

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

PRINTED: 05/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/09/2013
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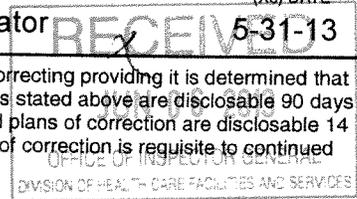
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056
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F 000	INITIAL COMMENTS A standard health survey was initiated on 05/07/13 and concluded on 05/09/13 and a Life Safety Code Survey was initiated and concluded on 05/08/13 with deficiencies cited at the highest scope and severity of an "F", with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, Resident's Bill of Rights, it was determined the facility failed to treat residents with dignity and respect when staff failed to include one (1) of twenty-four sampled residents and three (3) unsampled residents in conversation during care when multiple staff members assisted Resident #8 with incontinence care and maintained a private conversation during provision of care to the resident. The facility failed to protect the dignity of one (1) of twenty-four sample residents and three (3) unsampled residents. Resident #15 when staff placed a white incontinence pad on top of the resident's bed which was made for the day. The facility failed to ensure three (3) of six (6) tables received the meal at the same time when multiple	F 241	1. Social Service conducted an interview with Resident # 8 on 5-24-13 to discuss the interaction with staff during care and his/her feelings of insignificant. Resident did not recall any other incident during care, and was encouraged to notify nursing or social service of any further occurrences. Residents A, B and C were served promptly upon identification of concern on the date stated, and were interviewed on 5-29-13 by SDN to discuss concerns. Residents were encouraged to notify nursing or social Service of any further occurrences. The white incontinent pad was removed from Resident #15 bed immediately. Resident information posted on bulletin board in the East Dining Room was removed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 5-31-13
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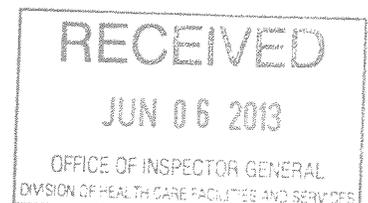
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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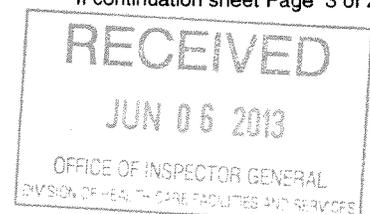
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F 241	<p>Continued From page 1</p> <p>independent residents were observed to wait in the dining room for an hour to be served, while residents who received restorative dining were served and assisted to feed by staff. In addition, The facility failed ensure the residents' privacy when the staff posted the names of residents in the East and North dining rooms identifying who received thickened liquids and assistance to feed, on the bulletin boards in public view.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Resident Bill of Rights, revealed residents had a right to personal privacy and confidentiality of his/her personal and clinical records. The policy also stated residents were to be cared for in a manner and in an environment to maintain or enhance the resident's dignity and respect.</p> <p>1. Review of the clinical record for Resident #8 revealed the facility admitted the resident on 09/18/12 with diagnoses of: Dementia; Diabetes; Congestive Heart Failure; Muscle Weakness; and Fractured Leg. The facility assessed Resident #8 at a score of 10 of 15 on the Brief Interview for Mental Status testing to determine cognitive abilities.</p> <p>Interview, on 05/08/13 at 10:00 AM, in a meeting with the Resident Council group revealed Resident #8 had concerns regarding staff who worked in pairs to provide incontinent care to him/her. Resident #8 stated, staff rolled him/her back and forth in bed, as they carried on a personal conversation. Resident #8 wished the staff would not talk to each other as care was provided, because it made him/her feel</p>	F 241	<p>2. Interviews with all residents with a BIM score of 8 and above was conducted by Social Service on 5-24-13 & 5-27-13. Areas discussed included – All Staff focusing on residents as individuals when they talk to them and addressing residents with respect and as individuals when providing care and services. Residents were encouraged to voice any concerns of past events and to report any future occurrences. Any areas identified were addressed during the interview. All non-interviewable residents were monitored daily by staff to ensure dignity and respect during the delivery of care.</p> <p>3. Systemic changes included a comprehensive review and modification to the policy/procedure for meal service delivery times and dining room seating by the DON, Unit Managers, Dietary Manager and RD (see sample). An in-service was conducted for Licensed Nurses on 5-23-13, will be for CNAs on 5-30-13 and All Staff on 6-6-13 by the DON and SDN on Dignity and Respect of Residents individuality. An in-service was conducted for all nursing and dietary staff on 6-6-13 by the DON, SDN and DM/RD to review the changes in the meal</p>		



