

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

MAR 14 2014

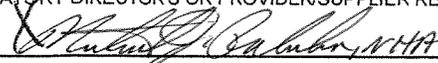
PRINTED: 02/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185361	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/06/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  KINDRED HOSPITAL - LOUISVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205
---	---

(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	<p><b>INITIAL COMMENTS</b></p> <p>A standard health survey was initiated on 02/04/14 and concluded on 02/06/14. A Life Safety Code survey was conducted on 02/05/14. Deficiencies were cited with the highest scope and severity of an "F".</p>	F 000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
F 328 SS=D	<p>This was a Nursing Home Initiative Survey started on Tuesday, 02/04/14 at 7:45 AM.</p> <p><b>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</b></p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure intravenous (IV) tubing for fluids and antibiotics were labeled according to facility and pharmacy policies for one (1) of ten (10) sampled residents, (Resident #4).</p> <p>The findings include:</p>	F 328	<p><b>F 328</b></p> <p>Resident # 4's IV tubing for the continuous TPN fluid and the antibiotics were labeled per policy on 2/5/2014. TPN was labeled to be discarded in 24 hours. Antibiotic tubing was labeled to be discarded in 96 hrs.</p> <p>Current residents were reviewed. IV tubing hanging in resident rooms were labeled per policy. No other deficient practice noted.</p> <p>Unit Manager standardized IV discard labels. One label ordered and stocked on the unit for nursing staff to utilize. Appropriate training or retraining of nursing staff will be conducted by Staff Development Coordinator to be completed by 2/28/2014.</p> <p>Daily monitoring of IV tubing labels will be conducted by Unit Manager, Staff Development Coordinator or Charge Nurse until 100% compliance noted for</p>	3/22/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 3/14/14
---	-----------------------------	----------------------

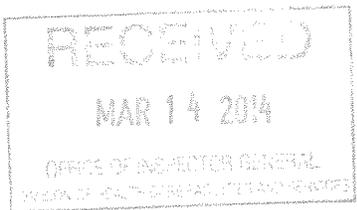
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

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

PRINTED: 02/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185361	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/06/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED HOSPITAL - LOUISVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205	
(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)
F 328	<p>Continued From page 1</p> <p>Review of the facility's policy regarding Continuous Infusion of Medications and Solutions, revised 07/01/12, revealed Administration sets (tubing) used for continuous infusion would be changed every ninety-six (96) hours.</p> <p>Review of the facility's policy regarding Administration of an Intermittent Infusion via a Secondary Line, revised 07/01/12, revealed a secondary administration set (tubing) used for an intermittent infusion continually connected to the primary set is changed every ninety-six (96) hours. A secondary administration set (tubing) used for an intermittent infusion disconnected from the primary set should be changed every twenty-four (24) hours.</p> <p>Review of the Medication Administration Record (MAR) for Resident #4 revealed Dextrose 10% was to infuse at fifty (50) milliliters per hour until Total Parental Nutrition (TPN) was restarted, dated 02/01/14. The MAR further revealed on 01/31/14 the medications Flagyl 500 milligrams intravenous over six (6) hours for ten (10) days and Zosyn 3.375 milligrams intravenous every eight hours was written.</p> <p>Observation, on 02/04/14 at 11:00 AM, of Resident #4's IV infusions revealed Dextrose 10% infusing at fifty (50) milliliter per hour and the tubing was labeled, initiated on 02/01/14, to discard on 02/03/14. An IV bag of Flagyl 500 mg was hanging, and disconnected from the primary set. Zosyn 3.375 mg IV was connected to the primary set. Both Flagyl and Zosyn tubing were labeled, initiated 02/02/14 with no discard date. All three (3) IV infusions (tubing) had labels that stated discard after twenty-four (24) hours at the</p>	F 328	<p><b>F 328</b></p> <p>one week until 100% compliance is met. Then audits will be conducted 3 times a week for 1 month, then bi-weekly. Audits that show less than 100% compliance will be used by the Director of nursing Services or RN Supervisor to identify staff responsible for the deficient practice and address using the facility's progressive discipline policy. Results of the audits will be presented to the Quality Assurance Committee monthly by the Director of Nursing Services or Unit Manager and audits will continue until 100% compliance is achieved for 3 consecutive months. The QA committee consists of the Administrator (Executive Director), Director of Nursing Services, Medical Director, Activities Director, Social Services Director, MDS Coordinator, Registered Dietitian, Medical Records Clerk, Staff Development Coordinator, and Wound Care Nurse.</p> <p>To ensure continued compliance, the Director of Nursing Services or RN Supervisor will conduct an audit at least monthly to ensure adherence to the requirement. Any deviations found during these audits will be addressed using the facility's progressive discipline policy.</p>

