

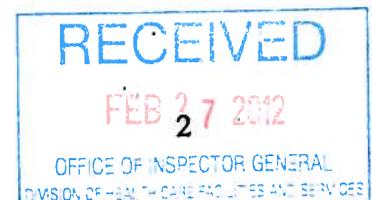
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/02/2012
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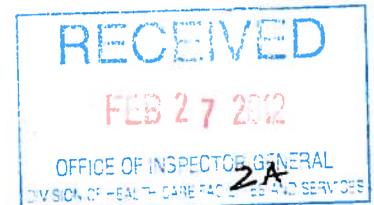
NAME OF PROVIDER OR SUPPLIER EPISCOPAL CHURCH HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 7604 WESTPORT ROAD LOUISVILLE, KY 40222
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F 309	<p>Continued From page 1</p> <p>Review of Resident #10's orders for the month of January 2012, revealed an order for "no shoes, only slipper socks".</p> <p>Observations of Resident #10, on 01/31/12 at 11:40 AM and 4:39 PM, on 02/01/12 at 7:55 AM and 4:45 PM, revealed Resident #10 wearing black shoes on his/her feet.</p> <p>Interview with the Certified Nursing Assistant (CNA) #1, on 02/02/12 at 3:20 PM, revealed she did notice the shoes on his/her feet when she came in to work and since Resident #10 was not on her work load she did not take off the shoes. CNA #1 further stated she was aware he/she had an order for no shoes.</p> <p>Interview with CNA #2, on 02/02/12 at 3:35 PM, revealed she was aware Resident #10 had ulcers on his/her feet. CNA #2 stated if they place TED hose on his/her feet, they place his/her shoes on then. CNA #2 stated she was not familiar with the order that stated Resident #10 was not to wear shoes.</p> <p>Interview with the Nurse Manager of C-Hall, on 02/02/12 at 3:45 PM, revealed she was aware of Resident #10's skin issues to his/her feet. She further stated she was not aware of an order for Resident #10 to not wear shoes on his/her feet. The CNA's would not know to keep shoes off Resident #10's feet if it was not documented on the CNA Sheet. She stated the order was written because Resident #10 suffered from blisters on his/her feet. The Nurse Manager further stated she was responsible to make sure the CNA sheets were updated.</p>	F 309	<p>(Royce Carter, RN) has also been involved with addressing the special needs of residents with the Clingman Neighborhood nurses and evaluating their implementation with special communication through a wound report to the Clingman Nurse Manager (Megan Wesselman, RN) and Director of Clinical Services (Kathy Shireman, RN) and with medical record notations. The Clingman Neighborhood Nurse Manager (Megan Wesselman, RN), charge nurses, or House Supervisors (Donna Basham, RN, Tom Valerius, RN, Rhonda Day, RN) are communicating with aides at shift start and monitoring for orders being followed.</p> <p>The measures put in place to prevent incidents include keeping a master assignment sheet upon which changes needing to be communicated to the aides will be hand written by the assigned nurse until typed into the computer by the respective Neighborhood Nurse Managers (Clingman-Megan Wesselman, RN; Marmion-Donna Watson, RN; Morton-Teresa Shircliff, RN) or their designee. Nurses are not to use the original master except by copying. The master will be marked as such with a yellow highlighter that will allow copying thus allowing updates via handwritten instructions. New orders will also be communicated on a 24-hour report with written entries made by the assigned</p>	



nurse for the shift and shared via verbal shift report to the oncoming nurse.