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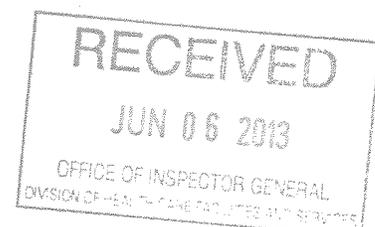
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F 241	<p>Continued From page 2 insignificant.</p> <p>Interview, on 05/09/13 at 2:48 PM, with the Director of Nursing (DON) revealed that staff were trained to understand that when staff conducted a private conversation in the presence of residents or during care, the resident's dignity would be jeopardized.</p> <p>Interview, on 05/09/13 with the Administrator, revealed he was told by multiple residents that staff conducted private conversations while providing resident care. The Administrator stated this was forbidden and said that some staff were reprimanded for not adhering to the facility's Resident Rights policy. The Administrator cited multiple in-services provided to staff members to ensure staff understood the expectations of the facility.</p> <p>2. Observation of the South Dining room during the dinner meal, on 05/08/13 at 4:20 PM, revealed there were six tables and residents were assisted to the six dining room tables.</p> <p>Interview with Family Member #1, on 05/08/13 at 2:45 PM, revealed he/she was concerned about how the staff brought the residents into the dining room and let them sit for forty-five (45) minutes before trays were delivered. Family Member #1 stated some residents would be eating and the other residents had to sit and wait. Family Member #1 stated residents were not offered drinks or interacted with during the period of time they sat waiting.</p>	F 241	<p>service delivery.</p> <p>4. Unit Managers and Charge Nurses will monitor care delivery and staff resident interaction daily during routine shift rounds and meal service to assure the Dignity and Respect of all Residents is maintained. The DON and SDN will conduct weekly rounds and observance of meal service to assure compliance. Social service will conduct random interviews with 5% of Residents to discuss concerns of any dignity related issues and provide results to the Administrator. Any areas of concerns identified will be corrected immediately and all results will be reviewed in the weekly/monthly QA meeting.</p> <p>5. Completion date: 6-14-13</p>	6-14-13



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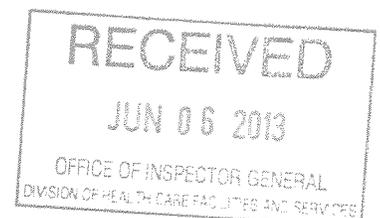
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F 241	<p>Continued From page 3</p> <p>Observations of the south dining room, on 05/08/13 at 4:50 PM, revealed six (6) tables full of residents. Three (3) tables were observed to serve the restorative dining meal and three (3) tables were observed to serve the independent residents. Six (6) staff members were observed to be helping the restorative residents at three (3) tables with feeding and twelve (12) residents at three (3) tables were observed to be waiting for their meals as the restorative residents ate.</p> <p>Interview with Unsampled Resident A, on 05/08/13 at 4:50 PM, revealed he/she had waited for his/her meal for a half an hour and did not like to have to wait for his/her meal and watch others eat their meal.</p> <p>Interview with Unsampled Resident B, on 05/08/13 at 4:55 PM, revealed he/she wanted to know where his/her tray was because he/she wanted to eat.</p> <p>Interview with Unsampled Resident C, on 05/08/13 at 4:57 PM, revealed he/she wanted to have his/her tray and was tired of waiting for his/her meal.</p> <p>Observation of the South Dining room, on 05/08/13 at 5:09 PM, revealed the independent residents were served only water. No food was delivered to the independent residents at this time.</p> <p>Observation of the South Dining room, on 05/08/13 at 5:20 PM, revealed the trays arrived for the independent residents.</p> <p>Interview with Certified Nursing Assistant (CNA)</p>	F 241			



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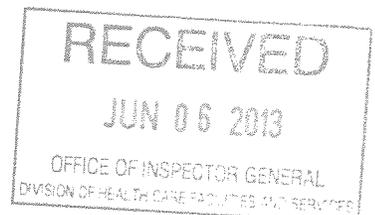
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F 241	<p>Continued From page 4</p> <p>#7, on 05/09/13 at 2:45 PM, revealed the restorative residents used to eat first and then the independent residents would come in after the restorative residents were finished with their meal. The independent residents should not be watching the other residents eat their meals. CNA #7 stated the residents would start to ask about where their food was and it would affect their dignity.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 05/09/13 at 2:53 PM, revealed the first carts came in at 4:30 PM for the restorative residents to eat first. LPN #6 stated the food carts should never take that long to come out to the dining room. LPN #6 stated the facility was trying to make some changes to the meal delivery. LPN #6 stated the independent residents waiting for their meal was a dignity concern.</p> <p>Interview with the Director of Nursing (DON), on 05/09/13 at 3:34 PM, revealed the staff had to accommodate the residents who needed assistance with feeding. Some of the staff thought the restorative residents needed to be assisted first, but it seemed to take longer when doing this process and caused the independent residents to have to wait longer. The DON stated she knew the dining room had been a problem. The DON stated that it would probably be unpleasant for the residents to have to wait for their meal while other residents ate in front of them and that it would affect the dignity of the residents.</p>	F 241		