(X5) COMPLETION DATE



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

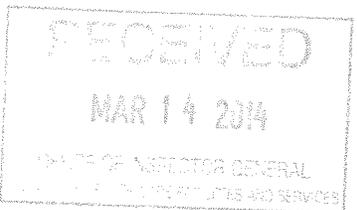
PRINTED: 02/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/06/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 328	<p>Continued From page 2 top of the label.</p> <p>Observation, on 02/04/14 at 3:22 PM, of Resident #4's IV revealed what appeared to be a full bag of Dextrose 10% IV fluids, and empty bags of IV Flagyl and IV Zosyn. None of the three (3) IV infusions (tubing) were labeled or dated.</p> <p>Observation, on 02/05/14 at 8:20 AM, of Resident #4 revealed TPN was infusing at eighty-three (83) ml/hr. It was labeled, initiated on 02/04/14 discard on 02/05/14. IV Flagyl and IV Zosyn were both hung, but not connected to a primary line or on the IV pump. The IV Flagyl was labeled, initiated on 02/05/14 time 0000, discard 02/06/14, time 0000. The IV Zosyn was labeled, initiated on 02/05/14 timed 0600, discard 02/06/14, timed 0600.</p> <p>Observation, on 02/05/14 at 1:45 PM, revealed Licensed Practical Nurse (LPN) #1 administered Zosyn 3.375 mg IV using an IV pump for Resident #4.</p> <p>Interview with LPN #1, on 02/05/14 at 1:55 PM, revealed TPN tubing was changed with each new bag. She stated tubing sets for IV fluids were good for seventy-two (72) hours and tubing for IV antibiotics were good for seventy-two (72) hours. She stated the facility had recently changed pharmacies and believed the policies had changed for IV administration labeling procedures.</p> <p>Review of the education/training attendance roster, revealed the Pharmacy had conducted training on IV administration and the new policies on six (6) different occasions. LPN #1 had signed the training log, on 12/20/13 at 1:30 PM.</p>	F 328		
-------	---	-------	--	--



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

PRINTED: 02/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/06/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

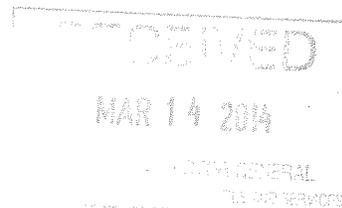
F 328 Continued From page 3

F 328

Interview with Registered Nurse #1, on 02/06/14 at 10:20 AM, revealed the facility had recently changed Pharmacs and they had been trained on the new policies related to IV administration. She stated TPN tubing was changed with each set, tubing for Dextrose 10% IV fluids were changed every twenty-four (24) hours and IV antibiotic tubing was good for ninety-six (96) hours; if it was not piggybacked into a primary setup. She stated the purpose was to prevent contamination.

Interview with the Unit Manager, on 02/06/14 at 1:40 PM, revealed she had only been at the facility for about two (2) weeks. She stated the Director of Nursing (DON) was training her a little at a time. She stated the policy on IV tubing directed it was good for ninety-six (96) hours, as long as, it was continuously running, but she would need to look at the policy if it was not a continuous infusion. She stated TPN tubing was changed with each bag. She stated there were different labels in the medication room and the labels for 24 hour use only, were usually for TPN. The green labels should have been used for IV infusions used for longer than twenty-four (24) hours such as IV fluids and antibiotics. She stated the purpose of dating and changing tubing for IV medication was to reduce the chance of contamination.

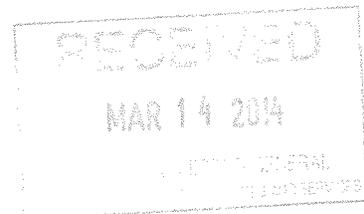
Interview with the DON, on 02/06/14 at 2:00 PM, revealed the facility changed pharmacies on January 1, 2014 and their representatives in-serviced the staff on the new policy/procedures including changes related to labeling and dating IV tubing. She stated her expectations were the tubing would be dated and labeled based on the



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

PRINTED: 02/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/06/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE
F 328	Continued From page 4 policy. She stated there was a potential for infection if not changed or dated per standards and policy.	F 328		



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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/22/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE</b> <b>LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 03/22/14 as alleged.</p>	{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.

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

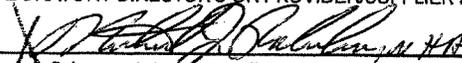
PRINTED: 02/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
--	---	---	---

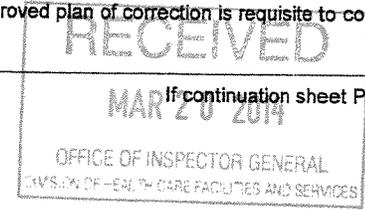
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</b>
--	---

(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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Plan Approval: 1962, 1992</p> <p>Survey under: 2000 existing</p> <p>Facility type: SNF/NF on the third floor of a Hospital.</p> <p>Type of structure: Third (3rd) Floor of a Six (6) story with Basement, Type II protected construction.</p> <p>Smoke Compartment: Four (4) smoke compartments 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 I generators, 600 KW and 300 KW, fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 02/05/14. The skilled nursing facility located on the third floor of Kindred Hospital 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</p>	K 000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
-------	--	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Executive Director</b>	(X6) DATE <b>3/18/14</b>
---	------------------------------------	-----------------------------

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.



