

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

PRINTED: 12/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/27/2013
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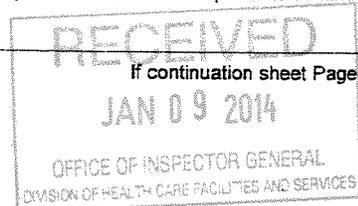
NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219
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F 000	INITIAL COMMENTS	F 000	The submission of this plan of correction does not indicate an admission of Franciscan Health Care that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to our residents. This facility recognized its obligation to provide legally and medically necessary care and services to its residents. the facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to maintain accurately documented medical records for one (1) of sixteen (16) sampled residents, Resident #2. Resident #2's weight log was documented inaccurately.  The findings include:  Policy review revealed no evidence of a policy on keeping an accurate weight record.	F 514	This facility asks that this plan of correction and any supporting documentation be considered for desk review for compliance.  1. Resident #2 was reweighed under supervision of ADHS and correct weight documented accordingly.  2.Weight report for all residents will be reviewed weekly to ensure accurate documentation by DHS, ADHS or Unit Manager.	1-7-14 1-6-14 MPS 1-10-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

\* Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

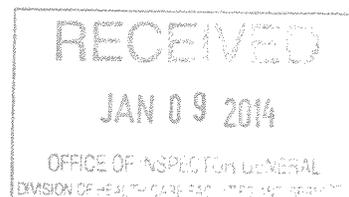


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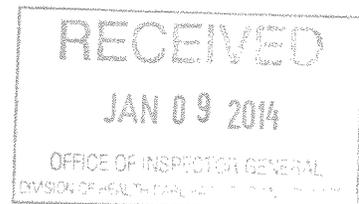
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F 514	<p>Continued From page 1</p> <p>Review of Resident #2's clinical record revealed the facility admitted the resident on 08/01/13 with diagnoses of Unspecified Rehab Procedures, Physical Therapy, Muscle Disorder, Essential Hypertension and Coronary Artery Disease. Review of Resident #2's Significant Change Minimum Data Set (MDS), dated 11/11/13, revealed the facility assessed Resident #2 with a BIMS score of ten (10) which meant Resident #2 was interviewable.</p> <p>Observation of Resident #2, on 11/26/13 at 10:22 AM, 1:50 PM and 2:15 PM, revealed Resident #2 was sitting in his/her wheelchair.</p> <p>Record review of Resident #2's Weight Flow Sheet, revealed Resident #2 had an admission weight (wt) of 198.4 pounds (08/01/13). On 08/07/13 the resident's weight was documented as 198.3 pounds. On 08/12/13 Resident #2's weight was documented as 199.0 pounds. On 08/25/13 the resident's weight was documented as 199.0 pounds. On 08/25/13 Resident #2's weight was documented as 157.6 pounds. Resident #2 appeared to have had a 41.4 pound weight loss.</p> <p>Continued review revealed on 09/01/13 Resident #2's weight was documented as 200.1 pounds, which appeared Resident #2 had a weight gain of forty-two (42) pounds in one week. On 09/08/13 the staff documented Resident #2's weight of 198.2 pounds. On 09/15/13 Resident #2's weight was documented as 199.4 pounds. On 09/22/13 the staff documented Resident #2's weight of 167.4 pounds. Resident #2 appeared to have had a thirty-two (32) pound wt loss.</p> <p>Interview with Resident #2, on 11/26/13 at 2:58</p>	F 514	<p>3. Nursing staff will be educated on (date) related to proper procedure for weighing residents in wheelchairs, as well as documentation of resident weights. DHS or ADHS to provide education. Nurses will also be educated on (date) by DHS and Medical Records on the importance of accurate documentation in the medical record.</p> <p>4. 100 % of residents on weekly weights will be reviewed each week, for twelve (12) weeks by DHS or ADHS prior to Clinically At Risk Meetings. Staff responsible for weighing residents will complete competency testing on weighing residents while in wheelchair. These competencies will be completed by (date). After initial competency checkoffs, staff will be required to complete annually thereafter to insure that weights are obtained and documented accurately. Results of audits and competency testing for the previous four weeks will be reviewed at monthly by the Quality Assurance Committee, consisting of Executive Director, Director of Health Services, Assistant Director of Health Services, Maintenance Director and Environmental Services Director, and by the Medical Director at least quarterly, until team concludes issue is resolved.</p>		



