

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

PRINTED: 04/09/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/04/2013
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF EAST LOUISVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE LOUISVILLE, KY 40220
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  A standard health survey was initiated on 04/02/13 and concluded on 04/04/13 with no deficiencies cited. A Life Safety Code survey was initiated and concluded on 04/03/13 with deficiencies cited at the highest scope and severity of an F with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator (X6) DATE 4/19/13

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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If continuation sheet Page 1 of 1  
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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  BUILDING: 01  PLAN APPROVAL: 1973, 1985  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One (1) story, Type III (111)  SMOKE COMPARTMENTS Nine (9) smoke compartments  FIRE ALARM: Complete fire alarm system with heat and smoke detectors  SPRINKLER SYSTEM: Complete automatic dry sprinkler system.  GENERATOR: Type II generator, installed in 1984. Fuel source is Natural Gas.  A standard Life Safety Code survey was conducted on 04/03/13. Signature Health Care of East Louisville was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred sixteen (116) on the day of the survey.  The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from	K 000	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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.

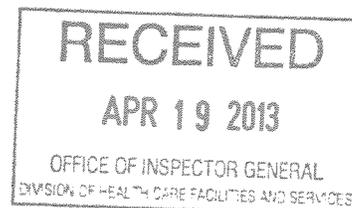
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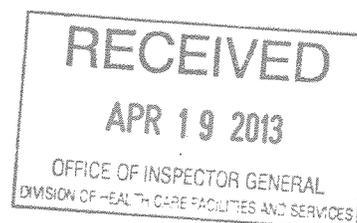
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K 000	Continued From page 1 Fire)  Deficiencies were cited with the highest deficiency identified at " F " level.	K 000		5/13/13
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred sixteen (116) on the day of the survey. The facility failed to provide self-closing devices for rated doors protecting hazardous areas.  The findings include:	K 029	<b>What corrective action will be accomplished for those residents found to have been affected?</b>  1) Unrated door to boiler room will be replaced with correctly rated door with self closing device by May 10, 2013.  2) Janitor closet door in kitchen replaced w/ a correctly rated door and door closure added by May 10, 2013.  3) Closures installed on serving line doors in kitchen on 4/17/2013.  4) Closure device installed on kitchen closet door on 4/17/2013.  5) Closure device installed on clean linen room on 300 hall laundry on 4/17/2013.  6) Closure device installed on door in 300 hall laundry on 4/17/2013.  <b>How will the facility identify other residents that have the potential to be affected?</b>  An audit was conducted, by the Regional Director of Plant Operations, on 4/17/2013, for fire door ratings and doors requiring being self closing.  <b>What measures will be put into place to ensure that the deficient practice will not recur?</b>  Education was provided by the Administrator on 4/26/2013, to the Maintenance Director and Maintenance Assistant about the requirement regarding fire rated doors and self closing devices.	



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K 029	Continued From page 2  Observation, on 04/03/13 between 9:00 AM and 3:00 PM, with the Regional Plant Operations Director revealed rooms required being self-closing or containing a hazardous amount of combustibles did not have self-closing device to keep the door closed. The rooms identified as hazardous requiring a rated door with a self-closing device were located in the following areas:  1) An unrated door located in the basement to the Boiler Room. 2) The Janitor closet located in the Kitchen did not have a rated door or self-closing device. 3) Two (2) doors to the Serving Line Room located in the Kitchen. 4) A closet located in the Dining Room. 5) The Clean Linen Room located in the 300 Hall Laundry. 6) The Boiler Room located in the 300 Hall Laundry.  Interview, on 04/03/13 between 9:00 AM and 3:00 PM, with the Regional Plant Operations Director revealed he was not aware the doors to these rooms did not meet the requirements for protection from hazards.  8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.  Reference:	K 029	<b>How the facility will monitor its performance to ensure solutions are sustained.</b>  Monthly, the Maintenance Director will audit doors requiring self closures and document on a log. Results from this audit will be presented monthly to the Safety committee for six months. After this time, the audit will be conducted quarterly and results taken to the Safety committee quarterly.	