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

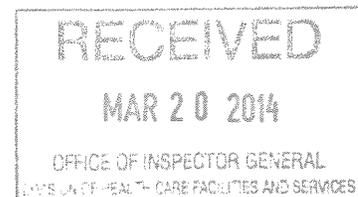
PRINTED: 02/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
--	---	---	---

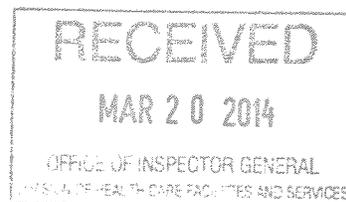
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</b>
--	---

(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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

<p>K 000</p> <p>K 018 SS=F</p>	<p>Continued From page 1 Regulations, 483.70 (a) et seq. (Life Safety from Fire).</p> <p>Deficiencies were cited with the highest deficiency identified at a F level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors protecting corridor openings were constructed to resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke</p>	<p>K 000</p> <p>K 018 <b>K018</b></p>	<p>Doors to rooms #304, 383, 384, and 385; were repaired by 3/7/2014 to have no greater than one half inch gap from the door stop. Door lock set to room #306 was repaired on 3/7/2014 to restore proper latching capability. Doors #331 and #304 will be replaced to meet requirement by 3/19/14.</p> <p>An inspection by the Director of Plant Operations of all other doors was completed by 3/7/2014 and doors were found to meet the requirement.</p> <p>The facility's Preventative Maintenance program will be updated by 3/14/2014 by the Director of Plant Operations to include inspection of fire and smoke doors at least quarterly by a Maintenance Technician to ensure adherence to the requirement. Completion of the Preventative Maintenance is a policy of the facility.</p> <p>Director of Plant Operations was educated on the requirements on 2/24/2014 by the West Region Facilities Manager. The Plant Operations staff will be educated by 3/19/2014 by the Director of Plant Operations.</p> <p>Corridor fire/smoke doors will be inspected</p>	<p>3/22/2014</p>
------------------------------------	--	---------------------------------------	---	------------------



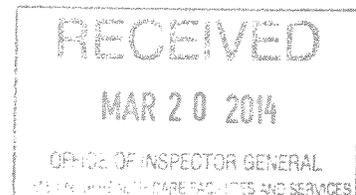
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE
K 018	<p>Continued From page 2</p> <p>compartments, forty seven (47) residents, staff and visitors. The facility is certified for forty seven (47) beds with a census of thirty nine (39) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/05/14 between 10:00 AM and 3:00 PM, with the Executive Director, Regional Facility Manager, and the Maintenance Technician revealed the corridor doors to room's #304, 331, 383, 384, and 385 had greater than one half inch gap from the door stop and would not resist the passage of smoke. Further observation revealed the corridor doors to rooms # 304 and 306 would not latch when tested.</p> <p>Interview, on 02/05/14 between 10:00 AM and 3:00 PM, with the Executive Director, Regional Facility Manager, and the Maintenance Technician revealed they were not aware the doors had too large of a gap or would not latch to resist the passage of smoke.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding</p>	K 018	<p><b>K018</b></p> <p>weekly for one month and monthly thereafter. Results will be presented to the Quality Assurance Committee by the Director of Plant Operations and audits continued until 100% compliance is achieved for three (3) consecutive months. The QA committee consists of the Executive Director (Administrator), Director of Nursing Services, Medical Director, Activities Director, Social Services Director, MDS Coordinator, Registered Dietitian, Medical Records Clerk, Staff Development Coordinator, and Wound Care Nurse.</p> <p>To ensure continued compliance, doors will be inspected at least quarterly and maintained as outlined in facility's Preventative Maintenance Program by a Maintenance Technician and reported to the Director of Plant Operations. The Director of Plant Operations will present the Preventative Maintenance information to the QA committee at least quarterly to be reviewed for adherence to the requirement.</p>	



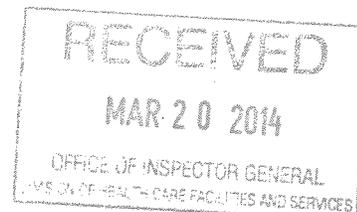
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE
K 018	Continued From page 3 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018		
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8  This STANDARD is not met as evidenced by: Based on observation and interview the facility did not meet the requirements for illumination of	K 045	K045  Illumination of the Means of Egress for the outside of stairwells N1, C2, C3, and E2 will be corrected by installing new lighting. Lights will be installed by Henderson Services LLC by 3/22/14 to meet the requirement.  Other locations were inspected by Director of Plant Operations by 3/7/2014 and no other issues needing correction were found.	3/23/2014