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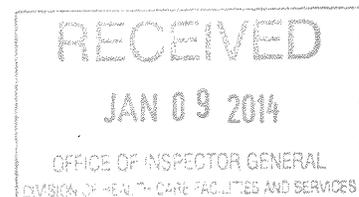
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F 514	Continued From page 2 PM, revealed Resident #2 never weighed 200 pounds and that his/her average weight was in the 160's.  Observation of Certified Nursing Assistant (CNA) #1 weighing Resident #2, on 11/27/13 at 9:44 AM, revealed CNA #1 weighed Resident #2 in his/her wheelchair and obtained a weight of 195.4 pounds. CNA #1 then took Resident #2 back to his/her room and then weighed the wheelchair which weighed forty (40) pounds.  Interview with CNA #1, on 11/27/13 at 9:44 AM, revealed CNA #1 would then take Resident #2's weight plus the wheelchair (195.4 pounds) and subtract Resident #2's wheelchair weight of 40 pounds which equaled 155.4 pounds. CNA #1 stated she would document Resident #2's weight without the weight of the wheelchair on the Weight Flow Sheet as 155.4 pounds to ensure accuracy.  Interview with CNA #2, on 11/27/13 at 10:52 AM, revealed she was familiar with Resident #2 and Resident #2's clothes always fit the same. CNA #2 stated she could not see Resident #2 weighing 199 pounds and would say that 160 pounds was more accurate. CNA #2 stated she thought the weight documented on the Weight Flow Sheet was the wheelchair weight added to Resident #2's weight. CNA #2 stated the weight on the Weight Flow Sheet was not an accurate account of Resident #2's weight.  Interview with Licensed Practical Nurse (LPN) #1, on 11/27/13 at 10:28 AM, revealed she could not remember Resident #2 weighing 200 pounds. LPN #1 stated the added weight was possibly Resident #2's wheelchair. LPN #1 stated she did	F 514			



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F 514	Continued From page 3  not think it was accurate for Resident #2 to weigh 199 one week and then 167 the next week. LPN #1 stated Resident #2 had a strong appetite.  Review of the Nutrition Progress Note, dated 10/14/13, revealed Resident #2 did not appear to be 200 pounds on admission. Intake 94.3 % times (x) seven (7) days. Visually Resident #2 did not appear to have lost thirty (30) plus pounds either. The Registered Dietician spoke with the resident and several CNAs and nursing staff who reported Resident #2 may have had some weight loss visually, but not thirty (30) plus pounds. Resident #2's clothes were still fitting the same. Resident denied ever being two hundred (200) pounds.  Interview with the Registered Dietician (RD), on 11/27/13 at 11:22 AM, revealed looking at the Weight Flow Sheet it appeared Resident #2 had a significant wt loss. The RD stated she had documented that the admission weight was not correct. The RD stated Resident #2 ate well and the fit of his/her clothes had not changed. The RD stated she would say the Weight Flow Sheet weights was an inaccurate account of Resident #2's weight.  Interview with the Assistant Director of Nursing (ADON), on 11/27/13 at 11:01 AM, revealed Resident #2 had been about the same size since she had known Resident #2. The ADON stated she had educated the staff on how to obtain weights. The CNA's should be subtracting the wheelchair weight from the residents wt. The ADON stated looking at the Weight Flow Sheet it appeared Resident #2 had had a major weight loss and that was not accurate.	F 514			



