfast and lunch are recorded on the same intake sheet, after lunch the South Hall nurse shall collect the intake sheets and take the sheets to the CNA charting room and intakes are recorded on the CNA flow sheets at the end of the shift.
    - Dinner is recorded on an intake sheet, after dinner the South Hall nurse shall collect the intake sheets and take the sheets to the CNA charting room and intakes are recorded on the CNA flow sheets at the end of the shift.
12. The restorative nurse/nurse aide shall determine the seating arrangement in the dining room. The restorative nurse/nurse aide shall maintain the dining seating chart, post and copy changes for the kitchen to ensure that trays are brought out according to the seating arrangement.
13. The restorative nurse/nurse aide shall maintain name tags on the tables in the dependent dining room, updating the name tags as the dining room arrangement changes.
14. Staff shall be arranged at tables in the dependent dining room as follows:

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SUBJECT: F441 FEEDING RESIDENTS IN THE DEPENDENT DINING ROOM AND INDEPENDENT DINING ROOM	REFERENCE #
	PAGE: 4 OF: 4
DEPARTMENT: WESLEY MANOR HEALTH CARE CENTER	EFFECTIVE:
APPROVED BY: Resident Care Policies Committee	REVISED: 1/06, 10/07, 9/09, 3/10

PROCEDURE FOR INDEPENDENT DINING ROOM:

1. The North Hall Nurse shall be in charge of the independent dining room
2. Resident that dine in the independent dining room shall be able to feed themselves or need minimal assist such as occasional cueing.
3. The nurse shall stay in the independent dining room until all resident have finished eating and are out of the dining room.
4 The nurse shall set up all trays for the residents, offer alternates, monitor and record intakes. The intake sheet shall be taken to the CNA charting room after lunch and after dinner for the CNA to record intakes on the flow sheets and the end of the shift.
5 Tray set up shall be as follows:
    a. Staff shall ensure that gloves are worn when setting up the tray and handling, or having direct contact with resident food (ei buttering toast or bread). Gloves shall be changed between setting up each resident's tray and hands washed or hand sanitizer used.
    b. Before adding items such as salt, pepper, sugar, jelly etc ask the resident for preferences when possible or try to obtain information from family.
    c. Remove all trash from tray before presenting the tray to the resident.

6. The nurse shall discuss with the shift supervisor and restorative nurse if changes occur and the resident is no longer appropriate for the independent dining room for appropriate interventions.
7. The North hall nurse shall go to the dependent dining room when all residents are out of the independent dining area to assist with feeding and transport. The

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

Wesley Manor Health Care Center F425

On The Spot In-service

All Nurses

Date: March 25, 2010

Topic: Emergency Medication Box

Discussion: State Survey Plan of Correction 2010. Our emergency box is replaced weekly. The pharmacy should ensure that when it is delivered that all medication in the box does not expire until the next box is delivered, however it is the facilities responsibility to ensure that all medications in the box are in date. Weekly audits will be done by the night shift nurse or CMT on the emergency box to ensure that all medications are within date. This will be done on the day the new box arrives.
When medications are used out of the box during that week a slip is completed and then that medication is replaced. It is critical that when replacing that medication to that box that the nurse replacing the medication check the expiration date and ensures that it will not expire for at least a week in order for the facility to remain in compliance.
See me if you have questions.
Thanks Deanna Young RN

Attendance Signatures: Please initial by typed name

Shepherds (South) Wing	Peters (West) Wing	Slider (North) Wing	Shift Supervisor/Ancillaries

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DIVISION OF HEALTH CARE

Omnicare, Inc

DAILY OPERATIONAL CHECK LIST (MONDAY-FRIDAY)

Date _____

Temperature logs _____

Weekly

E-kits sample check _____
Credits Sample _____
Perpetual inventory _____
Med Error report _____

REFILLS

	Responsibility	Time	Initials
9:00 am run complete	AM Tech	_____	_____
Refills Scanned & Printed	Lead Tech	_____	_____

