

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

PRINTED: 01/05/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/23/2015
NAME OF PROVIDER OR SUPPLIER PARK TERRACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 8700 STONESTREET ROAD LOUISVILLE, KY 40272		
(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 Recertification Survey was initiated on 12/21/15 and concluded on 12/23/15 with deficiencies cited at the highest scope and severity of an "E". An Abbreviated Survey was initiated on 12/21/15 and concluded on 12/23/15 to investigate complaint KY24179. The Division of Health Care unsubstantiated the allegation with no deficiencies cited.	F 000	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and Material Safety Data Sheets (MSDS), it was determined the facility failed to ensure residents were free from potentially hazardous substances to prevent accidents. Nine (9) bottles containing hazardous chemicals were stored in an unlocked closet accessible to residents on one (1) of four (4) halls. The findings include: Review of the facility's policy regarding Storage of	F 323	F 323 It is the policy of the facility to ensure that the resident environment remains free of accident hazards. The deficient practice identified have been corrected with a new lock that is coded and will automatically lock when the door closes. All locks to areas that could have potentially hazardous substances has been checked for proper functioning and locking when door closes and all other locks are	1-09-16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

X [Signature]

TITLE

X ED

(X6) DATE

X 1-14-16

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

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F 323	<p>Continued From page 1</p> <p>Hazardous Chemicals, not dated, revealed all hazardous chemicals would be stored in a locked area when not in use.</p> <p>Observation during the initial environmental tour, on 12/21/15 at 1:47 PM, revealed an open janitor's closet on the Woods North Hall that housed nine cleaning bottles that were labeled Wiwax Cleaning & Maintenance Emulsion, Oxivir Five 16 Concentrate, Heavy Duty Prespray Plus, Extraction Rinse SC RTD, Red Carpet Rombus Carpet Clean W145, Virex II 256, Snapback UHS Restorer, Stench and Stain Digester, and Defoamer Anti-Mousse Anties Puma. Further observation revealed the janitor's closet was located in the back corner of Woods North Hall across from resident's rooms and the janitor's closet was not visible by staff at the nursing station, nor was any facility staff close by the unlocked closet containing the chemicals.</p> <p>1. Review of the Material Safety Data Sheets (MSDS) for Wiwax Cleaning and Maintenance Emulsion, dated 10/28/09, revealed Wiwax Cleaning and Maintenance Emulsion contained the cleaning ingredients of Diethylene glycol monoethyl ether and Propylene glycol. The MSDS also revealed, the product's First Aid Measures were the following: EYE CONTACT: Flush immediately with plenty of water. If irritation develops, get medical attention; SKIN CONTACT: Flush immediately with plenty of water. If irritation develops, get medical attention; INHALATION: No specific first aid measures are required; and INGESTION: No specific first aid measures are required.</p> <p>2. Review of the Material Safety Data Sheets</p>	F 323	<p>meeting safety requirements. Environmental Services staff have been educated by the Director of Environmental Services to ensure that all doors are locked when leaving an area that contains potentially hazardous materials and report immediately any lock that is not functioning properly. No other resident's were affected by the deficient practice. As part of the Preventive Maintenance Program, the Director of Plant Operations will check each door lock monthly to ensure they are properly functioning and any lock found to not function properly will either be repaired or replaced immediately.</p>	