Performance will be monitored by all of the Nurse Management Team: Director of Clinical Services (Kathy Shireman, RN), Assistant Director of Nursing (Beth Fryer, RN), Neighborhood Nurse Managers (Clingman-Megan Wesselman, RN, Morton-Theresa, Shircliff, RN, Marmion-Donna Watson, RN) and House Supervisors (Donna Basham, RN, Tom Valerius, RN, Rhonda Day, RN) or designees using duplicate order copies to check the paperwork for needed additions/deletions accuracy and the 24 hour report forms. A visual review of new orders by the Neighborhood Nurse Managers (Clingman-Megan Wesselman, RN, Morton-Theresa, Shircliff, RN, Marmion-Donna Watson, RN) or designees will include monitoring of the new order implementation process and follow up with the individuals involved-training or counseling-as appropriate. Summary reporting by each Neighborhood Nurse Manager (Clingman-Megan Wesselman, RN, Morton-Theresa, Shircliff, RN, Marmion-Donna Watson, RN) will be provided to the Nursing Leadership Team meeting monthly and action plan findings will be reported by the Neighborhood Nurse Managers (Clingman-Megan Wesselman, RN, Morton-Theresa, Shircliff, RN, Marmion-Donna Watson, RN) or the Director of



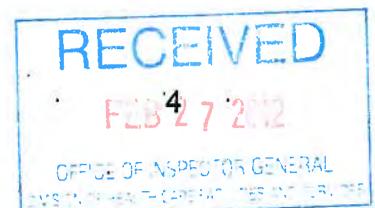
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F 309	Continued From page 2 Interview with the Director of Nursing (DON), on 02/02/12 at 4:35 PM, revealed nurse managers were responsible to update the CNA Sheet. They have also asked nurses to report any changes to the CNA's. The DON further stated she was ultimately responsible to make sure staff was doing what they were suppose to do.	F 309	Clinical Services (Kathy Shireman, RN) to the facility QA/QI Committee meetings.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an Individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	F441--483.65 Infection Control, Prevent Spread, Linens: Linens--All Environmental Services staff completed the Infection Control and Linen In-service on 2/3/2012. The in-service was taught by the Director of Environmental Services/Purchasing (Hope Jantzen Williams) and the Environmental Services Supervisor (Bryan Berman). Cart covers for each linen cart were purchased by Hope Jantzen Williams, Director of Environmental Services/Purchasing on 2/3/2012 and were received on 2/16/2012 and placed into service on the linen carts on the same date in order to prevent partially covered linen carts and potential contamination of clean linens. On 2/20/2012 Housekeeper #2 received a documented coaching for not following policy concerning proper infections control in the transport of clean linens. Observation of linen transport and linen handling with environmental services staff will be done by Hope Jantzen Williams Director of Environmental Services/Purchasing or designee on a	2/25/12



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F 441	<p>Continued From page 3 professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of the facility's policies, was determined the facility failed to maintain an Infection Control Program to ensure the linen cart was covered during the transport and delivery of linen to one (1) of three (3) units, the Morton Unit. The facility failed to store respiratory equipment in plastic bags to prevent contamination for three (3) of twenty-four (24) sampled residents, Residents #1, #7 and #13 and one (1) of two (2) unsampled resident. Unsampled Resident #B. In addition, the facility failed to use proper handwashing techniques during the skin assessments for two (2) of eleven (11) sampled residents, Residents #3 and #10.</p> <p>The findings include:</p> <p>Review of the Infection Control Policy (Revised 07/21/10) revealed the facility had established and maintained an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent or control the development and transmission of diseases and infections. The policy stated personnel must handle, store, process and transport linens so as to prevent the spread of</p>	F 441	<p>routine basis and violations will be addressed through the facilities progressive discipline process. A summary of violations will be collected monthly and reported during the facility QA/QI committee meetings. Additionally the facility's new hire orientation and annual Infection control in-service includes the proper infection control techniques in the handling of linen.</p> <p>The heightened awareness of all staff with reporting/ coaching after in-servicing about: proper transport and handling of linens will also be monitored by the Neighborhood Nurse Managers (Clingman-Megan Wesselman, RN, Morton-Theresa, Shircliff, RN, Marmion-Donna Watson, RN) or their designees on at least a weekly basis with violations addressed individually through the Episcopal Church Homes Progressive Discipline process and a summary of violations will be reported during the QA/QI committee meetings.</p>	