	Responsibility	1pm Run Time	1pm Run Initials	7pm Run Time	7pm Run Initials
Last label print complete	Lead tech	_____	_____	_____	_____
(PV2) Screen Cleared (22).	Lead Tech	_____	_____	_____	_____
Delivery screen Cleared (23).	Lead Tech	_____	_____	_____	_____
Empty Hotel (To go in Tote).	Lead Tech	_____	_____	_____	_____
Delivery Receipts Printed & totes sealed.	Closing Tech	_____	_____	_____	_____
All Totes Have Left the Building.	Closing Tech	_____	_____	_____	_____
All Medical records & IV supplies are gone.	Closing Tech	_____	_____	_____	_____
1 Back-up Pumps available in delivery area. (Located in pump room)	Closing tech	_____	_____	_____	_____

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

Wesley Manor Health Care Center F253

On The Spot In-service

All Nursing Staff

Date: March 25, 2010

Topic: Cleaning of wheelchairs and geri-chairs

Discussion: State Survey Plan of Correction 2010. It was noticed during our state survey that we had multiple wheelchairs and geri-chairs with foam exposed and in need of repair (This creates an infection control risk for the staff and the residents).

Night Shift Staff: When placing the chairs out to be cleaned on Sunday night—inspect the chairs for damages and report the damages on the maintenance log. If you feel that the damages create a safety risk, report the issue to your supervisor and pull the chair from service and have it replaced with a safe chair for the resident.

All other staff: It is also your responsibility to notice and report damages to equipment. Safety is everyone's responsibility.

If at any time you feel that any chair is unsafe for resident use, if there is a large cut in the fabric exposing the foam causing a infection control issue, a risk for resident injury, or other mechanical error please take the chair out of service and notify the shift supervisor immediately so that a replacement chair can be found to provide proper care for the resident,

Thanks Deanna Young RN

Attendance Signatures: Please initial by typed name

Shepherds (South) Wing	Peters (West) Wing	Slider (North) Wing	Shift Supervisor/Ancillaries

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

Wesley Manor Health Care Center F253

On The Spot In-service

All Maintenance Staff

Date: March 16, 2010

Topic: Wheelchairs and geri-chairs in need of repair

Discussion: State Survey Plan of Correction 2010. It was noticed during our state survey that we had multiple wheelchairs and geri-chairs with foam exposed and in need of repair (This creates an infection control risk for the staff and the residents). During housekeeping weekly cleaning of the chairs any repairs of the wheelchairs and geri-chairs will be noted on the maintenance log.
The maintenance staff will determine what parts to order and will do immediate repairs to ensure the chair is safe for use.
If at any time you feel that any chair is unsafe for resident use, if there is a large cut in the fabric exposing the foam causing a infection control issue, a risk for resident injury, or other mechanical error please take the chair out of service and notify the shift supervisor immediately so that a replacement chair can be found to provide proper care for the resident.

Thanks Deanna Young RN

Attendance Signatures: Please initial by typed name

Maintenance Staff Signatures

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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

SUBJECT: F253 CLEANING OF EQUIPMENT (W/C's, Geri-chairs, lifts, w/p stretcher, Merry Walkers, shower chairs, ice carts	REFERENCE #
DEPARTMENT: WESLEY MANOR HEALTH CARE CENTER	PAGE: 1 OF: 1
	EFFECTIVE: 6/17/02
APPROVED BY: Resident Care Policies Committee	REVISED: 1/06, 1/10, 3/10

POLICY:

Housekeeping personnel are assigned to clean wheelchairs and Geri-chairs on alternate Mondays from 6:00 a.m. – 7:00 a.m. All other equipment listed above every Monday from 6:00 a.m. – 7:00 a.m.
All above equipment will be spot washed daily or as needed to ensure cleanliness.
A cleaning schedule composed by the Health Care Center Housekeeping Supervisor will be posted in the employee break room and in the housekeeping closet.