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE
K 045	<p>Continued From page 4</p> <p>means of egress in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, forty seven (47) residents, staff and visitors. The facility is certified for forty seven (47) beds with a census of thirty nine (39) on the day of the survey. The facility failed to provide required illumination outside an exit for discharge.</p> <p>The findings include:</p> <p>Observation, on 02/05/14 between 10:00 AM and 3:00 PM, with the Executive Director, Regional Facility Manager, and the Maintenance Technician revealed four (4) of six (6) stairwells did not have a light fixture installed outside to provide the required illumination for exit discharge. The stairwells were identified by signage inside the stairwell as: N1, C2, C3, and E2.</p> <p>Interview, on 02/05/14 between 10:00 AM and 3:00 PM, with the Executive Director, Regional Facility Manager, and the Maintenance Technician revealed they were not aware the exits did not have the required illumination for egress lighting.</p> <p>Reference NFPA 101 (2000 edition) 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in</p> <p>7.7 DISCHARGE FROM EXITS 7.7.1* Exits shall terminate directly at a public way or at</p>	K 045	<p><b>K045</b></p> <p>The Director of Plant Operations was educated on this requirement by the West Region Facilities Manager on 2/24/2014. The Plant Operations staff will be educated on this requirement by the Director of Plant Operations by 3/19/2014.</p> <p>The Preventative Maintenance Program was updated on 3/14/2014 by the Director of Plant Operations to include a monthly inspection of the illumination of the means of egress by a Maintenance Technician to ensure adherence to the requirement. Completion of the Preventative Maintenance is a policy of the facility.</p> <p>Means of Egress for the outside of the stairwells will be inspected weekly for one month and monthly thereafter. Results will be presented to the Quality Assurance Committee by the Director of Plant Operations monthly and audits continued until 100% compliance is achieved for three (3) consecutive months. The QA committee consists of the Executive Director (Administrator), Director of Nursing Services, Medical Director, Activities Director, Social Services Director, MDS Coordinator, Registered Dietitian, Medical Records Clerk, Staff Development Coordinator, and Wound Care Nurse.</p> <p>To ensure continued compliance, illumination of means of egress will be inspected and maintained as outlined in facility's Preventative Maintenance Program by a Maintenance Technician and reported to</p>	



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

PRINTED: 02/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
--	---	---	---

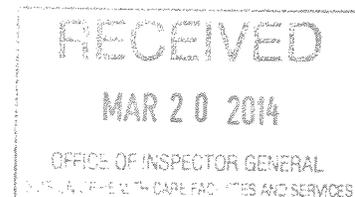
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</b>
--	---

(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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 045	Continued From page 5 an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23. 7.7.2 Not more than 50 percent of the required number of exits, and not more than 50 percent of the required egress capacity, shall be permitted to discharge through areas on the level of exit discharge, provided that the criteria of 7.7.2(1) through (3) are met: (1) Such discharge shall lead to a free and unobstructed way to the exterior of the building, and such way is readily visible and identifiable from the point of discharge from the exit. (2) The level of discharge shall be protected throughout by an approved, automatic sprinkler system in accordance with Section 9.7, or the portion of the level of discharge used for this purpose shall be protected by an approved, automatic sprinkler system in accordance with Section 9.7 and shall be separated from the nonsprinklered portion of the floor by a fire resistance rating meeting the requirements for the enclosure of exits (see 7.1.3.2.1). Exception: The requirement of 7.7.2(2) shall not apply where the discharge area is a vestibule or foyer meeting all of the following: (a) The depth from the exterior of the building shall not be more than 10 ft (3 m) and the length	K 045	K045 the Director of Plant Operations. The Director of Plant Operations will present the Preventative Maintenance information to the QA committee at least quarterly to be reviewed for adherence to the requirement.	
-------	--	-------	--	--

RECEIVED  
MAR 20 2014  
INSPECTOR GENERAL  
CENTERS FOR MEDICARE AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185361	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/05/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED HOSPITAL - LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205	
(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 045	Continued From page 6 shall not be more than 30 ft (9.1 m). (b) The foyer shall be separated from the remainder of the level of discharge by construction providing protection not less than the equivalent of wired glass in steel frames. (c) The foyer shall serve only as means of egress and shall include an exit directly to the outside. (3) The entire area on the level of discharge shall be separated from areas below by construction having a fire resistance rating not less than that required for the exit enclosure. Exception No. 1: Levels below the level of discharge shall be permitted to be open to the level of discharge in an atrium in accordance with 8.2.5.6. Exception No. 2: One hundred percent of the exits shall be permitted to discharge through areas on the level of exit discharge as provided in Chapters 22 and 23. Exception No. 3: In existing buildings, the 50 percent limit on egress capacity shall not apply if the 50 percent limit on the required number of exits is met. 7.7.3 The exit discharge shall be arranged and marked to make clear the direction of egress to a public way. Stairs shall be arranged so as to make clear the direction of egress to a public way. Stairs that continue more than one-half story beyond the level of exit discharge shall be interrupted at the level of exit discharge by partitions, doors, or other effective means. 7.7.4 Doors, stairs, ramps, corridors, exit passageways, bridges, balconies, escalators, moving walks, and other components of an exit discharge shall comply with the detailed requirements of this chapter for such	K 045		