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F 323	<p>Continued From page 2</p> <p>(MSDS) for Oxivir Five 16 Concentrate, dated 04/08/11, revealed Oxivir Five 16 Concentrate contained the cleaning ingredients of 2 Hydroxybenzoic Acid, Phosphoric Acid, and Hydrogen Peroxide. The MSDS also revealed, the product's First Aid Measures were the following: EYE CONTACT: Hold eye open and rinse slowly and gently with water for 15-20 minutes. Get medical attention immediately; SKIN CONTACT: Take off contaminated clothing and rinse skin immediately with plenty of water for 15-20 minutes. If irritation develops, get medical attention; INHALATION: If breathing is affected, remove to fresh air. Get medical attention immediately; and INGESTION: Call medical attendant, doctor, or poison control center immediately. Have person sip water if able to swallow. Do not induce vomiting unless told to do so by a poison control center or doctor.</p> <p>3. Review of the Material Safety Data Sheets (MSDS) for Heavy Duty Prespray Plus, dated 09/04/08, revealed Heavy Duty Prespray Plus contained the cleaning ingredients of 2-Ethylhexyl Sodium Sulphate and Alcohol Ethoxylates. The MSDS also revealed, the product's First Aid Measures were the following: EYE CONTACT: Flush immediately with plenty of water. If irritation persists, get medical attention; SKIN CONTACT: Flush immediately with plenty of water. If irritation persists, get medical attention; INHALATION: No specific first aid measures are required; and INGESTION: If Swallowed, give a cupful of water or milk.</p> <p>4. Review of the Material Safety Data Sheets (MSDS) for Extraction Rinse SC RTD, dated 10/09/08, revealed Extraction Rinse SC RTD contained the cleaning ingredients of</p>	F 323	
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F 323	Continued From page 3 Hydroxyacetic Acid. The MSDS also revealed, the product's First Aid Measures were the following: EYE CONTACT: Flush immediately with plenty of water. If irritation persists, get medical attention; SKIN CONTACT: Flush immediately with plenty of water. If irritation persists, get medical attention; INHALATION: No specific first aid measures are required; and INGESTION: If Swallowed, give a cupful of water or milk. 5. Review of the Material Safety Data Sheets (MSDS) for Red Carpet Rombus Carpet Clean W145, dated 07/02/03, revealed Red Carpet Rombus Carpet Clean W145 contained the cleaning ingredients of Surfactants. The MSDS also revealed, the product's First Aid Measures were the following: EYE CONTACT: Immediately irrigate with flowing water continuously for 15 minutes. If irritation persists consult medical personnel; SKIN CONTACT: Wash with soap and water; INHALATION: Move to fresh air. If irritation persists consult medical personnel; and INGESTION: If swallowed DO NOT induce vomiting unless directed to do so by medical personnel. If injured party is conscious, give two glasses of water. Seek medical attention if irritation persists. 6. Review of the Material Safety Data Sheets (MSDS) for Virex II 256, dated 08/03/11, revealed Virex II 256 contained the cleaning ingredients of N-Alkyk Dunethyl Benzyl Ammonium Chloride, Didecyl Dimethyl Ammonium Chloride, Ethyl Alcohol, Lauryl Dimethyl Amine Oxide. The MSDS also revealed, the product's First Aid Measures were the following: EYE CONTACT: Hold eye open and rinse slowly and gently with water for 15-20 minutes. Get medical attention	F 323			

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F 323	Continued From page 4 Immediately; SKIN CONTACT: Take off contaminated clothing and rinse skin immediately with plenty of water for 15-20 minutes. Get medical attention immediately; INHALATION: If breathing is affected, remove to fresh air. If person is not breathing call 911 or an ambulance then give artificial respiration, preferably by mouth to mouth, if possible. Get medical attention immediately; and INGESTION: Call a doctor or poison control center immediately for treatment and advice. Have person sip a glass water if able to swallow. Do not induce vomiting unless told to do so by a poison control center or doctor. 7. Review of the Material Safety Data Sheets (MSDS) for Snapback UHS Restorer, dated 10/27/11, revealed Snapback UHS Restorer contained the cleaning ingredients of Diethylene Glycol Monoethyl Ether and Dipropylene Glycol Methyl Ether. The MSDS also revealed, the product's First Aid Measures were the following: EYE CONTACT: Flush immediately with plenty of water. If irritation develops, get medical attention; SKIN CONTACT: Flush immediately with plenty of water. If irritation develops, get medical attention; INHALATION: No specific first aid measures are required; and INGESTION: No specific first aid measures are required. 8. Review of the Material Safety Data Sheets (MSDS) for Stench and Stain Digester, dated 03/07/11, revealed Stench and Stain Digester contained the cleaning ingredients of Sodium Lauryl Sulphate and Alcohol Ethoxylates. The MSDS also revealed, the product's First Aid Measures were the following: EYE CONTACT: Immediately Flush eyes with running water for at least 15 minutes, keeping eyelids open. Get medical attention; SKIN CONTACT: Flush	F 323			