PROCEDURE:

1. The third shift nursing personnel will remove all above equipment (as specified by the schedule) from the resident's room and place in the hallway prior to 6:00 a.m. on Monday mornings.
    - Staff will inspect the equipment for any damages and report damages on the maintenance log for repairs.
    - If the damaged equipment poses a safety risk to the resident the equipment shall be immediately taken to the shift supervisor and pulled from service.
    - The shift supervisor shall work to find the resident with an equivalent chair until repairs are made.
2. Housekeeping personnel will transport the equipment to be cleaned to the whirlpool room bathroom, where they are thoroughly washed with a disinfectant cleaner (properly diluted), rinsed, dried and then returned to the proper hall.
    - Staff will inspect the equipment for any damages and report damages on the maintenance log for repairs.
    - If the damaged equipment poses a safety risk to the resident the equipment shall be immediately taken to the shift supervisor and pulled from service.
    - The shift supervisor shall work to find the resident with an equivalent chair until repairs are made.
3. No special needs devices are to be removed from any of the above equipment at any time during its cleaning by the housekeeping staff. This includes seatbelts, trunks support and leg supports.
4. Nursing personnel are responsible for removing and exchanging all special needs devices as needed when soiled.
5. Housekeeping personnel are to see the shift supervisor immediately if a special needs device is extremely soiled during the equipment cleaning and needs immediate replacement.
6. After all cleaning is complete, housekeeping personnel will remove all cleaning supplies/rags and thoroughly clean and disinfect the whirlpool bathroom before beginning their daily job assignment.

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

Wesley Manor Health Care Center F253

On The Spot In-service

All Housekeeping Staff

Date: March 16, 2010

Topic: Wheelchairs and geri-chairs in need of repair

Discussion: State Survey Plan of Correction 2010. It was noticed during our state survey that we had multiple wheelchairs and geri-chairs with foam exposed and in need of repair (This creates an infection control risk for the staff and the residents). When doing your weekly cleaning of the chairs please make note of any repairs of the wheelchairs and geri-chairs. Place repairs on the maintanence log. The maintanence staff will determine what parts to order and will do immediate repairs to ensure the chair is safe for use.

If at any time you feel that any chair is unsafe for resident use, if there is a large cut in the fabric exposing the foam causing a infection control issue, a risk for resident injury, or other mechanical error please take the chair out of service and notify the shift supervisor immediately so that a replacement chair can be found to provide proper care for the resident,

Thanks Deanna Young RN

Attendance Signatures: Please initial by typed name

Housekeeping Signatures

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MAR 29 2013
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE

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

PRINTED: 03/16/2010
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 _____	03/04/2010

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 000	INITIAL COMMENTS A state Life Safety Code survey was conducted on 03/04/10 for compliance with Title 42, Code of Federal Regulations, 483.70 (a) (Life Safety from fire, requirements for Long Term Care Facilities) NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest scope/severity identified at an "F".	K 000		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to assure the exit door knobs from the dining room were not located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation, equipped with a manual means of egress, and marked on how to exit the doors under normal conditions. The findings include: Observation during the Life Safety Code inspection on 03/04/10 at 10:30am revealed the round door knobs on the corridor exit egress doors, to the residents' private dining room, were	K 038	Specific measures utilized to correct the violation- The round door knob currently on this door shall be replaced with certified panic hardware. Specific measures utilized to ensure the violation will not recur- The replacement of the door knob with panic hardware will ensures that the facility is in compliance for this particular regulation.	4-17-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
x Jeremy L Hogansen	x Administrator	3-26-10

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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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 01 - MAIN BUILDING 01 B. WING _____	03/04/2010