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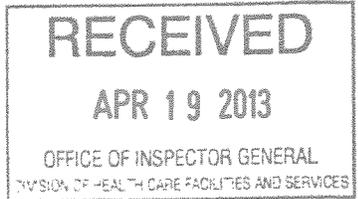
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K 038 SS=D	Continued From page 4  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred sixteen (116) on the day of the survey. The facility failed to ensure doors equipped with delayed egress had proper signage.  The findings include:  Observation, on 04/03/13 between 9:00 AM and 3:00 PM, with the Regional Plant Operations Director revealed the egress signage located in the 100 Hall, 200 Hall, and the Dining Room did not have letters 1" high with a contrasting background.  Interview, on 04/03/13 between 9:00 AM and 3:00 PM, with the Regional Plant Operations Director revealed he was unaware of the egress signage requirements.	K 038	K 038  <b>What corrective action will be accomplished for those residents found to have been affected?</b>  On May 1, 2013, egress signage on 100 hall, 200 hall, and the dining room was installed by the Administrator.  <b>How will the facility identify other residents that have the potential to be affected?</b>  An audit was conducted by the Regional Director of Plant Operations, on 4/17/2013, to identify other exit doors requiring egress signage. All other doors were found to be in compliance.  <b>What measures will be put into place to ensure that the deficient practice will not recur?</b>  Education was provided by the Administrator on 4/26/2013, to the Maintenance Director and Maintenance Assistant about the requirement regarding egress signage on exit doors per NFPA guidelines.  <b>How the facility will monitor its performance to ensure solutions are sustained.</b>  Monthly, the Maintenance Director will audit doors requiring egress signage and document on a log. Results from this audit will be presented monthly to the Safety committee for six months. After this time, the audit will be conducted quarterly and results taken to the Safety committee quarterly.	5/13/13
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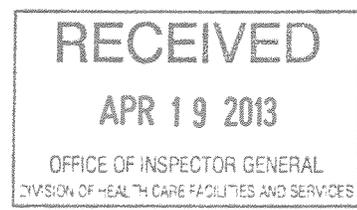
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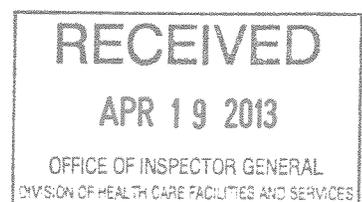
K 038	<p>Continued From page 5</p> <p>Reference:</p> <p>NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15</p>	K 038		
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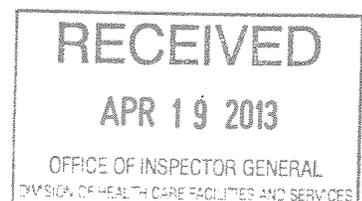
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K 038	Continued From page 6 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.  (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS  7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.	K 038		



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K 038	Continued From page 7  7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.	K 038		5/13/13
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 047	K 047  What corrective action will be accomplished for those residents found to have been affected?  On 4/17/2013, Exit signage was added by the facilities maintenance staff, per the findings, to the corridor connecting the 100 and 200 halls and the living room to indicate direction of egress.	



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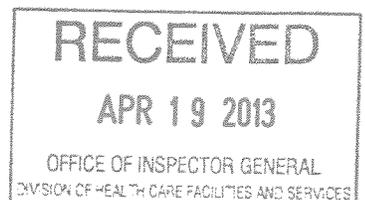
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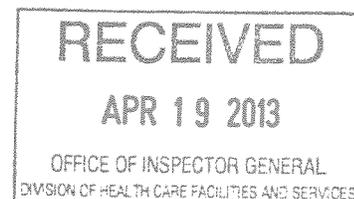
<p>K 047</p> <p>Continued From page 8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred sixteen (116) on the day of the survey. The facility failed to ensure exits were clearly recognizable with proper exit signage.</p> <p>The findings include:</p> <p>Observation, on 04/03/13 at 12:52 PM, with the Regional Plant Operations Director revealed the corridor connecting the 100 Hall and 200 Hall did not have an exit sign indicating the direction of egress into the Living Room. Further observation revealed the Living Room did not have an exit sign indicating the direction of egress through a door to the Front Hall. The facilities evacuation map which hangs on the wall in various locations throughout the facility indicated the path through the living room was the path of egress in an emergency.</p> <p>Interview, on 04/03/13 at 12:52 PM, with the Regional Plant Operations Director revealed he was not aware the egress path through the living room did not have proper signage.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.10.1.2* Exits, Exits, other than main exterior</p>	<p>K 047</p> <p><b>How will the facility identify other residents that have the potential to be affected?</b></p> <p>5/13/13</p> <p>On 4/17/2013, an audit was conducted by the Regional Director of Plant Operations, to identify other exit signage needing to be added. As a result of the audit, additional signage was added on 4/17/2013, to the newly renovated therapy department.</p> <p><b>What measures will be put into place to ensure that the deficient practice will not recur?</b></p> <p>Education was provided by the Administrator on 4/26/2013, to the Maintenance Director and Maintenance Assistant about the requirement regarding emergency signage that indicates direction of egress per NFPA guidelines.</p> <p><b>How the facility will monitor its performance to ensure solutions are sustained.</b></p> <p>Monthly, the Maintenance Director will audit emergency signage that indicates direction of egress and document on a log. Results from this audit will be presented monthly to the Safety committee for six months. After this time, the audit will be conducted quarterly and results taken to the Safety committee quarterly.</p>
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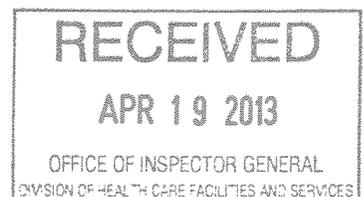
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K 047	Continued From page 9 exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.  (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.  (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.  (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of	K 066	<b>K 066</b>  <b>What corrective action will be accomplished for those residents found to have been affected?</b>  On 4/03/2013, the facility ordered it's "butt bucket" for designated smoking areas. On 4/17/2013, the facility received the "butt bucket" and placed in designated smoking areas. No resident's specifically indentified.  <b>How will the facility identify other residents that have the potential to be affected?</b>  This is the only area that is designated as a smoking area for residents or visitors. No additional residents have the potential to be affected.  <b>What measures will be put into place to ensure that the deficient practice will not recur?</b>  On 4/26/2013, Education was provided by the Administrator to the Maintenance Director, Maintenance Assistant and Flousekeeping director about the requirement to have a metal container, with a self closing lid to dump ashtrays. Education was provided by the Housekeeping director, to the housekeeping department staff on 4/26/2013, about the procedure regarding the cleaning of the designated smoking area.	5/13/13