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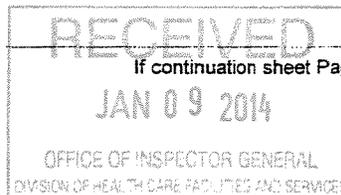
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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  BUILDING: 01  PLAN APPROVAL: 1964, 1975, 2001  SURVEY UNDER: 2000 Existing  FACILITY TYPE: S/NF DP  TYPE OF STRUCTURE: One (1) story, Type V (Protected).  SMOKE COMPARTMENTS: Seven (7) smoke compartments.  FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier.  FIRE ALARM: Complete fire alarm system with heat and smoke detectors.  SPRINKLER SYSTEM: Complete automatic dry sprinkler system.  GENERATOR: Type II generator. Fuel source is natural gas.  A standard Life Safety Code survey was conducted on 11/26/13. Franciscan Health Care Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Antoinette Swallow</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>1/6/14</i>
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K 029 Continued From page 2

K 029

Observations, on 11/26/13 between 8:12 AM and 8:47 AM, with the Maintenance Director revealed both the Therapy Storage Room and the Record Keeping Storage Room had small holes on the interior side of the rooms where shelves had been removed.

Interviews, on 11/26/13 between 8:12 AM and 8:47 AM, with the Maintenance Director revealed he was not aware of the holes within the storage rooms not being filled smoke tight and able to resist the passage of smoke in the event of an emergency.

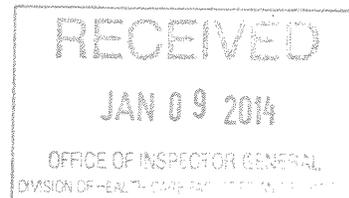
Reference:

NFPA 101 (2000 Edition).

19.3.2 Protection from Hazards.

19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:

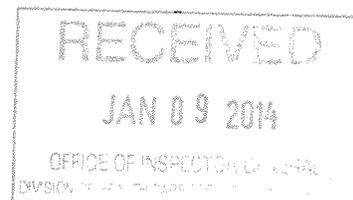
- (1) Boiler and fuel-fired heater rooms
- (2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)
- (3) Paint shops
- (4) Repair shops
- (5) Soiled linen rooms



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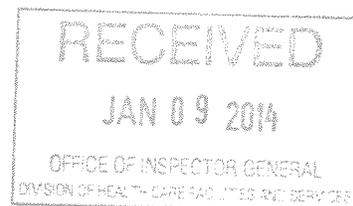
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K 029	Continued From page 3 (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. K 062 SS=D NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, approximately twenty-five (25) residents, staff and visitors. The facility has eighty-five (85) certified beds and the census was seventy-six (76) on the day of the survey. The facility failed to ensure sprinkler head spray patterns were not obstructed.  The findings Include:	K 029	K 062 The facility will maintain the sprinkler system in accordance with NFPA standards in all areas. The sprinkler head in the Record Keeping Storage Room has been replaced to allow proper operating condition by our sprinkler vendor Kentuckiana Sprinkler on December 6th, 2013.  The Director of Plant Operations audited other sprinkler heads to ensure full compliance with this NFPA standard. No other sprinkler heads were found to be out of compliance.	1-6-14