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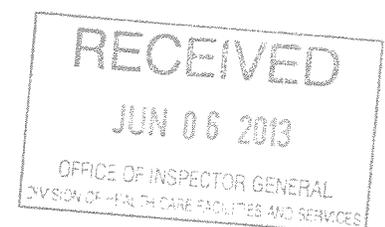
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F 241	Continued From page 5 3. Observation of the East Dining Room, on 05/07/13 at 11:30 AM, and of the Women's North Dining Room, on 05/07/13 at 11:30 AM, revealed lists were posted on the bulletin boards in each dining room. One list named the residents needing assistance with meals and the other list named the residents on thickened liquids. These bulletin boards were in full view of anyone in the dining rooms. Interview with Certified Nurse Aide (CNA) #2, on 05/07/13 at 12:20 PM, revealed the lists were posted in order for staff to know which residents needed to be fed and which residents received thickened liquids. She stated the list needed to be turned over so the residents names were not visible. 4. Observation of Resident #15, on 05/09/13 at 9:10 AM and 11:15 AM, revealed the resident sitting up in a chair at the bedside. The resident's bed was made and in the middle of the bed was a large white incontinent pad. Interview with CNA #8 and CNA #9, on 05/09/13 at 11:20 AM, revealed the incontinent pad on the bed meant Resident #15 was incontinent. They stated visitors walking by the room did not need to know the resident was incontinent. They stated this violated the resident's right to dignity. Interview with the DON, on 05/09/13 at 1:15 PM, revealed the lists on the bulletin boards were to be turned over so names were not revealed and the facility did not allowed incontinent pads to be placed on top of beds.	F 241			
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE	F 252	1. No Residents were identified to be affected by cited deficiency.		



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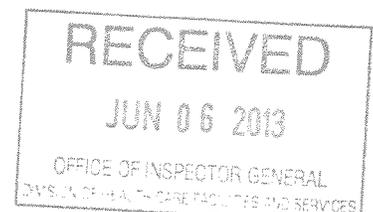
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F 252	<p>Continued From page 6 ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's chemical cleaning information, it was determined the facility failed to maintain floors in the East and Women's North Dining Rooms in a manner that prevented the floors from being sticky. Both floors were sticky and made a sticking noise when walked on.</p> <p>The findings include: Review of the Manufacturer's Recommendations for use of Neutral Disinfectant Cleaner revealed no instructions on managing problems with use of the cleaner.</p> <p>Observation of the East Dining Room, on 05/07/13 at 11:30 AM and on 05/08/13 at 4:50 PM, revealed the floors were sticky and shoes stuck to the floor when walking.</p> <p>Observation of the North Women's Dining Room, on 05/07/13 at 11:40 AM and 05/08/13 at 1:30 PM, revealed the floor was sticky and shoes stuck to the floor when walking.</p> <p>Interview with Housekeepers #1, #2, #3, on</p>	F 252	<p>2. Upon the observation of residents in the area no resident was effected and the area was cleaned by the vendor recommendation.</p> <p>3. The vendor representative was notified on 5-9-13 and was in the facility on 5-22-13 to evaluate the identified problem. A floor cleaning demo with required chemicals was conducted on 5-22-13. Recommendations were provided to the Housekeeping Supervisor and a new procedure was developed. All housekeeping staff was in-serviced by the vendor representative on 5-27-13.</p> <p>4. Housekeeping staff will monitor area daily during floor care. The Housekeeping Supervisor will monitor the floors weekly to assure compliance. All results will be reviewed in weekly/monthly QA meeting.</p> <p>5. Completion Date: 6-14-13</p>	6-14-13	



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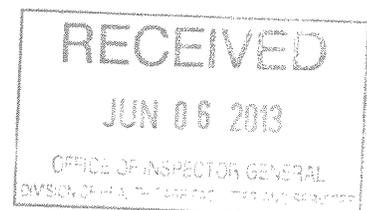
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F 252	Continued From page 7 05/08/13 at 3:40 PM, revealed the floors were sticky and they had reported this problem to their supervisor several weeks ago. They stated the supervisor was not in the facility at this time. They stated the chemical they used when mopping made the floors sticky. Interview with the Administrator, on 05/09/13 at 11:15 AM, revealed he had been told about the sticky floors. He stated the facility used the chemical as instructed. He stated the manufacturer needed to be called and advised of the problem.	F 252		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	1. Resident # 16 Comprehensive Care Plan was reviewed by the interdisciplinary care team on 5-29-13. The Care Plan was revised with accurate measurable goals and interventions to reflect the residents current status needs as indicated. All care records were updated as indicated. 2. All residents' Comprehensive Care Plans will be reviewed and revised by the interdisciplinary care team to assure accurate measurable goals and interventions to reflect the residents current status needs. All care records will be updated to include individual resident care information.	