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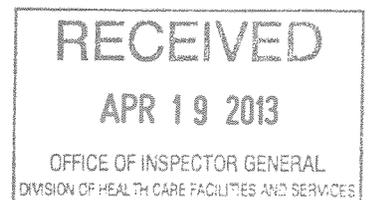
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K 066	<p>Continued From page 10</p> <p>approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred sixteen (116) on the day of the survey. The facility failed to ensure the smoking areas had a metal container with a self-closing lid to dump ashtrays.</p> <p>The findings include:</p> <p>Observation, on 04/03/13 at 1:10 PM, with the Regional Plant Operations Director revealed the facility failed to provide a metal container with a self-closing lid to dump the ashtrays, located in the designated smoking area outside the Dining Room exit. Cigarette butts were noted all over the ground in this area, even though an approved ashtray was provided.</p> <p>Interview, on 04/03/13 at 1:10 PM, with the Regional Plant Operations Director revealed he was not aware the smoking area did not have the required metal container with a self-closing lid for dumping ashtrays.</p> <p>Reference: NFPA Standard 101 (2000 Edition).</p> <p>19.7.4 Smoking (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p>	K 066	<p>How the facility will monitor its performance to ensure solutions are sustained.</p> <p>Monthly, the Maintenance Director will audit the placement of the butt bucket to ensure that the bucket is in place per NFPA guidelines and document on a log. Results from this audit will be presented monthly to the Safety committee for six months. After this time, the audit will be conducted quarterly and results taken to the Safety committee quarterly.</p>
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant	K 072	



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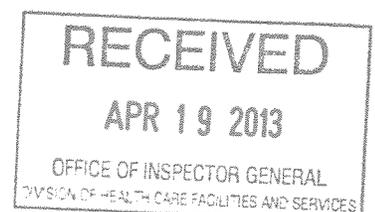
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K 072	<p>Continued From page 11</p> <p>use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect two (2) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred sixteen (116) on the day of the survey. The facility failed to ensure the means of egress was free of all obstructions or impediments.</p> <p>The findings include:</p> <p>Observations, on 04/03/13 between 9:00 AM and 3:00 PM, with the Regional Plant Operations Director revealed med carts and wheel chairs were being stored in the 100 and 200 Hall.</p> <p>Interview, on 04/03/13 between 9:00 AM and 3:00 PM, with the Regional Plant Operations Director revealed the items were routinely stored in these areas.</p> <p>Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or</p>	K 072	<p>What corrective action will be accomplished for those residents found to have been affected?</p> <p>No specific residents identified. All wheelchairs and med carts were immediately moved to appropriate storage locations by nursing staff.</p> <p>How will the facility identify other residents that have the potential to be affected?</p> <p>All residents have the potential to be affected.</p> <p>What measures will be put into place to ensure that the deficient practice will not recur?</p> <p>On 5/10/2013, Education will be provided by the Director of Clinical Education to all staff about the requirement to have a means of egress free of all obstructions and impediments.</p> <p>How the facility will monitor its performance to ensure solutions are sustained.</p> <p>Weekly, the interdisciplinary team will audit the performance of our solution to the deficiency by adding proper storage or wheelchair and med carts to our weekly call bell audit. The audit will be completed weekly and turned into the administrator weekly for review.</p>	5/13/13