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 038	Continued From page 1 five feet (60 inches) off the floor. The operating devices should be capable of being operated with one hand and should not require tight grasping, tight pinching, or twisting of the wrist to operate. NFPA 101 2000. Interview with the Maintenance Director on 03/04/10 at 10:30am revealed the Maintenance Director was not aware there was a regulation concerning the door knobs on the dining room exit doors. NFPA:101 2000 7.2.1.7 Panic Hardware and Fire Exit Hardware. 7.2.1.7.1 Where a door is required to be equipped with panic or fire exit hardware, such hardware shall meet the following criteria: (1) It shall consist of cross bars or push pads, the actuating portion of which extends across not less than one-half of the width of the door leaf and not less than 34 in. (86 cm), nor not more than 48 in. (122 cm), above the floor. Exception: Existing installations shall be permitted to be minimum 30 in. (76 cm) above the floor. (2) It shall be constructed so that a horizontal force not to exceed 15 lbf (66 N) actuates the cross bar or push pad and latches. 7.2.1.7.2 Only approved panic hardware shall be used on doors that are not fire doors. Only approved fire exit hardware shall be used on fire doors.	K 038		

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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 01 - MAIN BUILDING 01 B. WING _____	03/04/2010

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 038	Continued From page 2 7.2.1.7.3 Required panic hardware and fire exit hardware shall not be equipped with any locking device, set screw, or other arrangement that prevents the release of the latch when pressure is applied to the releasing device. Devices that hold the latch in the retracted position shall be prohibited on fire exit hardware unless listed and approved for that purpose. Exception: This requirement shall not apply where otherwise provided in Chapters 22 and 23. NFPA: 101 2000 A.7.2.1.5.4 Examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This requirement is permitted to be satisfied by the use of conventional types of hardware, whereby the door is released by turning a lever, knob, or handle or by pushing against a panic bar, but not by unfamiliar methods of operation such as a blow to break glass. The operating devices should be capable of being operated with one hand and should not require tight grasping, tight pinching, or twisting of the wrist to operate. NFPA: 101 2000 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor.	K 038		

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MAR 29 2010
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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 01 - MAIN BUILDING 01 B. WING _____	03/04/2010

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 038	Continued From page 3 Doors shall be operable with not more than one releasing operation.	K 038		
K 039 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain a safe environment for residents by ensuring the corridor aisles were clear for easy movement and egress. The Findings Included: Observation during the Life Safety Code tour of the facility on 03/04/10 at 10:30am revealed the facility stored items in front of the residents' private dining room. The items blocked the door preventing entrance or exit to the area. Stored in the egress pathway were three Rubber maid carts, one Serving tray cart, and one medium size garbage can blocking the exit. In addition on 03/04/10 at 9:33am there were obstructions in the path of egress. Interview with the Maintenance Director and Administrator on 03/04/10 at 10:30am revealed the items stored in the entrance could be a potential hazard and needed to be cleared for emergency egress.	K 039	Specific measures utilized to correct the violation- Equipment blocking the door will be removed and warning tape will be placed on the floor near the door. Staff will be informed by memo and via "On-the-Spot" in-service informing them of the need to keep this area clear. Specific measures utilized to ensure the violation will not recur- Routine, monthly observations will be performed by the director of maintenance to ensure compliance with this regulation.	4-17-10
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA	K 052	Specific measures utilized to correct the violation- The fire alarm maintenance company will be contacted to revise the system to ensure that trouble signals are	4-17-10

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	185136	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 052	Continued From page 4 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the building's fire alarm system as required by the National Fire Protection Association (NFPA) Standard 72. This deficient practice affected all residents and staff. The findings include: During the Life Safety Code tour conducted on 03/04/10 at 10:04am a test of the Fire Alarm Automatic Dialer Component was conducted inside the mechanical-phone room. The phone room's only entry door was located outside the building. The test revealed when the two phones were placed in trouble, no trouble signals could be heard at the Fire Alarm Panel located in the center hall area. Observation also revealed no trouble signals were distinctively and descriptively annunciated at the Fire Alarm Panel. Observation on 03/04/10 at 10:04am revealed no smoke detection in the mechanical-phone room	K 052	Distinctively and descriptively annunciated at the fire alarm panel. An integrated smoke detector will be installed in the mechanical-phone room where the DACT phone dialer is located. Specific measures utilized to ensure the violation will not recur- The system revision to allow for annunciation at the panel and the installation of the smoke detector in the dialer room will ensure that the facility is in compliance.	