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F 441	<p>Continued From page 4</p> <p>infection. The policy also stated, staff were required to wash their hands before gloving and after each direct resident contact.</p> <p>1. Review of the Linen/Laundry Policy, revised 01/07, revealed when transporting linen, all linen must be covered and contained.</p> <p>Observation, on 02/01/12 at 7:40 AM, revealed the linen cart for the Morton Unit was transported partially covered. A sheet covered the top of the cart (front to back) leaving approximately a foot uncovered at the bottom. Both sides of the cart were completely uncovered.</p> <p>Interview, on 02/01/12 at 7:45 AM, with Housekeeper #2 revealed linen was to be transported covered. She stated the policy was to cover the linen during transport but "sometimes I don't". She stated, the reason to cover the linen was to keep germs and dust out. She revealed she had been in-serviced on the transport of linens.</p> <p>Interview, on 02/02/12 at 10:05 AM, with the Environmental Services Manager revealed linen was to always be covered during transport. She stated the staff had been in-serviced on the transport of linen and the reason linen was to be covered during transport was for infection control.</p> <p>Interview, on 02/02/12 at 2:20 PM, with the Unit A (Morton Unit) Nurse Manager revealed linens were to be transported completely covered. She stated you do not want to contaminate your clean linen.</p> <p>Interview, on 02/02/12 at 3:00 PM, with</p>	F 441		



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F 441	<p>Continued From page 5</p> <p>Housekeeper #1 revealed the linen cart was to be covered with two (2) sheets during transport. She revealed that was to make sure no linen was exposed.</p> <p>2. Review of the facility's Oxygen Therapy/Respiratory Care Services Policy, revised 04/27/11, revealed nasal cannulas were to be marked with the date they were changed and when not in use, rolled into a plastic bag for cleanliness. Hand held nebulzers were to have a set up bag attached to the equipment and marked with the change date and the resident's name. The policy stated all supplies should be put away in the plastic set up bag labeled with the resident's name and discard date.</p> <p>Review of SCM Truair technologies procedure for servicing weekly change out facilities, not dated, revealed to replace nasal cannulas on active residents. If there is a question as to whether the resident is still using it, leave it wrapped and keep it in the set up bag and if still not used on next visit get the equipment discontinued. Replace mini neb kit. It is up to the facility to decide if they want you to pre-assemble the kit and place it in a setup bag or leave unassembled (when not assembled it is much easier to determine if it is being used).</p> <p>Observation of Resident #7 during initial tour, on 01/31/12 at 9:20 AM, revealed a mini neb mouthpiece lying on its side, on top of the nebulzer machine, not in a bag. Subsequent observations, on 01/31/12 at 11:40 AM and 02/01/12 at 9:00 AM, revealed the mini neb mouthpiece sitting on top of the nebulzer, on the</p>	F 441	<p>Respiratory equipment was replaced for the residents affected and new items were placed in set-up bags with a name label & discard date by Morton Neighborhood Nurse Manager (Teresa Shircliff, RN) and Clingman Neighborhood Nurse Manager (Megan Wesselman, RN) on February 2, 2012. Nurses and aides were in-services by Beth Fryer, ADON or a Neighborhood Nurse Manager (Clingman-Megan Wesselman, RN, Morton-Theresa Shircliff, RN, Marmion-Donna Watson, RN) on placing respiratory equipment in a set-up bag when removed/used. The bag is to be labeled with the resident's name & discard/replace date and is to be distributed to each resident room by the supplier-SCM on a weekly basis.</p> <p>A check of all rooms with residents using respiratory equipment was conducted by the Neighborhood Nurse Managers (Clingman-Megan Wesselman, RN, Morton-Theresa, Shircliff, RN, Marmion-Donna Watson, RN) on February 2, 2012. No other violations were identified.</p> <p>All nurses and aides have been trained on the proper respiratory therapy equipment storage measures required for proper infection control by a Neighborhood Nurse Manager (Clingman-Megan Wesselman, RN, Morton-Theresa, Shircliff, RN, Marmion-Donna Watson, RN) by February 25, 2012. Nursing staff will implement</p>	