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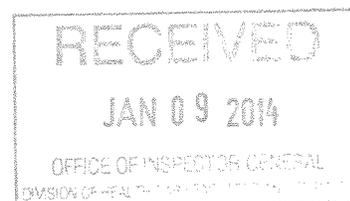
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K 062	<p>Continued From page 4</p> <p>Observation, on 11/26/13 at 8:47 AM, with the Maintenance Director revealed the sprinkler head within the Record Keeping Storage Room, had its spray pattern obstructed by a surface mounted fluorescent light fixture. The light fixture was positioned less than four (4) inches from the sprinkler head and extended further down from the ceiling than the sprinkler head diffusers did.</p> <p>Interview, on 11/26/13 at 8:47 AM, with the Maintenance Director revealed he was unaware the positioning of the surface mounted light fixture would obstruct the spray patterns of the sprinkler head upon activation of the automatic sprinkler system.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition)</p> <p>4.6.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition.</p> <p>NFPA 13 (1999 Edition)</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development.</p> <p>5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing Shall comply with 5-5.5.2.</p> <p>Table 5-6.5.1.2. Positioning of sprinklers to avoid obstructions to discharge requires at least one foot clearance between sprinkler heads and</p>	K 062	<p>The our sprinkler vendor conducts quarterly inspections of all sprinkler heads and will notify the Director of Plant Operations if a sprinkler head is found in need or replacement or in any way does not meet NFPA standards. Director of Plant Operations will report findings to the QA Committee for 6 months, then as needed thereafter.</p>	1-6-14



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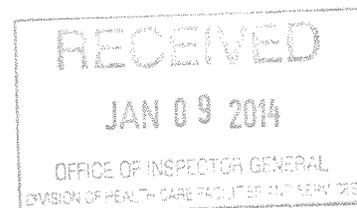
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K 062	Continued From page 5 obstructions to spray patterns that are level with or taller than the sprinkler head.  NFPA 25 (1998 Edition)  2-2.1.1. Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, 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. 2-2.1.2*. Unacceptable obstructions to spray patterns shall be corrected.	K 062		
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.  Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13  Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3), 10.3.4. 19.7.5.3	K 074	The facility will maintain compliance with NFPA standards related to installation of shower curtains. The one shower curtain that did not meet the NFPA standards was removed the day of this inspection, 11/27/13, and was replaced with a shower curtain that meets these standards.  Our housekeeping staff inspect shower curtains during routine cleaning of shower. Housekeeping staff were trained on 1.6.14 on requirements of NFPA so these curtains meet all requirements. The Environmental Director will be to the Director of Plant Operations and Executive Director if any curtain is identified that is not in compliance. Any failure to meet this standard will be submitted to the QA Committee for further evaluation of the system. Will monitor monthly for 6 months, then thereafter if concerns are identified.	1-7-14 1-6-14 by 10/11/14



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185132</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/26/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3625 FERN VALLEY ROAD LOUISVILLE, KY 40219</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 074	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the installation of shower curtains were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, approximately twenty-five (25) residents, staff and visitors. The facility has eighty-five (85) certified beds and the census was seventy-six (76) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/26/13 at 8:55 AM, with the Maintenance Director revealed the privacy curtains hung in the Spa Room located in the TCU-1 Unit, were of a solid fabric hung directly below the ceiling. The solid fabric would obstruct the spray pattern of the automatic sprinklers in the event of an emergency.</p> <p>Interview, on 11/26/13 at 8:55 AM, with the Maintenance Director revealed he was aware of the requirements for proper coverage of the sprinkler system and acknowledged that a solid fabric curtain could obstruct the spray pattern in the event of an emergency.</p> <p>Reference: NFPA 13 (1998 Edition) Standard for the Installation of Sprinkler Systems</p> <p>19.3.5.5 For the proper operation of sprinkler systems, cubicle curtains and sprinkler locations need to be coordinated. Improperly designed systems might obstruct the sprinkler spray from reaching the fire or might shield the heat from the sprinkler. Many options are available to the</p>	K 074		



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

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NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3625 FERN VALLEY ROAD LOUISVILLE, KY 40219</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 074	Continued From page 7 designer including, but not limited to, hanging the cubicle curtains 18 in. (46 cm) below the sprinkler deflector; using a ½-in. (1.3-cm) diagonal mesh or a 70 percent open weave top panel that extends 18 in. (46 cm) below the sprinkler deflector; or designing the system to have a horizontal and minimum vertical distance that meets the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. The test data that forms the basis of the requirements of NFPA 13 is from fire tests with sprinkler discharge that penetrated a single privacy curtain.	K 074		