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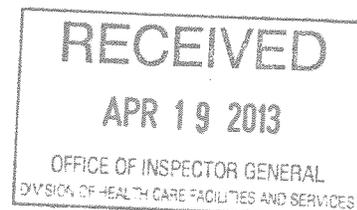
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K 072	Continued From page 12 impediments to full instant use in the case of fire or other emergency.	K 072		5/13/13
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, 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 oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred sixteen (116) on the day of the survey. The facility failed to ensure oxygen storage over 300 cu ft. was stored in a room with ignition sources located five (5) feet from the floor.  The findings include:	K 076  K 076  What corrective action will be accomplished for those residents found to have been affected?  On 4/16/2013, the facility Maintenance Director and Assistant relocated the light switch above the minimum 5 ft requirement.  How will the facility identify other residents that have the potential to be affected?  No additional residents were affected.  What measures will be put into place to ensure that the deficient practice will not recur?  On 4/26/2013, Education was provided by the Administrator to the Maintenance Director and Maintenance Assistant of the requirement of the minimum height requirement for an ignition source located by oxygen storage.  How the facility will monitor its performance to ensure solutions are sustained.  Monthly, the Maintenance Director will audit the placement of the oxygen storage to ensure that the height requirement is being met per NFPA guidelines and document on a log. Results from this audit will be presented monthly to the Safety committee for three months. After this time, if there is no further issue we will stop monitoring as compliance will be obtained.		



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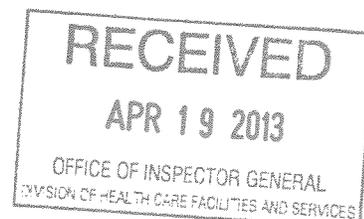
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K 076	Continued From page 13 Observation, on 04/03/13 at 3:02 PM, with the Regional Plant Operations Director revealed sixty nine (69) "E" oxygen tanks in the oxygen storage room. The oxygen storage room had a light switch installed under five (5) feet from the floor.  Interview, on 04/03/13 at 3:02 PM, with the Regional Plant Operations Director revealed he was unaware oxygen tanks could not be stored in a room with an ignition source below five (5) feet once the storage equals over 300 cubic feet in a smoke compartment.  Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m <sup>3</sup> (300 ft <sup>3</sup> ) but less than 85 m <sup>3</sup> (3000 ft <sup>3</sup> ) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid	K 076			



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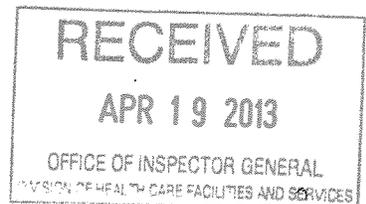
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K 076	Continued From page 14 storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076		
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, generator testing record review, and interview, it was determined the	K 144 K 144	<b>What corrective action will be accomplished for those residents found to have been affected?</b>  On 4/15/2013, the facility contacted its generator vendor and had them come and move the wires from the battery to the starter per NFPA guidelines. No resident's specifically identified.  <b>How will the facility identify other residents that have the potential to be affected?</b>  All residents have the potential to be affected.	5/13/13



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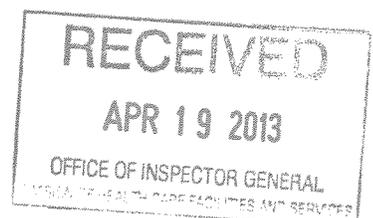
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K 144	Continued From page 15 facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred sixteen (116) on the day of the survey. The facility failed to ensure the battery charger for the emergency generator was not connected directly to the battery.  The findings include:  Observation, on 04/03/13 at 2:56 PM, with the Regional Plant Operations Director revealed the battery charger for the facilities emergency generator was connected directly to the battery.  Interview, on 04/03/13 at 2:56 PM, with the Regional Plant Operations Director revealed he was not aware the battery charger could not connect directly to the battery of the generator.  Reference: NFPA 110 (1999 Edition).  5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.	K 144	What measures will be put into place to ensure that the deficient practice will not recur?  As of 4/15/2013, the generator is in compliance with the NFPA regulation. In the event of a generator upgrade the new generator will comply with all NFPA standards.  How the facility will monitor its performance to ensure solutions are sustained.  Monthly, the Maintenance Director will audit the generator to ensure that compliance is maintained per NFPA guidelines and document on a log. Results from this audit will be presented monthly to the Safety committee for three months. After this time, if there is no further issue, we will stop monitoring as compliance will be obtained.		