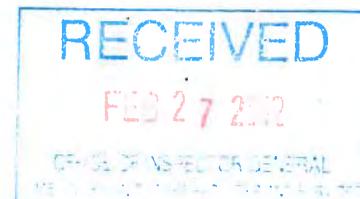
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F 441	<p>Continued From page 6 bedside table, not stored in a bag.</p> <p>Observation of Resident #13 during medication pass, on 02/01/12 at 2:00 PM, revealed the nurse opened the drawer of the bedside table and retrieved the mini neb mask, which was not stored in a bag. The mask had a cloudy film to the interior portion of the mask. Albuterol unit dose was distilled into the cannister and the mask was placed on the Resident for use during the respiratory treatment.</p> <p>Observation of Resident #13, on 2/2/12 at 3:10 PM, revealed the mini neb mask was lying interior side down in the bedside table top drawer. The mask had a cloudy film to the interior portion of the mask.</p> <p>Interview with License Practical Nurse #5, on 02/02/12 at 3:40 PM, revealed respiratory supplies should be changed weekly and the date should be placed on the storage bag. The LPN revealed without the storage bag, staff can not determine how old the equipment was and when it should be replaced. The LPN revealed SCM company was responsible to change out the equipment, but nurses should monitor. The LPN revealed a potential for bacteria to be on the mask without proper storage.</p> <p>Interview with the Director of Operation for SCM Trueair, on 02/02/12 at 3:45 PM, revealed a service tech rounds weekly and places a new mini neb set in each room, but the nurses are responsible to set up the equipment for use.</p> <p>Interview with the Clingman Unit Manager, on 02/02/12 at 4:05 PM, revealed mini nebs should</p>	F 441	<p>observation techniques during routine rounding of residents by aides, nurses and managers to include observation of the storage of respiratory equipment. A check-off of the proper storage of respiratory equipment by staff nurses at a minimum of every eight hours has been added to the TAR or mini neb sheets, as appropriate, for the resident. Neighborhood Nurse Managers (Clingman-Megan Wesselman, RN, Morton-Theresa, Shircliff, RN, Marlon-Donna Watson, RN) will conduct a weekly environmental audit that will be submitted weekly to the Director of Clinical Services (Kathy Shireman, RN). A summary report will be submitted to the QA/QI Committee meetings. The Care & Storage of Respiratory equipment will be included during the orientation of new hire nurses and aides as a part of infection control training. The Care & Storage of Respiratory Equipment has been added to the required annual Infection Control training.</p>	



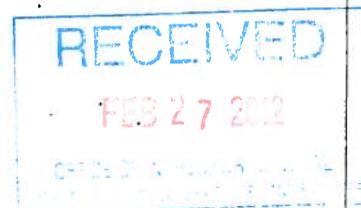
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F 441	<p>Continued From page 7</p> <p>be stored in the bag if not in use. The Unit Manager revealed nursing staff should be rinsing out the equipment after each use, and the whole set changed every 1 to 2 weeks. The Unit Manager revealed she assumed the bag was dated, but not sure. The Unit Manager revealed she did make resident room rounds, but did not specifically look to see if the mini nebs were being stored properly and dated. The Unit Manager revealed a potential for infection by not storing and dating equipment.</p> <p>Observation, on 01/31/12 at 8:22 AM, during the tour of the facility revealed in Room 42-2, Resident #1's room, an oxygen nasal cannula sitting out, uncovered and undated.</p> <p>Observation, on 02/01/12 at 11:30 AM, during the skin assessment of Resident #1 revealed the nasal cannula uncovered and undated on the bedside table next to his/her bed.</p> <p>Observation, on 02/02/12 at 10:20 AM, revealed the nasal cannula of Resident #1 uncovered and undated hanging over a grab bar the resident uses to assist him/herself in and out of bed. A plastic bag was noted on the floor in the corner of the room.</p> <p>Observation of unsampled Resident B during the initial tour, on 01/31/12 at 8:05 AM, revealed the oxygen tubing was lying on the floor, against the wall, behind the oxygen concentrator.</p> <p>Observation, on 02/02/12 at 2:35 AM, revealed the nasal cannula of Resident B draped over an oxygen concentrator with the nasal prongs on the floor. An additional nasal cannula was observed</p>	F 441		