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F 323	Continued From page 5 immediately with plenty of water. If irritation persists, get medical attention; INHALATION: If breathing is affected, remove to fresh air. Get medical attention; and INGESTION: Give a cupful of water or milk. THEN IMMEDIATELY CONTACT A PHYSICIAN OR POISON CENTER. DO NOT induce vomiting unless directed to do so by medical personnel. 9. Review of the Material Safety Data Sheets (MSDS) for Defoamer Anti-Mousse Anties Puma, dated 08/11/14, revealed Defoamer Anti-Mousse Anties Puma contained the cleaning ingredients of Methanol and 1,2-Benzisothiazol-3(2H)-One. The MSDS also revealed, the product's First Aid Measures were the following: EYE CONTACT: Immediately Flush eyes with plenty of water, if irritation occurs and persists, get medical attention; SKIN CONTACT: Rinse with plenty of water. If irritation occurs and persists, get medical attention; INHALATION: Rinse mouth with water. Interview with the Director of Environmental Services Housekeeping, on 12/23/16 at 8:43 AM, revealed the janitor's closet which contained the cleaning chemicals was supposed to be kept locked at all times because the chemicals in the cleaning products were dangerous and could cause serious harm to the residents. The Director of Environmental Services stated the housekeeping staff was trained during orientation, inserviced monthly and knew the importance of keeping the janitor's closets locked. In addition, the staff must have forgotten to turn the inside lock or to close the janitor's closet door completely and the lock on the door failed to automatically lock. The Director of Environmental Services further stated the house keeping staff was supposed to double check the janitor's closet	F 323			

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F 323	<p>Continued From page 6</p> <p>doors to ensure they were locked before they left the area.</p> <p>Interview with Housekeeper #2, on 12/23/15 at 8:47 AM, revealed she was the housekeeper assigned to work Woods North Hall on 12/21/15. Housekeeper #2 stated she couldn't remember if she closed the door completely or if the door was locked after she went into the janitor's closet to remove her mop bucket. Housekeeper #2 also stated she was trained by the facility to ensure the cleaning supplies were kept locked because they were potentially hazardous to staff and residents. Housekeeper #2 further stated she must have forgotten to re-check the janitor's closet door to ensure it was closed and locked appropriately.</p> <p>Interview with Housekeeper #1, on 12/23/15 at 9:00 AM, revealed she knew the janitor's closets on all the halls were to be kept locked because of the hazardous chemicals they housed were harmful to the residents. Housekeeper #1 stated the only times when the janitor's closet doors should be unlocked was when one of the housekeepers was close by or in the closet. Housekeeper #1 also stated the housekeeping staff had a key to unlock it and they must turn the button and push it in on the inside of the janitor's closet to relock it after it had been unlocked. Housekeeper #1 further stated staff was trained to double check the janitor's closet doors to ensure the doors were locked before they left the area.</p> <p>Interview with the Executive Director (ED), on 12/23/15 at 4:00 PM, revealed it was the facility's policy to keep all chemicals locked and inaccessible to the residents. The ED stated the</p>	F 323			

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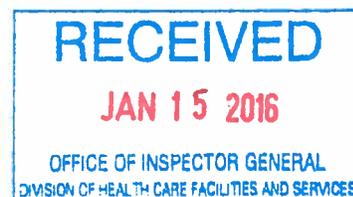
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F 323	Continued From page 7 janitor's closet on the Woods North Hall that contained the nine cleaning containers should have been locked. The ED also stated if any of the residents in the facility had come into contact with the chemicals the facility staff would have to follow the MSDS information and ensure the physician was contacted for medical direction and treatment.	F 323			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (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	F 441	F 441 It is the policy of the facility to establish and maintain a safe, sanitary and comfortable environment to help prevent the transmission of disease and infection. No other residents were affected by the improper cleaning technique and show no signs or symptoms of infection around the site. The Director of Post Acute Care Services has provided education to all licensed nursing staff on the proper cleaning technique for residents with foley catheters and supra pubic catheters.	1-29-16	