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K 052	Continued From page 5 where the (DACT) phone dialer was located. Interview with the Maintenance Director on 03/04/10 at 10:04am revealed the Maintenance Director was not aware there should be a trouble signal at the supervised location. Also he was not aware a smoke detector was needed in the Dialer room. A call to the monitoring station revealed they did receive the trouble signal and contacted personnel. Reference: NFPA 72 1999 edition 1-5.4.4 Distinctive Signals. Fire alarms, supervisory signals, and trouble signals shall be distinctively and descriptively annunciated. 1-5.4.6 Trouble Signals. Trouble signals and their restoration to normal shall be indicated within 200 seconds at the locations identified in 1-5.4.6.1 or 1-5.4.6.2. Trouble signals required to indicate at the protected premises shall be indicated by distinctive audible signals. These audible trouble signals shall be distinctive from alarm signals. If an intermittent signal is used, it shall sound at least once every 10 seconds, with a minimum duration of 1/2 second. An audible trouble signal shall be permitted to be common to several supervised circuits. The trouble signal(s) shall be located in an area where it is likely to be heard. 3-8.1* Fire Alarm Control Units. Fire alarm systems shall be permitted to be either	K 052		

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K 052	Continued From page 6 integrated systems combining all detection, notification, and auxiliary functions in a single system or a combination of component subsystems. Fire alarm system components shall be permitted to share control equipment or shall be able to operate as stand alone subsystems, but, in any case, they shall be arranged to function as a single system. All component subsystems shall be capable of simultaneous, full load operation without degradation of the required, overall system performance. Reference: NFPA 72 1999 edition 1-5.6* Protection of Fire Alarm Control Unit(s). In areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit(s) to provide notification of fire at that location. Exception: Where ambient conditions prohibit installation of automatic smoke detection, automatic heat detection shall be permitted. A-1-5.6 The intent of 1-5.6 is to have the fire alarm system respond before it is incapacitated by fire. There have been several fatal fires where the origin and path of the fire resulted in destruction of the control unit before a detector responded. CAUTION: The exception to 1-5.6 permits use of a heat detector if ambient conditions are not suitable for smoke detection. It is important to also evaluate whether the area is suitable for the control unit. The code intends that only one smoke detector is required at the control unit even when the area of	K 052		

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K 052	Continued From page 7 the room would require more than one detector if installed according to the spacing rules in Chapter 2 6-2.1* If implemented at the option of the authority having jurisdiction, a public fire alarm reporting system shall be designed, installed, operated, and maintained to provide the maximum practicable reliability for transmission and receipt of fire alarms.	K 052		
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 observation and interview it was determined the facility failed to maintain the building's fire alarm system as required by the National Fire Protection Association (NFPA) Standard 72. This deficient practice affected all residents and staff. The findings include: Observation during the Life Safety Code inspection on 03/04/10 at 10:20am revealed the four corridor doors located in the facility are currently operating with hold-open release-smoke detection devices. The facility replaces these older units when they become defective, as parts are no longer available for these devices. Observation on 03/04/10 at 10:20am revealed a	K 054	Specific measures utilized to correct the violation- Smoke detectors will be placed on the side of the automatic corridor doors where they currently do not exist, so that both sides of the doors have coverage. Specific measures utilized to ensure the violation will not recur- The smoke detectors will be tested according to our current policy to ensure that they are in proper operational condition.	4-17-10

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K 054	Continued From page 8 new installation of hold open devices and smoke detection. However, a smoke detector was observed only on one side of each corridor door, in the following locations; south corridor, east corridor, and the north corridor doors. Interview with the Maintenance Director on 03/04/10 at 10:20am revealed the Maintenance Director was not aware of the NFPA regulation. NFPA: 72, 1999 2-10.6 Smoke Detectors for Door Release Service. 2-10.6.1 Smoke detectors that are part of an open area protection system covering the room, corridor, or enclosed space on each side of the smoke door and that are located and spaced as required by 2-3.4 shall be permitted to accomplish smoke door release service. 2-10.6.2 Smoke detectors that are used exclusively for smoke door release service shall be located and spaced as required by 2-10.6. 2-10.6.3 When smoke door release is accomplished directly from the smoke detector(s), the detector(s) shall be listed for releasing service. 2-10.6.4 Smoke detectors shall be of the photoelectric, ionization, or other approved type. 2-10.6.5 Number of Detectors Required. 2-10.6.5.1 If doors are to be closed in response to smoke	K 054		