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F 441	<p>Continued From page 8</p> <p>wrapped around the back of the resident's wheelchair, uncovered, not dated and not in a plastic bag.</p> <p>Interview, on 02/02/12 at 10:30 AM, with Registered Nurse (RN) #2 revealed oxygen tubing and nasal cannulas were to be stored in a plastic bag and dated. He stated, this was to ensure the nasal cannula was not open to the air or contaminated. He also revealed, if not covered, the nasal cannula could pick up contaminants or expose contaminants to the air.</p> <p>Interview, on 02/02/12 at 12:20 PM, with the Unit A (Morton Unit) Nurse Manager revealed the policy was to keep both nasal cannulas and nebulzers in a bag for storage. She stated to not store these items in a bag could be an infection control problem, that the resident could "develop an infection." Both the nasal cannulas and nebulzers were to be changed weekly, she stated, or more often if needed. Continued interview at 4:00 PM revealed a company, SCM, delivered the oxygen equipment to the room of the resident's in a bag. She stated the night shift changed out the oxygen equipment and she monitored the equipment during her rounds on the unit.</p> <p>Interview, on 02/02/12 at 2:35 PM, with RN #1 revealed nasal cannulas and nebulzers should be stored in plastic bags when not in use. She stated because of a "sanitation issue" you do not want to put something in someone's nose or mouth if you do not know where it has been. She stated she attended an in-service recently on oxygen therapy. Continued interview at 4:10 PM revealed the "oxygen SCM company staff"</p>	F 441		