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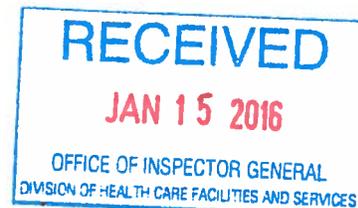
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F 441	<p>Continued From page 8 hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to maintain effective infection control practices for one (1) of seventeen (17) sampled residents (Resident #7). Certified Nurse Aide (CNA) #5 cleaned the stoma site for a suprapubic catheter from outer perimeters towards the stoma site.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Guidelines for Suprapubic Catheter Care, not dated, revealed the purpose was to prevent skin irritation around the stoma site and to prevent infection of the resident's urinary tract.</p> <p>Review of Resident #7's clinical record revealed the facility admitted the resident on 12/05/06 with diagnoses of Cerebral Infarction, Type II Diabetes Mellitus, Hematuria and Neuromuscular Dysfunction of the Bladder with a Suprapubic Catheter.</p> <p>Observations, on 12/23/15 at 10:30 AM, revealed</p>	F 441	<p>As part of the QA program, the Director of Post Acute Care Services or designee will complete a monthly audit of 10% of the resident population observing for proper infection control practices with regard to proper catheter care and incontinence care. These results will be part of the QA process. The audits will continue monthly for 6 months and if at that time the campus has 100% compliance with proper catheter care, then the audits will be completed quarterly as part of the QA process. If at anytime the campus does not achieve a 100% compliance with the audit, then the campus will return to completing audits monthly until they reach 100% compliance at which time this will return to quarterly audits for one year of QA process.</p>	



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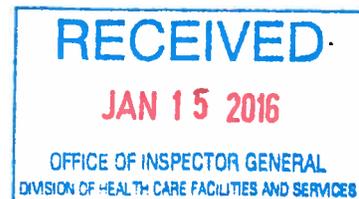
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F 441	<p>Continued From page 9</p> <p>CNA #5 performed suprapubic care with Resident #7. CNA #5 cleaned the area with a cloth from the left towards the stoma site. She followed the same motion on the right side towards the stoma site. She cleaned the distal (farthest away) area of the catheter tubing towards the stoma site. The catheter was attached to a bedside drainage bag placed in a dignity bag</p> <p>Interview with CNA #5, on 12/23/15 at 11:20 AM, revealed the technique she utilized during the suprapubic care was done in the manner she normally completed the procedure. She stated she wiped from side to stoma and usually clean the catheter in the same manner. She paused and stated she did not know that was a problem, but it could be a concern for infection. She further stated she should be cleaning away from the catheter and away from the opening into the bladder.</p> <p>Interview with Licensed Practical Nurse #1, on 12/23/15 at 11:30 AM, revealed suprapubic catheter care site cleaning should be done from the stoma site outward whether cleaning the catheter or the site. She stated she was not aware any staff was cleaning in any other direction. She stated the cleaning motion towards the stoma site would be a concern for the possibility of infection for the resident.</p> <p>Interview with the Director of Nursing, on 12/23/15 at 11:50 AM, revealed the suprapubic catheters were like any other catheter, the staff was trained to clean around the opening, outward. Then the catheter tubing was cleaned from the opening outward. She stated she was not aware any staff was cleaning in any other manner. She stated the concern was the</p>	F 441		



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F 441	Continued From page 10 Introduction of an infection when completed in the reverse.	F 441			
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to provide a functioning resident emergency call system in four (4) of five (5) unlocked staff and visitor restrooms accessible to residents. Per the Director of Nursing twelve (12) of eighty-three (83) residents were functionally capable of utilizing these restrooms independently. The findings include: Review of the facility's policy Guidelines for Answering Call Lights, not dated, revealed the purpose for the call lights was to respond to resident's requests and needs. Observation, on 12/23/15 at 9:13 AM, revealed there was a total of four unlocked staff and visitor restrooms that was accessible to residents. These were located in the facility on the second (2nd) and third (3rd) floors in the restroom in the living area across from the elevator; the restroom by the staff break room across from the dining area; the restroom in the hallway across from the	F 463	F 463 It is the policy of this facility to have functioning nurse call systems that communicate from all resident rooms, toileting and bathing facilities. The four restrooms identified as having deficient practice will have emergency call pull cords installed. The pull cords will be connected into the nurse call system for the 2nd floor nurse station and the 3rd floor restroom will have an independent call system which will be located at the 3rd floor nurse station. Both systems will allow nursing staff to be notified if the emergency cord is pulled in any of these 4 bathrooms. No other deficient practice has been identified with non available call cords.	1-22-16	