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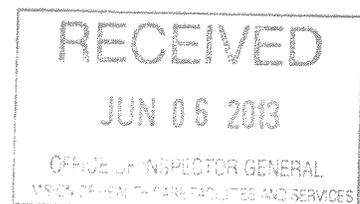
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F 280	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to update the care plan for one (1) of twenty-four (24) sampled residents, Resident #16. Resident #16 had a progressive weight gain over the last year. The facility failed to up date the careplan with measurable goals for a progressive weight gain, and did not include any nursing approaches over the last year for Resident #16 related to the weight gain. The findings include: Review of the facility's policy regarding care plans, titled Procedure for MDS/Care Plan Process, Revised 04/12/13, revealed interdisciplinary care conferences were conducted weekly and as indicated. It stated all assessments and care plans were reviewed and revised as indicated and signed by all disciplines. However, the care plan for Resident #16 was not revised when set goals were not met over a six (6) month period of time, and through two (2) quarterly reviews. Review of the care plan for Resident #16, with a review date of 01/21/13, revealed a problem that stated Resident #16 was at risk for weight loss related to intakes of 50%. It also stated the resident was at risk for weight fluctuations related to a diagnosis of Congestive Heart Failure (CHF) and the use of diuretics. However, there had not been a fluctuation or loss, only a steady weight gain. The Interdisciplinary Team (IDT) did not	F 280	3. An in-service was conducted for the interdisciplinary care team on 5-29-13 by RN Consultant & RN RAI Coordinator to review the federal guidelines for the RAI process, which includes the development and updating of the Comprehensive Care Plan with measurable goals and intervention to reflect resident's current status needs. 4. The interdisciplinary care team will review all assessments and care plans weekly during care conference of those residents scheduled to assure accuracy. All will be revised as indicated and documented. Unit Managers/Charge Nurses and MDS Nurses will monitor and update comprehensive care plans and all care records daily as indicated with change in residents' condition and orders. The DON and SDN will conduct weekly audits of 25% of scheduled assessments to assure accuracy in the Comprehensive Care Plan. Discrepancies will be corrected immediately. All audit results will be reviewed by administrator and presented in weekly/Monthly QA. 5. Completion date: 6-14-13	6-14-13	



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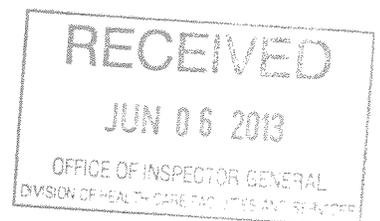
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F 280	<p>Continued From page 9</p> <p>revise the problem when reviewed, instead it was to be followed for another 90 days. An additional problem, of "weight gain of ten (10) pounds since the last review", was added on the review date 04/13/13, to be continued for 90 days. The weight loss remained listed as a current problem although the resident had documented weight gains. CHF and the use of diuretics were a problem concern listed, and had no interventions or approaches for nursing to monitor.</p> <p>Continued review of the care plan for Resident #16 under the heading Goals revealed during the last two (2) reviews listed above, the resident was to maintain a weight within a three (3) pound variance for the next 90 days, and this goal was not met. However, it stated to continue the same goal for an additional 90 days.</p> <p>Interview, on 05/09/13 at 1:15 PM, with the Minimum Data Set (MDS) Registered Nurse (RN) revealed when a goal was not met the process was to revise the care plan to where it would reflect the outcome you wanted to achieve. She continued, if the care plan was not revised, the process was not followed. Related to Resident #16, she revealed the part of the care plan which addressed weight did not reflect the care and status of the resident. She stated the goal for Resident #16 would have to be revised to reflect the problem the resident was having, be it eating or fluid retention. She added, his/her condition needed to be factored into his/her weight problem.</p> <p>Interview, on 05/09/13 at 1:22 PM, with Licensed Practical Nurse (LPN) #1 revealed the nursing role with a resident identified with a weight gain</p>	F 280			



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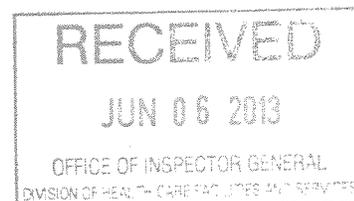
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F 280	<p>Continued From page 10</p> <p>was to assess the resident, notify the physician of any changes, notify dietary, monitor the intake of the resident and listen to the lung sounds of the resident. She revealed it was the responsibility of the nurses to update the care plan. However, the identified weight gain for Resident #16 did not have any nursing interventions listed.</p> <p>Interview, on 05/09/13 at 1:30 PM, with RN #2 the Charge Nurse on the unit that Resident #16 lived, revealed she was not aware of a weight gain for Resident #16 over the last year. She revealed the Nurse's Notes had not indicated a weight gain. She revealed that between quarterly reviews, the care plan for Resident #16 had not been updated. Following her review of the care plan she revealed the goals were not reasonable and the approaches were not realistic for Resident #16. She stated it looked like nursing was not aware of the weight gain for Resident #16. She continued, if nursing was aware, the care plan should have been updated.</p> <p>Interview, on 05/09/13 at 2:00 PM, with the Dietary Manager, a member of the interdisciplinary team, revealed she was aware Resident #16 had a weight gain. In addition, she stated she had spoken to the charge nurse responsible for Resident #16, specifically addressing the diagnosis of CHF. She stated, for her part of the care plan, the diet had been change to no added salt. She revealed, for the goal of the resident to maintain a weight within a three (3) pound variance, there was nothing she could do about the goal not being met. However, she did not change or revise the goal when it was not met.</p>	F 280			