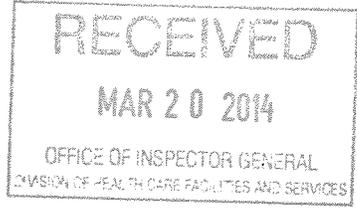
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</b>
--	---

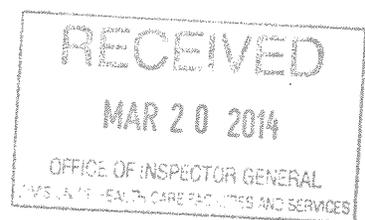
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 045	<p>Continued From page 7 components. 7.7.5 Signs. (See 7.2.2.5.4 and 7.2.2.5.5.) 7.7.6 Where approved by the authority having jurisdiction, exits shall be permitted to discharge to roofs or other sections of the building or an adjoining building where the following criteria are met: (1) The roof construction has a fire resistance rating not less than that required for the exit enclosure. (2) There is a continuous and safe means of egress from the roof.</p> <p>7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the</p>	K 045		



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

PRINTED: 02/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185361	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/05/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED HOSPITAL - LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205	
(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 045	Continued From page 8 means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on battery light testing record review, and interview, it was determined the facility failed to provide and test emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect four (4) of	K 046	K046  The ninety (90) minute emergency battery test was conducted on the emergency lighting fixture by a Maintenance Technician on 2/10/2014 and no problems found.  Other areas subject to this requirement were inspected by the Director of Plant Operations by 3/7/2014 and no other areas needing correction were found.	3/22/2014



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

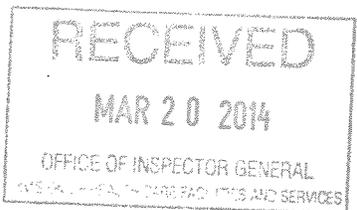
PRINTED: 02/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185361	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/05/2014
--	--	--	--

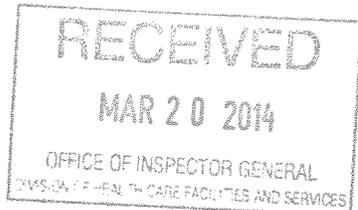
NAME OF PROVIDER OR SUPPLIER  KINDRED HOSPITAL - LOUISVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205
---	---

(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
--------------------	--	---------------	---	----------------------

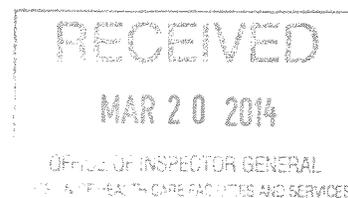
K 046	<p>Continued From page 9</p> <p>four (4) smoke compartments, forty seven (47) residents, staff and visitors. The facility is certified for forty seven (47) beds with a census of thirty nine (39) on the day of the survey. The facility failed to provide emergency battery lighting in required areas and test emergency battery lighting for ninety (90) minutes annually.</p> <p>The findings include:</p> <p>Battery light testing record review, on 02/05/14 at 2:20 PM, with the Executive Director, Regional Facility Manager, and the Maintenance Technician revealed the facility did not have documentation for the ninety (90) minute annual testing of emergency battery lighting located in the generator room.</p> <p>Interview, on 02/05/14 at 2:20 PM, with the Executive Director, Regional Facility Manager, and the Maintenance Technician revealed they were aware documentation was to be kept for emergency battery light testing, but not aware it had not been completed.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 11/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity</p>	K 046	<p><b>K046</b></p> <p>The Director of Plant Operations was educated on the requirement by the West Region Facilities Manager on 2/24/2014. The Plant Operation staff will be educated by the Director of Plant Operations by 3/19/2014.</p> <p>The Preventative Maintenance program was updated on 2/24/2014 to reflect the required ninety (90) minute test of the emergency battery for lighting to be completed at least annually by a Maintenance Technician to ensure adherence to the requirement. Completion of the Preventative Maintenance program is a policy of the facility.</p> <p>A ninety (90) minute emergency battery test will be conducted monthly for three (3) months by a Maintenance Technician or Director of Plant Operations. Results will be presented to the Quality Assurance Committee by the Director of Plant Operations monthly and tests will continue until 100% compliance is achieved for three (3) consecutive months. The QA committee consists of the Executive Director (Administrator), Director of Nursing Services, Medical Director, Activities Director, Social Services Director, MDS Coordinator, Registered Dietitian, Medical Records Clerk, Staff Development Coordinator, and Wound Care Nurse.</p> <p>To ensure continued compliance, the Preventative Maintenance Plan report will be submitted at least quarterly to the QA</p>	
-------	---	-------	--	--