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F 441	<p>Continued From page 9</p> <p>change out the nebulzers and nasal cannulas weekly. They have a resident list for who receives oxygen equipment. They place equipment in the resident's room but they do not open the packages. She did not know who monitors the oxygen equipment.</p> <p>Interview, on 02/02/12 at 2:40 PM, with Licensed Practical Nurse (LPN) #1 revealed resident nasal cannulas and nebulzers were to be stored in a plastic bag with the name of the resident and the date opened. They were to be placed in a drawer when not in use. The night shift changes the equipment. She had been trained on oxygen therapy and the in-service contained storage of oxygen equipment. In addition, she stated if the equipment was not properly stored, she would be worried that bacteria would be growing in the equipment.</p> <p>Interview, on 02/02/12 at 4:30 PM, with the Director of Nursing (DON) revealed nasal cannulas and nebulzers were to be stored inside a plastic bag when not in use. She stated the company SCM changes out the equipment and if needed, the nurses can change the equipment. She did not know if SCM dated the equipment when changed but that the equipment did need to be dated. The DON monitored the oxygen equipment during her rounds and she had not noted any issues with the oxygen equipment during her rounds.</p>	F 441		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/02/2012
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NAME OF PROVIDER OR SUPPLIER EPISCOPAL CHURCH HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 7604 WESTPORT ROAD LOUISVILLE, KY 40222
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 10</p> <p>3. Review of the Infection Control Program, revised 01/06, revealed appropriate ten (10) to fifteen (15) second handwashing must be performed under the following conditions: after removing gloves. The use of gloves does not replace handwashing.</p> <p>Observation of Resident #3's skin assessment, on 02/01/12 at 11:50 AM, revealed Licensed Practical Nurse #8 assessed Resident #3's head then donned new gloves. LPN #8 then assessed the residents peri (genital) area and buttocks, removed her gloves and placed the gloves in the pocket of her shirt. LPN #8 then donned new gloves to finish her assessment.</p> <p>Interview with LPN #8, on 02/01/12 at 2:27 PM, revealed she should have washed her hands after her glove change. She further stated they wash their hands to prevent the spread of germs and illness.</p> <p>Observation of Resident #10's skin assessment, on 02/01/12 at 9:25 AM, revealed LPN #9 assessed Resident #10's peri area, changed her gloves and did not wash her hands.</p> <p>Interview with LPN #8, on 02/01/12 at 2:25 PM, revealed she was not aware she was to wash her hands when she changed her gloves. LPN #8</p>	F 441	<p>Handwashing--The corrective action taken for those affected residents included retraining of the involved LPNs #8 & #9 regarding proper handwashing and disposal of gloves after changing gloves and before putting on another pair of gloves.</p> <p>All residents receive skin assessments, thus all nurses were re-educated as of February 25, 2012 on how to conduct a skin assessment inclusive of gloving/ de-gloving and handwashing after de-gloving & before re-gloving by the ADON (Beth Fryer, RN), Clingman Nurse Manager (Megan Wesselman, RN), and Marmion Nurse Manager (Donna Watson, RN). Training in new-hire orientation and in the annual infection control training by the ADON (Beth Fryer, RN) or designee will stress handwashing after de-gloving with any action and proper disposal of gloves after use.</p> <p>As a QA/QI measure, Clingman Nurse Manager (Meghan Wesselman, RN) will conduct skills competency observations of skin assessments on the identified nurses by 2/25/2012. All nurses will complete an annual skill competency evaluation on skin assessments to include the proper use of gloves & handwashing by the Neighborhood Nurse Managers and/or House Supervisors after re-education at a monthly rate of 8 % or for cause. Special attention will be placed on</p>	



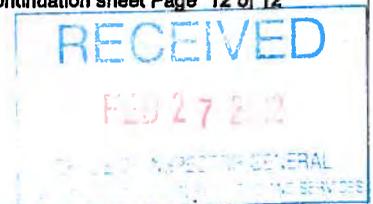
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/02/2012
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NAME OF PROVIDER OR SUPPLIER EPISCOPAL CHURCH HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 7604 WESTPORT ROAD LOUISVILLE, KY 40222
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 11</p> <p>also stated they wash their hands to prevent contamination, disease and infection.</p> <p>Interview with the Unit Manager of C-Hall, on 02/02/12 at 3:45 PM, revealed when the nurses change their gloves, the nurses were to use hand sanitizer or wash their hands. She further stated, they wash their hands to prevent the spread of infection.</p> <p>Interview with the Director of Nursing, on 02/02/12 at 4:35 PM, revealed when the nurses conduct skin assessments, the nurses were to wash their hands. If one set of gloves were contaminated and the nurse removed them and donned new gloves, the nurse should wash her hands. They are to wash their hands to prevent infection.</p>	F 441	<p>infection control related to gloving, degloving and handwashing. A skills competency check in this area will be performed during the first week of orientation for all new nurses by their mentor. Reporting of observation findings will be made to the Nursing Leadership team monthly and to the QA/QI Committee meetings by the Neighborhood Nurse Managers (Clingman-Megan Wesselman, RN, Morton-Theresa, Shircliff, RN, Marmion-Donna Watson, RN) and/or the Director of Clinical Services (Kathy Shireman, RN) with any identified plans of actions.</p>	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185310	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
NAME OF PROVIDER OR SUPPLIER EPISCOPAL CHURCH HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7504 WESTPORT ROAD LOUISVILLE, KY 40222	
(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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1975, 1986</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type II Unprotected.</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 02/01/12. Episcopal Church Home was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).</p>	K 000		

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.