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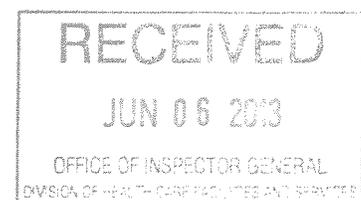
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F 280	Continued From page 11 Interview, on 05/09/13 at 2:20 PM, with the Director of Nursing (DON) revealed she had been monitoring the care plans on a regular basis. She stated the care plans were in a rotation for review to keep them current. She stated one discipline worked with the other and everyone knew if a resident was gaining or losing weight. The DON stated there were no approaches on the care plan for nursing and that the nursing approaches should work in conjunction with dietary. In addition, she stated the IDT should have come up with different interventions or goals and looked into the disease process for the weight gain of Resident #16.	F 280		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure proper handwashing between resident contacts in the East Dining Room. A staff member failed to wash their hands when going from resident to resident. The findings include:	F 371	1. No Residents were identified to be affected by cited deficiency. 2. Based on the observation of the residents in the East Dining Room no residents were effected by the potential of cross contamination. 3. One on one and smallgroup riew of hand washing procedure for care between residents was conducted immediately by SDN and DON. Although the policy did not state hand washing between resident contact, staff had been in-serviced on requirement. Policy was updated to include statement. An in-service was conducted for Licensed Nurses on 5-23-13, and will be for CNAs on 5-30-13 by the DON and SDN on hand washing	



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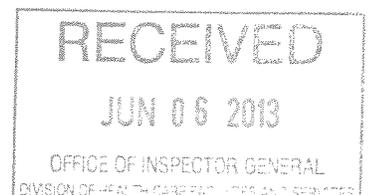
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F 371	Continued From page 12 Review of the facility's policy, undated, regarding Handwashing revealed handwashing was the single most important means of preventing the spread of infection. The policy did not address handwashing between resident contacts. Observation of the East Dining Room, on 05/07/13 at 11:40 AM, revealed CNA #2 going from resident to resident, fifteen total, and placing bibs on each resident. She touched each resident and stopped once to pull a resident up in a gerichair. She was not observed washing her hands after any resident contact. Interview with CNA #2, on 05/07/13 at 12:20 PM, revealed she was not aware that her hands needed to be washed between resident contacts. She stated she had not been trained to perform this procedure between resident contacts; however, she saw the potential for the spread of infection from touching all the residents without handwashing. Interview with the Director of Nursing, on 05/09/13 at 1:00 PM, revealed the staff had been trained on handwashing and the CNA should have washed her hands after rendering care before moving on to the next resident.	F 371	and sanitary food service requirement. 4. Unit Manager and Charge Nurses will monitor meal service daily to assure staff is using safe sanitary procedures. The DON and SDN will observe meal service weekly to assure compliance. Any areas of concern identified will be corrected immediately and all results will be reviewed in the weekly/monthly QA meeting. 5. Completion Date: 6-14-13	6-14-13	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	1. Resident #4 wounds were assessed to assure no negative outcome was identified due to improper hand hygiene during dressing change. Resident #5 tubing used for tube feeding was changed and dated immediately.		



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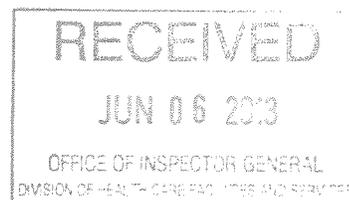
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F 441	Continued From page 13 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to follow their Infection Control Program when staff failed to store clean linen in a sanitary manner on the north and south dining	F 441	2. All residents with wounds had ongoing assessment of areas to assure no negative outcome was identified due to improper hand hygiene. Tubing for all residents receiving tube feeding were checked on date stated and no other problems were identified. Linens were appropriately stored/covered on date problem was identified. 3. Nurse identified during wound dressing changed was counseled and reeducated on the proper techniques. Infection control program was reviewed by the DON and RN Consultant on 5-23-13 to assure processes in place to: 1) Investigate, control, and prevent the spread of infections 2) Surveillance to investigate possible root causes to decrease risk Clarification on hand washing was made to policy (sample). All licensed nurses were in-serviced on 5-23-13 and CNAs will be on 5-30-13 by The Staff Development/Infection Control Nurse on Infection Control Program, which includes; Standard Precautions, Proper Hand Washing Technique, Storage and distribution of linen and Preventing the Spread of Infection. Proper technique for wound care and tube feeding equipment was reviewed with all licensed nurses.	



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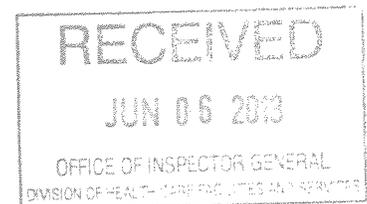
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F 441	<p>Continued From page 14</p> <p>rooms. Staff failed to use proper hand hygiene when conducting a dressing change for one (1) of twenty-four (24) sampled residents and three (3) unsampled residents, Resident #4. In addition, the staff failed to date tube feed tubing for two (2) days of the survey for one (1) of twenty-four sampled resident and three (3) unsampled residents, Resident #5.</p> <p>The findings include:</p> <p>Review of the Hand Hygiene policy, reference date 10/22/02, revealed the purpose of the policy was to decrease the risk of transmission of infection by appropriate hand hygiene. Handwashing/hand hygiene was generally considered the most important single procedure which prevented healthcare associated infections.</p> <p>Review of the Wound/Treatment Guidelines, no date, revealed hand hygiene must be completed upon removal of the soiled dressing, pull glove over dressing and discard into trash bag or biohazard and then repeat hand hygiene and apply new gloves.</p> <p>1. Observation of Resident #4's dressing change, on 05/08/13 at 10:04 AM, revealed Licensed Practical Nurse (LPN) #2 placed gloves on her hand and applied wound cleaner to Resident #4's wound on his/her big toe. LPN #2 then cleaned Resident #4's wound, removed her soiled gloves and applied new gloves without washing her hands. LPN #2 then applied Betadine to the big toe and bandaged the wound. LPN #2 then removed her gloves and placed new gloves on with out washing her hands. LPN #2 then applied Granulex to the bottom of Resident</p>	F 441	<p>4. Unit Manager (M-F) will monitor wound care, tube feeding equipment and storage of linen daily during routine rounds and will observe wound care on 5% of residents weekly. The DON and SDN will observe wound care on 5% of resident bi-weekly. Discrepancies will be corrected immediately. All results will be reviewed by administrator and presented in weekly/monthly QA.</p> <p>5. Completion Date: 6-14-13</p>	6-14-13