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER PARK TERRACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 9700 STONE STREET ROAD LOUISVILLE, KY 40272		
(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 463	<p>Continued From page 11</p> <p>physical therapy department and the dining area. The fourth (4 th) unlocked restroom was located on the third (3rd) floor in the living area across from the elevator. Further observation of all four (4) restrooms revealed there was no emergency pull cords nor any communication system available for residents to have the ability to directly communicate with nursing staff in the event of an emergency.</p> <p>Interview with the Director of Nursing (DON), on 12/23/15 at 10:17 AM, revealed twelve (12) of the eighty-three (83) residents that lived in the facility had the ability to get up on their own and self-ambulate.</p> <p>Interview with Certified Resident Care Assistant (CRCA) #1, on 12/23/15 at 9:55 AM, revealed there were unlocked restrooms on the second (2nd) and third (3rd) floors for staff and visitors. CRCA #1 stated the residents also had access to the unlocked restrooms and could use them anytime. CRCA #1 also stated the unlocked restroom should have a call alert system for the residents because in the event of an emergency the resident would currently have to yell for help if they needed assistance.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 12/23/15 at 10:03 AM, revealed there were unlocked restrooms on the second (2nd) and third (3rd) floors for staff and visitors. LPN #1 stated she had personally helped residents into the restrooms by the staff break room because those restrooms were close to the dining room and the residents frequently used them. LPN #1 also stated all restrooms that are utilized by residents need a call system in them for the resident's safety. LPN #1 further stated she</p>	F 463			

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F 463	<p>Continued From page 12 wasn't aware those restrooms did not have a resident emergency pull cord in them.</p> <p>Interview with the Director of Plant Operations, on 12/23/15 at 10:10 AM, revealed there were unlocked restrooms in the facility that residents, staff, and guest had access to. The Director of Plant Operations stated that all restrooms in the facility the residents had access to should have a call system available to the residents for their safety.</p> <p>Continued interview with the Director of Nursing (DON), on 12/23/15 at 10:17 AM, revealed the residents had free access to all the restrooms in the facility. The DON stated all restrooms the residents had access to should have a call alert system.</p> <p>Interview with the Executive Director (ED), on 12/23/15 at 10:21 AM, revealed she was aware there were unlocked restrooms on the second (2nd) and third (3rd) floors and that residents had access to because they were guest restrooms. The ED stated all restrooms accessible to residents should have a communication systems for residents to have direct contact to facility staff.</p>	F 463		

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{F 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 01/22/16 as alleged.	{F 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.

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NAME OF PROVIDER OR SUPPLIER PARK TERRACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 8700 STONESTREET ROAD LOUISVILLE, KY 40272	
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1974</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF DP, occupying the second and third floors.</p> <p>TYPE OF STRUCTURE: Three (3) stories, Type II protected.</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments; four (4) on the second floor and three (3) on the third floor.</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: Two (2) Type II, 300 KW generators, installed in 1976. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 12/22/15. The facility was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

X [Signature]

TITLE

X ED

(X6) DATE

X 1/15/16

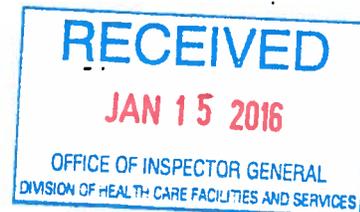
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