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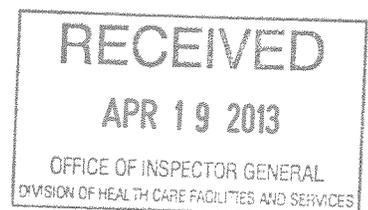
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K 144	Continued From page 16  Reference: NFPA 99 (1999 Edition)  Actual NFPA Standard: NFPA 99, 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1. (b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b). Actual Standard: NFPA 110, 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 transfer switch from the standard position to the alternate position and then a return to the standard position. Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems,	K 144		



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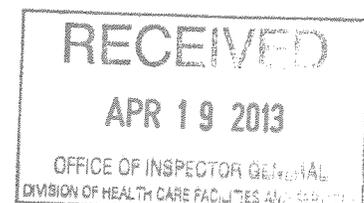
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K 144	Continued From page 17 Chapter 6. (b) Inspection and Testing. 1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. 2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads. 3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures. Actual Standard: NFPA 99, 3- 3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.	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	K 147  K 147	5/13/13  <b>What corrective action will be accomplished for those residents found to have been affected?</b>  On 4/3/13, the maintenance director and assistant corrected the oxygen concentrator that was plugged into a multi plug adaptor, removed the extension cord from the resident room and removed the refrigerator from the power strip located in the ADON office.



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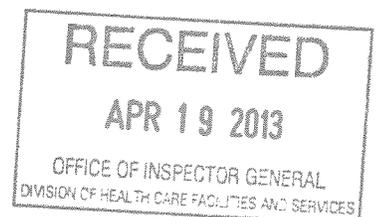
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K 147	<p>Continued From page 18</p> <p>wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, residents, staff, and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred sixteen (116) on the day of the survey. The facility failed to maintain proper use of multi-plug adaptors, power strips, and extension cords.</p> <p>The findings include:</p> <p>Observations, on 04/03/13 between 9:00 AM and 3:00 PM, with the Regional Plant Operations Director revealed:</p> <ol style="list-style-type: none"> <li>1) An oxygen concentrator was plugged into a multi-plug adaptor located in room 206.</li> <li>2) An extension cord was in use located in room 210.</li> <li>3) A refrigerator was plugged into a power strip located in the 200 Hall ADON Office.</li> </ol> <p>Interview, on 04/03/13 between 9:00 AM and 3:00 PM, with the Regional Plant Operations Director revealed he was aware of the proper use of multi-plug adaptors, power strips, and extension cords; however, he was not aware the misuse of multi-plug adaptors, power strips and extension cords, and stated they had been missed during the checks for misuse.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p>	K 147	<p><b>How will the facility identify other residents that have the potential to be affected?</b></p> <p>All residents have the potential to be affected.</p> <p><b>What measures will be put into place to ensure that the deficient practice will not recur?</b></p> <p>On 5/10/2013, Education will be provided by the Director of Clinical Education to all staff about the misuse of multi plug adaptors, power strips and extension cords. On May 3, 2013, social services will send a letter to all families regarding the misuse of multi plug adaptors, power strips and extension cords.</p> <p><b>How the facility will monitor its performance to ensure solutions are sustained.</b></p> <p>Weekly, the interdisciplinary team will audit the performance of our solution to the deficiency by adding "free of extension cords" and "appropriate multi plug adaptor use" to the weekly call bell audit form. The audit will be completed weekly and turned into the administrator weekly for review.</p>	



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

PRINTED: 04/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185350	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  04/03/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF EAST LOUISVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE LOUISVILLE, KY 40220	
(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 147	<p>Continued From page 19</p> <p>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.</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>370.28(c) Covers.</p> <p>All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric.</p> <p>Electrical wiring and equipment shall be in</p>	K 147	



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NAME OF PROVIDER OR SUPPLIER  <b>SIGNATURE HEALTHCARE OF EAST LOUISVILLE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2529 SIX MILE LANE LOUISVILLE, KY 40220</b>	
(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)
K 147	Continued From page 20 accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.  Reference: NFPA 70 400-8 ( Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the 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	K 147	