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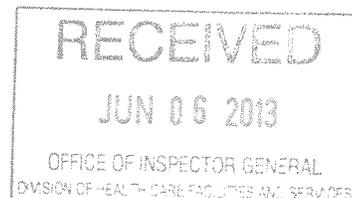
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F 441	<p>Continued From page 15</p> <p>#4's heal, removed her gloves and applied socks to Resident #4's feet. LPN #2 then picked up some gloves off of the floor, applied new gloves and assessed Resident #4's hand per Resident #4's request.</p> <p>Interview of LPN #2, on 05/08/13 at 10:11 AM, revealed LPN #2 thought that when she was in the room with the same resident there was no need to wash her hands. LPN #2 stated she removed her gloves because the gloves were soiled and she was going to apply a clean dressing to the resident's foot. LPN #2 stated she was taught to wash her hands when she removed her gloves. LPN #2 stated she should have washed her hands to prevent the spread of infection.</p> <p>Interview with the Unit Manager of the North Hall, on 05/09/13 at 2:30 PM, revealed she educated the staff that when they removed their gloves they were to wash their hands and apply new gloves on to finish the dressing. The Unit Manager of the North hall stated she encouraged the staff to wash their hands to prevent the spread of infections.</p> <p>Interview with the Infection Control Nurse, on 05/09/13 at 2:39 PM, revealed she educated the staff on infection control upon hire and annually. The Infection Control Nurse stated she had a class on infection control last month in which staff were educated on standard precautions, hand washing, peri care and communicable diseases. The Infection Control Nurse stated she educated staff to wash their hands after the removal of gloves and stated she did not instruct staff, that if they were with the same resident they would not</p>	F 441			



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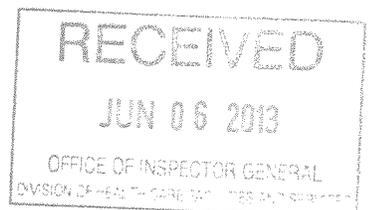
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F 441	Continued From page 17 10:15 AM, revealed the clean cloth bibs were stored on the coffee table awaiting the next meal service. They stated the bibs were in an area where residents mingled and the bibs could be contaminated by a resident with soiled hands. Interview with the Director of Nursing, on 05/09/13 at 1:10 PM, revealed the clean bibs were not to be placed in the dining room until it was mealtime. She stated the bibs could be contaminated by a resident with soiled hands. Review of the facility's policy regarding Gastric Tube Feedings, undated, revealed the tube feeding container, tubing and syringe were changed daily to prevent infection. 4. Observation of Resident #5, on 05/07/13 at 2:00 PM and on 05/08/13 at 9:30 AM, revealed the resident had a tube feeding infusing via pump into a gastric tube. The tubing was not dated. Interview with Licensed Practical Nurse #5, on 05/08/13 at 2:15 PM, revealed the tubing used for the tube feeding was changed daily. She stated the tubing was dated to ensure no bacteria build-up caused infection.	F 441		
F 514 SS=B	483.75(l)(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;	F 514	1. Physician order for residents # 2, 3, 7, 9, 10, 13, 15, and 16 were all reviewed and dated by attending physician as indicate on 6-14-13.	



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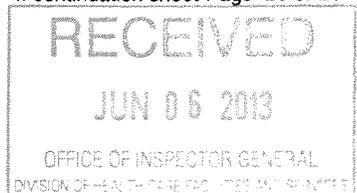
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F 514	<p>Continued From page 18 accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and review of the facility's policy, it was determined the facility failed to ensure physician orders were dated when signed for eight (8) of twenty-four (24) sampled residents and three (3) unsampled residents. Those residents were Residents #2, #3, #7, #9, #10, #13, #15 and #16.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Physician's Orders, undated, revealed its purpose was to have established uniform guidelines in the receiving and recording of physician orders and to assure all physician orders were complete, valid and followed for safe quality resident care. Physician orders were to be signed and dated.</p> <p>Review of the medical record for Resident #2 revealed the current physician's order sheet for May 1, 2013 through May 31, 2013, with orders actively being followed, were not dated when signed by the physician.</p> <p>Review of the medical record for Resident #3</p>	F 514	<p>2. All resident current physician order will be reviewed by Unit Managers, and Charge Nurses and physicians notified and correction made as indicated.</p> <p>3. The Medical Director and all attending physicians reviewed, signed and dated a copy of the facility policy on guidelines for Physician Orders. Licensed nurses were in-serviced on 5-23-13 by the DON and SDN on guidelines for Physician Orders.</p> <p>4. The Charge Nurse will review and assure all physician orders are dated and signed during Physician Visits. The Unit Managers will monitor daily (M-F) to assure compliance. The DON/SDN will conduct weekly audits of 5% record review. Discrepancies will be corrected immediately. All audit results will be reviewed by administrator and presented in weekly/monthly QA.</p> <p>5. Completion Date: 6-14-13</p>	6-14-13