JAN 15 2016

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K 000 K 038 SS=F	<p>Continued From page 1 Fire).</p> <p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress doors to all stairs to exit the building that were equipped with fifteen (15) second delayed egress hardware, had displayed the required signage in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the four (4) smoke compartments on the second floor, and each of the three (3) smoke compartments on the third floor, all residents, staff and visitors. The facility has eighty-eight (88) certified beds and the census was eighty-three (83) on the day of the survey.</p> <p>The findings include:</p> <p>1. Observation, on 12/22/15 at 11:58 AM, with the Interim Executive Director, the Senior Director of Plant Operations and the Director of Plant Operations revealed the stair door to exit the second floor Administrative area emergency exit was equipped with fifteen (15) second delayed</p>	K 000 K 038	<p>K038</p> <p>All egress doors identified as deficient with regard to proper identification with signage in accordance with NFPA standards have been corrected.</p> <p>All egress doors now have the proper signage attached to them where it is visible.</p> <p>No other deficient practice has been identified.</p>	1-22-16



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NAME OF PROVIDER OR SUPPLIER PARK TERRACE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 6700 STONESTREET ROAD LOUISVILLE, KY 40272		
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K 038	<p>Continued From page 2</p> <p>egress hardware, but did not display the proper signage identifying the door would open after fifteen (15) seconds upon activation of the door hardware.</p> <p>Interviews, on 12/22/15 at 12:00 PM, with the Interim Executive Director, the Senior Director of Plant Operations and the Director of Plant Operations revealed they were not aware the fifteen (15) second delayed egress signage was not displayed on stair doors to exit the building in the event of an emergency.</p> <p>2. Observation, on 12/22/15 at 12:31 PM, with the Interim Executive Director, the Senior Director of Plant Operations and the Director of Plant Operations revealed the stair door to exit the second floor South emergency exit was equipped with fifteen (15) second delayed egress hardware, but did not display the proper signage identifying the door would open after fifteen (15) seconds upon activation of the door hardware.</p> <p>Interviews, on 12/22/15 at 12:33 PM, with the Interim Executive Director, the Senior Director of Plant Operations and the Director of Plant Operations revealed they were not aware the fifteen (15) second delayed egress signage was not displayed on stair doors to exit the building in the event of an emergency.</p> <p>3. Observation, on 12/22/15 at 12:38 PM, with the Interim Executive Director, the Senior Director of Plant Operations and the Director of Plant Operations revealed the stair door to exit the second floor Lobby emergency exit was equipped with fifteen (15) second delayed egress hardware, but did not display the proper signage</p>	K 038		

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K 038	<p>Continued From page 3</p> <p>identifying the door would open after fifteen (15) seconds upon activation of the door hardware.</p> <p>Interviews, on 12/22/15 at 12:40 PM, with the Interim Executive Director, the Senior Director of Plant Operations and the Director of Plant Operations revealed they were not aware the fifteen (15) second delayed egress signage was not displayed on stair doors to exit the building in the event of an emergency.</p> <p>4. Observation, on 12/22/15 at 12:43 PM, with the Interim Executive Director, the Senior Director of Plant Operations and the Director of Plant Operations revealed the stair door to exit the second floor North emergency exit was equipped with fifteen (15) second delayed egress hardware, but did not display the proper signage identifying the door would open after fifteen (15) seconds upon activation of the door hardware.</p> <p>Interviews, on 12/22/15 at 12:45 PM, with the Interim Executive Director, the Senior Director of Plant Operations and the Director of Plant Operations revealed they were not aware the fifteen (15) second delayed egress signage was not displayed on stair doors to exit the building in the event of an emergency.</p> <p>5. Observation, on 12/22/15 at 1:02 PM, with the Interim Executive Director, the Senior Director of Plant Operations and the Director of Plant Operations revealed the stair door to exit the third floor South emergency exit was equipped with fifteen (15) second delayed egress hardware, but did not display the proper signage identifying the door would open after fifteen (15) seconds upon</p>	K 038		