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE
K 046	Continued From page 10 ratio of 40 to 1 shall not be exceeded.  7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.  Reference: NFPA 110 (1999 edition)  5-3.1. Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch. Exception: This requirement shall not apply to units housed outdoors.	K 046	<b>K046</b>  committee by the Director of Plant Operations and be reviewed for adherence to the requirement.	
K 050 SS=F	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware	K 050	<b>K050</b>  Fire drills were conducted during the day shift on 2/24/2014 at 11:00am and on the night shift on 2/27/2014 at 8:00pm by the Director of Security.	3/22/2014



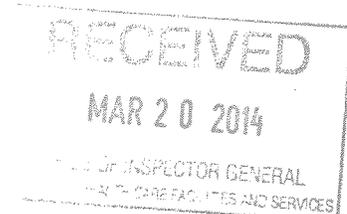
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE
K 050	<p>Continued From page 11 that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, forty seven (47) residents, staff and visitors. The facility is certified for forty seven (47) beds with a census of thirty nine (39) on the day of the survey. The facility failed to ensure the fire drills were conducted quarterly on each shift at unexpected times.</p> <p>The findings include:</p> <p>Fire Drill record review, on 02/05/14 at 2:25 PM, with the Executive Director, Regional Facility Manager, and the Maintenance Technician revealed the facility failed to conduct quarterly fire drills for each shift. The fire drills were being conducted in conjunction with the Hospital. The staff of the skilled nursing facility on the third (3rd) floor was involved in two (2) fire drills in the year 2013. The fire drills that involved the staff of the skilled nursing facility were conducted on 10/24/13 at 5:00 PM, and 05/29/13 at 11:45 AM. The facility had two (2) shifts during the week.</p>	K 050	<p><b>K050</b></p> <p>The drills were conducted in the Skilled Nursing Facility.</p> <p>The Director of Security was educated on the requirement by the Executive Director (Administrator) on 2/19/2014. The Director of Security will educate the Security staff on the requirement by 3/19/2014.</p> <p>The fire drill records have been updated to separate the Skilled Nursing Facility and Hospital drills by the Director of Security on 2/24/2014. Fire drills will be conducted within the Skilled Nursing Facility at least once a shift quarterly in accordance with the requirement and will be conducted by the Director of Security or a qualified Security Officer. It is the policy of the facility to adhere to the fire drill requirements.</p> <p>Fire drills will be conducted monthly for Three (3) months by the Director of Security, Security Officer or Director of Plant Operations. Results will be presented to the Quality Assurance Committee by the Director of Security monthly until 100% compliance is achieved for three (3) consecutive months. The QA committee consists of the Executive Director (Administrator), Director of Nursing Services, Medical Director, Activities Director, Social Services Director, MDS Coordinator, Registered Dietitian, Medical Records Clerk, Staff Development Coordinator, and Wound Care Nurse.</p> <p>To ensure continued compliance, the Fire Drill Report will be presented to the QA</p>	3/22/2014



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

PRINTED: 02/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE
K 050	Continued From page 12 They were scheduled 7-AM to 7-PM and 7-PM to 7-AM. The facility also had a weekend shift.  Interview, on 02/05/15 at 2:25 PM, with the Executive Director, Regional Facility Manager, and the Maintenance Technician revealed they were not aware the fire drills were not conducted in accordance with NFPA standards.  Reference: NFPA 101 (2000 edition)  19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.  Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7* OPERATING FEATURES 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills	K 050	<b>K050</b>  committee by the Director of Security at least quarterly to be reviewed for adherence to the requirement.	



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

PRINTED: 02/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

**K 050** Continued From page 13  
shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.  
Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.

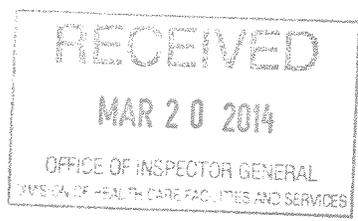
**K 050**

**K 051**  
SS=F  
NFPA 101 LIFE SAFETY CODE STANDARD  
A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6

**K 051**

**K051**  
Fire Detection Devices, including the remote enunciator panel, were repaired by licensed personnel from Simplex Grinnell by 2/24/2014. A new remote enunciator for the Fire Alarm Control Panel was installed on 3/14/2014 by Simplex Grinnell in an area staffed on all shifts.  
  
The Director of Plant Operations was educated on this requirement by the West Region Facilities Manager on 2/24/2014. The Plant Operations staff will be educated on this requirement by the Director of Plant Operations by 3/19/2014.  
  
The Preventative Maintenance program was updated on 3/7/2014 to reflect at least a monthly test of the proper functionality of the remote enunciator panel by a Maintenance Technician. Completion of the Preventative Maintenance program is a policy of the facility.