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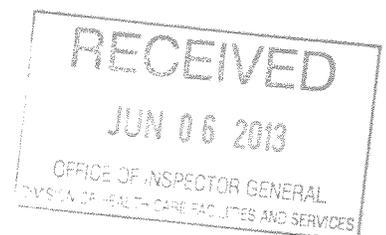
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F 514	<p>Continued From page 19</p> <p>revealed the current physician's order sheet for May 1, 2013 through May 31, 2013, with orders actively being followed, were not dated when signed by the physician.</p> <p>Review of the medical record for Resident #10 revealed the physician's order sheet for April 1, 2013 through April 30, 2013 were not dated when signed by the physician.</p> <p>Review of the medical record for Resident #16 revealed the current physician's order sheet for May 1, 2013 through May 31, 2013, with orders actively being followed, were not dated when signed by the physician.</p> <p>Review of the clinical record for Resident #7 revealed the facility admitted the resident with diagnoses of Hypertension, Hypothyroidism and Depression. Review of the physician orders for April 2013 revealed they were signed, however, they were not dated by the physician.</p> <p>Review of the clinical record for Resident #9 revealed the facility admitted the resident with diagnoses of Hypothyroidism and Dementia. Review of the physician orders for April 2013 revealed they were signed, however, they were not dated by the physician.</p> <p>Review of the clinical record for Resident #13 revealed the facility admitted the resident with diagnoses of Dementia and Colitis. Review of the physician orders for April 2013 revealed the</p>	F 514			



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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056	
(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 514	<p>Continued From page 20 orders were signed, however, they were not dated by the physician.</p> <p>Review of the clinical record for Resident #15 revealed the facility admitted the resident with diagnoses of Dementia and a Behavior Disturbance. Review of the physician orders for April 2013 revealed they were signed, however, they were not dated by the physician.</p> <p>Interview, on 05/09/13 at 12:50 PM, with the Minimum Data Set (MDS) Registered Nurse (RN) revealed physicians were to sign and date their orders. She gave the reason being to ensure the correct month of orders were followed and approved by the physician.</p> <p>Interview, on 05/09/13 at 2:20 PM, with the Director of Nursing (DON) revealed physician's orders were to be signed and dated. She stated the reason to both sign and date an order was to make sure the order was a current order and not an old order. She revealed the orders were monitored by the Unit Managers and Medical Records was to make sure the records were complete.</p> <p>Interview, on 05/09/13 at 2:35 PM, with Medical Records revealed she was responsible for the completeness of the medical record. She stated she monitored each record every other month; however, she was not aware orders were to be dated.</p>	F 514		



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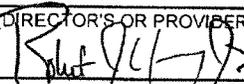
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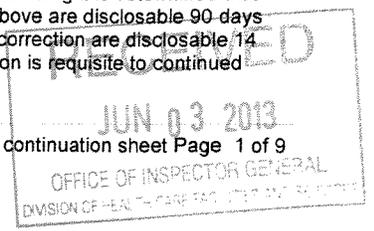
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1968, 1984 and 1997 (The facility has current plans for a Building expansion in 2013).</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story with a partial basement, Type V Protected Construction.</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments on the Ground Floor. Two (2) in the Basement.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Two (2), Type II generators. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 05/08/13. Friendship Manor Nursing Home 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>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 5-31-13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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K 000	Continued From page 1 Regulations, 483.70 (a) et seq. (Life Safety from Fire).	K 000		
K 029 SS=D	<p>Deficiencies were cited with the highest deficiency identified at an F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiencies had the potential to affect one (1) of seven (7) smoke compartments on the Ground Floor and each of the two (2) smoke compartments in the basement, including all residents, staff and visitors. The facility has one-hundred and twenty-eight (128) certified beds and the census was one-hundred and eighteen (118) on the day of the survey.</p>	K 029	<p>1 & 2. No specific residents were identified, but the cited deficiency stated the potential to affect residents.</p> <p>3. The drywall hole identified in the conference room closet was repaired on 5-8-13 by the maintenance assistant. A technician from Landmark Sprinkler Inc. evaluated the area on 5-23-13 and a sprinkler head will be installed on 6-14-13. Two 4" brass self-closing hinges were installed on the dry storage door in dietary on 5-8-13 by maintenance. All dietary staff was instructed to keep door closed at all times. The (3) unsealed pipe penetrations in the laundry's linen closet were sealed on 5-8-13 by maintenance. Maintenance Director and Assistant were in-serviced by the Administrator 6-3-13 regarding requirement. A facility walk thru was conducted by the Maintenance Director and Assistant to evaluate for compliance.</p>	