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K 038	<p>Continued From page 4 activation of the door hardware.</p> <p>Interviews, on 12/22/15 at 1:04 PM, with the Interim Executive Director, the Senior Director of Plant Operations and the Director of Plant Operations revealed they were not aware the fifteen (15) second delayed egress signage was not displayed on stair doors to exit the building in the event of an emergency.</p> <p>6. Observation, on 12/22/15 at 1:08 PM, with the Interim Executive Director, the Senior Director of Plant Operations and the Director of Plant Operations revealed the stair door to exit the third floor Lobby emergency exit was equipped with fifteen (15) second delayed egress hardware, but did not display the proper signage identifying the door would open after fifteen (15) seconds upon activation of the door hardware.</p> <p>Interviews, on 12/22/15 at 1:08 PM, with the Interim Executive Director, the Senior Director of Plant Operations and the Director of Plant Operations revealed they were not aware the fifteen (15) second delayed egress signage was not displayed on stair doors to exit the building in the event of an emergency.</p> <p>7. Observation, on 12/22/15 at 1:13 PM, with the Interim Executive Director, the Senior Director of Plant Operations and the Director of Plant Operations revealed the stair door to exit the third floor North emergency exit was equipped with fifteen (15) second delayed egress hardware, but did not display the proper signage identifying the door would open after fifteen (15) seconds upon activation of the door hardware.</p>	K 038			

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K 038	<p>Continued From page 5</p> <p>Interviews, on 12/22/15 at 1:15 PM, with the Interim Executive Director, the Senior Director of Plant Operations and the Director of Plant Operations revealed they were not aware the fifteen (15) second delayed egress signage was not displayed on stair doors to exit the building in the event of an emergency.</p> <p>The census of eighty-three (83) was verified by the Interim Executive Director on 12/22/15. The findings were acknowledged by the Interim Executive Director and verified by the Senior Director of Plant Operations and the Director of Plant Operations at the exit interview on 12/22/15.</p> <p>Reference: 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</p>	K 038		

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K 038	<p>Continued From page 6</p> <p>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 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.</p> <p>(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</p> <p>7.10.8.1* No Exit. Any door, passage, or stairway</p>	K 038		

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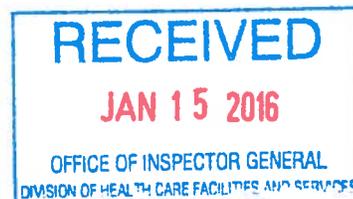
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K 038	Continued From page 7 that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word 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. 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		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185462	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PARK TERRACE AT NORTON SOUTHWEST B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER PARK TERRACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 9700 STONESTREET ROAD LOUISVILLE, KY 40272	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062 SS=D	<p>Continued From page 8</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the automatic sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments on the second floor, approximately twenty (20) residents, staff and visitors. The facility has eighty-eight (88) certified beds and the census was eighty-three (83) on the day of the survey. The facility failed to ensure escutcheon plates were installed at all sprinkler heads throughout the facility.</p> <p>The findings include:</p> <p>Observation, on 12/22/15 at 12:24 PM, with the Interim Executive Director, the Senior Director of Plant Operations and the Director of Plant Operations revealed an escutcheon plate was missing at one (1) of the sprinkler heads located in second floor, South Spa Room.</p> <p>Interviews, on 12/22/15 at 12:26 PM, with the Interim Executive Director, the Senior Director of Plant Operations and the Director of Plant Operations revealed they were unaware of the escutcheon plate missing at the sprinkler head</p>	K 062	<p>K 062</p> <p>The automatic sprinkler identified as deficient has been corrected and meets NFPA standards.</p> <p>All campus sprinkler heads meet NFPA standards. No further deficient practice identified.</p> <p>The Director of Plant Operations will observe sprinkler heads as part of the preventive maintenance program to ensure they all meet NFPA standards at all times. The current program directs the Plant Operations to inspect at a minimum of every month.</p> <p>Any deficient practice identified will be corrected immediately.</p>	1-29-16



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 062	<p>Continued From page 9 located in the second floor, South Spa Room.</p> <p>The census of eighty-three (83) was verified by the Interim Executive Director on 12/22/15. The findings were acknowledged by the Interim Executive Director and verified by the Senior Director of Plant Operations and the Director of Plant Operations at the exit interview on 12/22/15.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>4.6.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:</p> <p>(1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height</p> <p>The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers</p>	K 062		

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K 062	Continued From page 10 are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 062			

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NAME OF PROVIDER OR SUPPLIER PARK TERRACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 9700 STONESTREET ROAD LOUISVILLE, KY 40272
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{K 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 01/22/16 as alleged.</p>	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.