3/22/2014

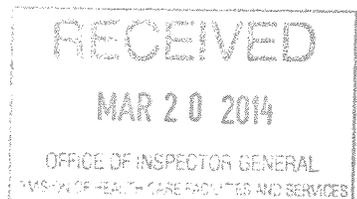


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 051	<p>Continued From page 14</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building fire alarm system was installed as required by NFPA standards. The deficient practice has the potential to affect four (4) of four (4) smoke compartments, forty seven (47) residents, staff, and visitors. The facility is certified for forty seven (47) beds with a census of thirty nine (39) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/05/14 at 3:00 PM, with the Executive Director, Regional Facility Manager, and the Maintenance Technician revealed the Fire Alarm Control Panel (FACP) was located in an area of the basement that was not staffed. The FACP indicated a Trouble Signal. The remote annunciator panel was located at the Front Desk and was not staffed on Third (3rd) shift. The remote annunciator indicated the system was Normal. The remote annunciator failed to indicate the trouble signal from the FACP. The remote annunciator was not installed in an area that it was likely to be heard.</p> <p>Interview, on 02/05/14 at 3:00 PM, with the Executive Director, Regional Facility Manager, and the Maintenance Technician revealed they were aware the FACP was indicating Trouble. The trouble signal was due to a bad duct detector. The fire alarm contractor had already been contacted and was scheduled to make</p>	K 051	<p><b>K051</b></p> <p>Proper functioning of the remote enunciator panels will be tested weekly for one month, then monthly for three (3) months by a Maintenance Technician or Director of Plant Operations. Results will be presented to the Quality Assurance Committee by the Director of Plant Operations monthly and tests will continue until 100% compliance is achieved for 3 consecutive months. The QA committee consists of the Administrator (Executive Director), Director of Nursing Services, Medical Director, Activities Director, Social Services Director, MDS Coordinator, Registered Dietitian, Medical Records Clerk, Staff Development Coordinator, and Wound Care Nurse.</p> <p>To ensure continued compliance, Preventative Maintenance checks of the fire panel and operation of the remote enunciator panel will be presented to the QA committee at least quarterly by the Director of Plant Operations to be reviewed for adherence to the requirement.</p>	
-------	---	-------	--	--



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 051	<p>Continued From page 15</p> <p>repairs the next day. Further interview revealed they were not aware the remote annunciator panel did not indicate the trouble signal. They were also not aware the remote annunciator was to be located in an area that was staffed and likely to be heard.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p><b>9.6 FIRE DETECTION, ALARM, AND COMMUNICATIONS SYSTEMS</b></p> <p><b>9.6.1 General.</b></p> <p><b>9.6.1.1</b></p> <p>The provisions of Section 9.6 shall apply only where specifically required by another section of this Code.</p> <p><b>9.6.1.2</b></p> <p>Fire detection, alarm, and communications systems installed to make use of an alternative allowed by this Code shall be considered required systems and shall meet the provisions of this Code applicable to required systems.</p> <p><b>9.6.1.3*</b></p> <p>The provisions of Section 9.6 cover the basic functions of a complete fire alarm system, including fire detection, alarm, and communications. These systems are primarily intended to provide the indication and warning of abnormal conditions, the summoning of appropriate aid, and the control of occupancy facilities to enhance protection of life.</p> <p><b>9.6.1.4</b></p> <p>A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the</p>	K 051		
-------	---	-------	--	--

**RECEIVED**

**MAR 20 2014**

OFFICE OF INSPECTOR GENERAL  
DEPARTMENT OF HEALTH CARE FACILITIES AND SERVICES

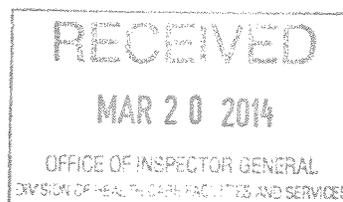
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE	
K 051	<p>Continued From page 16 authority having jurisdiction.</p> <p>9.6.1.5 All systems and components shall be approved for the purpose for which they are installed.</p> <p>9.6.1.6 Fire alarm system installation wiring or other transmission paths shall be monitored for integrity in accordance with 9.6.1.4.</p> <p>9.6.1.7* To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>1-5.4.4 Distinctive Signals. Fire alarms, supervisory signals, and trouble signals shall be distinctively and descriptively annunciated.</p> <p>1-5.4.6 Trouble Signals. Trouble signals and their restoration to normal shall be indicated within 200 seconds at the locations identified in 1-5.4.6.1 or 1-5.4.6.2. Trouble signals required to indicate at the protected premises shall be indicated by distinctive audible signals. These audible trouble signals shall be distinctive from alarm signals. If an intermittent signal is used, it shall sound at least once every 10 seconds, with a minimum duration of 1/2 second. An audible trouble signal shall be permitted to be common to several supervised circuits. The trouble signal(s) shall be located in an area where it is likely to be heard.</p> <p>5-2.6.1.4 Upon receipt of trouble signals or other signals pertaining solely to matters of equipment</p>	K 051			

RECEIVED  
MAR 20 2014  
INSPECTOR GENERAL  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