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K 054	Continued From page 9 flowing in either direction, the requirements of 2-10.6.5.1.1 through 2-10.6.5.1.3 shall apply. 2-10.6.5.1.1 If the depth of wall section above the door is 24 in. (610 mm) or less, one ceiling-mounted detector shall be required on one side of the doorway only. Figure 2-10.6.5.1.1, parts B and D, shall apply.	K 054		
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the compressed medical gas cylinders in the building were stored and secured as required. In addition, empty and full cylinders shall be segregated. The findings include: Observation during the Life Safety Code Inspection on 03/04/10 at 9:30am revealed twelve (12) oxygen cylinders were improperly stored in the oxygen storage room located on the south	K 076	Specific measures utilized to correct the violation- Empty and full Oxygen cylinders will be stored in separate areas of the storage room and there will be signs posted indicating which are full and which are empty. Staff will be instructed via "On-the-Spot" inservices for the purpose of educating them regarding proper cylinder storage. Specific measures utilized to ensure the violation will not recur- The Director of Maintenance will perform monthly visual checks of the storage room to ensure that this policy is being adhered to. If situations occur indicating that storage is not occurring properly, further inservices will be conducted.	4-17-10

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K 076	Continued From page 10 hall. Further observation revealed there was no separation between the cylinders indicating empty and full. Also there were no signs indicating empty and full. Interview with Maintenance Director on 03/04/10 at 9:30am revealed he was not aware the oxygen cylinders were not being separated. He stated he had not noticed this on the last monthly inspection. NFPA-99 4-3.1.1.2 Storage Requirements 1. Sources of heat in storage locations shall be protected so that cylinders or compressed gas shall not be heated to the activation point of integral safety devices. 3. Provisions shall be made for racks or fastenings to protect cylinders form accidental damage or dislocation. (Medical Gas Storage) NFPA 99, 1999 Edition 4-3.5.2.2 Storage of Cylinders and Containers - Level 1. .1. Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. 2 If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. NFPA: 99, 1999	K 076		

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K 076	Continued From page 11 8-6.4.1.7 All labeling shall be durable and withstand cleansing or disinfection. 8-6.4.2* Signs.	K 076		
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 residents were supplied a safe and uninterrupted source of electric power. The findings include: Observations during the Life Safety Code Inspection on 03/04/10 at 9:15am revealed the coordinators office had four prong electrical adaptor extension cords and power strips for electrical appliances. In addition, the extension cord was plugged into the power strip. Interview with the maintenance director on 03/04/10 at 9:15am revealed the Maintenance Director was not aware of the use of extension cords and power strips in the facility. NFPA 70 400-8. 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the	K 147	Specific measures utilized to correct the violation- All extension cords will be removed from offices and resident areas as required per regulation. The employee that was utilizing the extension cord will be inserviced so that she understands the intention of this regulation. Specific measures utilized to ensure the violation will not recur- The Director of Maintenance will perform monthly visual checks of the facility to ensure that extension cords are not used. A reminder of this regulation will be printed in the administrator's April newsletter to employees.	4-17-10

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K 147	Continued From page 12 following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces NFPA 99, Chapter 3 Electrical Systems. 3-3.2.1.2 D 2. Minimum number of Receptacles. The number of receptacles shall be determined by the 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. 3-3.4.2.3. Maintenance and Testing of Electrical System. a. Testing Interval for Receptacles in Patient Care Areas. I. Testing shall be performed after initial installation, replacement, or servicing of the device.	K 147		

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