PRINTED: 02/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE
K 051	<p>Continued From page 17</p> <p>maintenance of the fire alarm systems, the central station shall perform the following actions:</p> <p>(1) *Communicate immediately with persons designated by the subscriber A-5-2.6.1.4(1)</p> <p>The term immediately in this context is intended to mean "without unreasonable delay." Routine handling should take a maximum of 4 minutes from receipt of a trouble signal by the central station until initiation of the investigation by telephone.</p> <p>5-5.3.2.1.6.2</p> <p>The following requirements shall apply to all combinations in 5-5.3.2.1.6.1:</p> <p>(1) Both channels shall be supervised in a manner approved for the means of transmission employed.</p> <p>(3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes.</p> <p>(8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally.</p> <p>3-8.1* Fire Alarm Control Units.</p> <p>Fire alarm systems shall be permitted to be either integrated systems combining all detection, notification, and auxiliary functions in a single system or a combination of component subsystems. Fire alarm system components shall be permitted to share control equipment or shall be able to operate as standalone subsystems, but, in any case, they shall be arranged to function as a single system. All component subsystems shall be capable of simultaneous, full load operation without degradation of the required, overall system performance.</p>	K 051		

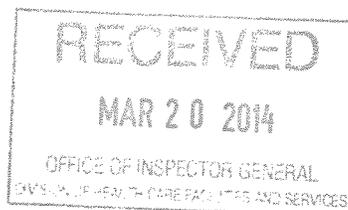


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

<p>K 144 K 144 SS=F</p>	<p>Continued From page 18 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, forty seven (47) residents, staff, and visitors. The facility is certified for forty seven (47) beds with a census of thirty nine (39) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/05/14 at 2:55 PM, with the Executive Director, Regional Facility Manager, and the Maintenance Technician revealed the emergency battery lighting installed in the generator room did not to function when tested. Further observation revealed the facility did not provide emergency battery lighting inside three (3) generator transfer switch rooms.</p> <p>Interview, on 02/05/14 at 2:55 PM, with the</p>	<p>K 144 K 144</p>	<p><b>K144</b></p> <p>The emergency battery lighting in the generator room was repaired and tested for functionality by a Maintenance Technician on 2/10/2014. Emergency battery lighting will be installed by Henderson Services LLC in the remaining three (3) generator switch rooms by 3/20/2014.</p> <p>The Director of Plant Operations was educated on this requirement by the West Region Facilities Manager on 2/24/2014. The Plant Operations staff will be educated on this requirement by the Director of Plant Operations by 3/19/2014.</p> <p>The Preventive Maintenance program was updated by the Director of Plant Operations by 3/14/2014 to reflect the inspection weekly and testing monthly of the emergency battery lighting by the Director of Plant Operations or a Maintenance Technician. Completion of the Preventative Maintenance program is a policy of the facility.</p> <p>Emergency battery lighting for the generator switch rooms will be inspected weekly and tested monthly for three months by a Maintenance Technician or Director of Plant Operations. Results will be presented to the Quality Assurance Committee by the Director of Plant Operations monthly and testing will continue until 100% compliance is achieved for three (3) consecutive months. The QA</p>	<p>3/22/2014</p>
---------------------------------	---	------------------------	--	------------------



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

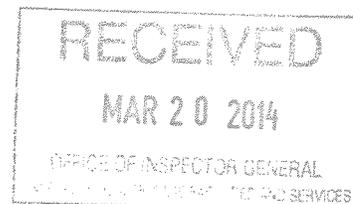
PRINTED: 02/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
--	---	--	---

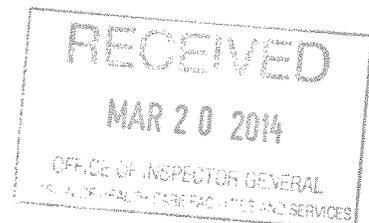
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</b>
--	---

(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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 144	<p>Continued From page 19</p> <p>Executive Director, Regional Facility Manager, and the Maintenance Technician revealed the emergency battery light was tested monthly; however, they were not aware the emergency battery light had stopped functioning. Further interview revealed they were not aware emergency battery lighting was required in the transfer switch rooms.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 11/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic,</p>	K 144	<p><b>K144</b></p> <p>committee consists of the Executive Director (Administrator), Director of Nursing Services, Medical Director, Activities Director, Social Services Director, MDS Coordinator, Registered Dietitian, Medical Records Clerk, Staff Development Coordinator, and Wound Care Nurse.</p> <p>To ensure continued compliance, Preventative Maintenance reports of the emergency battery lighting in the generator switch rooms for proper operation will be presented to the QA committee at least quarterly by the Director of Plant Operations to be reviewed for adherence to the requirement.</p>	
-------	---	-------	--	--



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE	
K 144	Continued From page 20 battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.  Reference: NFPA 110 (1999 edition)  5-3.1. Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch. Exception: This requirement shall not apply to units housed outdoors.	K 144			



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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/23/2014</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE</b> <b>LOUISVILLE, KY 40205</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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

{K 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 03/23/14 as alleged.</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.