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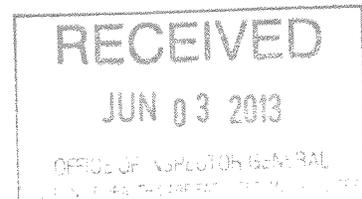
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K 029	<p>Continued From page 2 The findings include:</p> <p>1. Observation, on 05/08/13 at 12:35 PM, with the Maintenance Director and the Maintenance Assistant revealed the closet within the Conference Room had a twelve (12) inch by twelve (12) inch hole cut into the drywall to install control valves on the existing water pipes.</p> <p>Interview, on 05/08/13 at 12:35 AM, with the Maintenance Director and the Maintenance Assistant revealed they were not aware that the opening in the wall violated the integrity of the wall to remain smoke tight. They indicated that a rated access panel should be installed to maintain a smoke tight storage closet.</p> <p>2. Further observation, on 05/08/13 at 1:45 PM, with the maintenance Director and the Maintenance Assistant revealed the door to the Dry Storage Room located within the kitchen in the basement, was not equipped with a self-closing device.</p> <p>Interview, on 05/08/13 at 1:45 PM, with the Maintenance Director and Maintenance Assistant revealed the Staff kept the door closed when not in use. They were not aware of the room being classified as a hazardous storage room and acknowledged the requirement to install a self-closing device.</p> <p>3. Further observation, on 05/08/13 at 1:55 PM, with the Maintenance Director and Maintenance Assistant revealed the Laundry's Linen Closet, located in the basement, had three (3) unsealed pipe penetrations in the concrete masonry wall, compromising the required one-hour wall rating</p>	K 029	<p>4. The Maintenance assistant will complete a weekly life safety rounds, any discrepancies will be corrected and report provided to Maintenance Director. The Maintenance Director will conduct bi- weekly life safety rounds to assure compliance. All results will be reviewed with the Administrator and in the weekly/ monthly QA meetings.</p> <p>5. Completion Date: 6-14-13</p>	6-14-13
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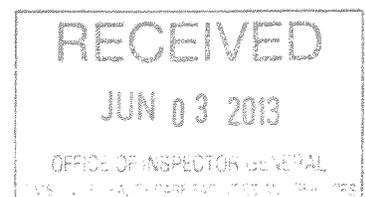
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K 029	<p>Continued From page 3 for the room classified as hazardous storage.</p> <p>Interview, on 05/08/13 at 1:55 PM, with the Maintenance Director and Maintenance Assistant revealed they were not aware of the penetrations in the wall not being sealed properly. He acknowledged the penetrations were required to be sealed with material equal to the rating of the walls penetrated.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of</p>	K 029		
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K 029 Continued From page 4
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

K 056 SS=F NFPA 101 LIFE SAFETY CODE STANDARD
If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system in accordance with NFPA Standards. The deficiency had the potential to affect each of the seven (7) smoke compartments on the Ground floor and each of the two (2) smoke compartments in the basement, all residents, staff and visitors. The facility has one-hundred and twenty-eight (128) certified beds and the census was one-hundred and eighteen (118) on the day of the survey.

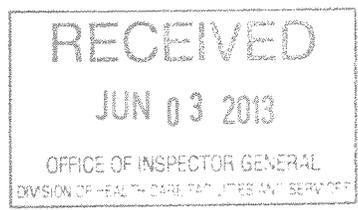
K 029

K 056

1 & 2. No specific residents were identified, but the cited deficiency stated the potential to affect residents.

3. A automatic sprinkler head will be added to the storage closet in the ground floor conference room on 6-14-13. The resident rooms located in the East Wing, Rooms 301 to 310 and 320 to 328 will install automatic sprinkler heads within the wardrobe units. The storage shelf located in the Linen Storage Room located near the sprinkler head was removed 6-14-13.

4. The maintenance assistant will complete a weekly life safety rounds, any discrepancies will be corrected and reported to the Maintenance Director.



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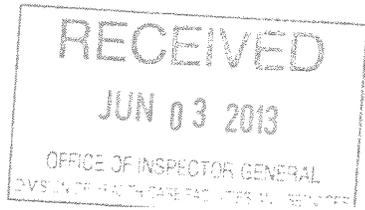
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K 056	<p>Continued From page 5</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation, on 05/08/13 at 12:40 PM, with the Maintenance Director and Maintenance Assistant revealed the storage closet located in the Conference Room on the Ground Floor, was not protected by automatic sprinkler coverage. <p>Interview, on 05/08/13 at 12:40 PM, with the Maintenance Director and Maintenance Assistant revealed they were not aware of the storage closet not being protected by automatic sprinkler coverage.</p> <ol style="list-style-type: none"> 2. Further observation, on 05/08/13 at 1:00 PM, with the Maintenance Director and Maintenance Assistant revealed the Resident Rooms located in the East Wing, Rooms 301 to 310 and 320 to 328, had full height (floor to ceiling) wardrobe units installed in each of the rooms. The enclosed wardrobe units were not protected by automatic sprinkler coverage. <p>Interview, on 05/08/13 at 1:00 PM, with the Maintenance Director and Maintenance Assistant revealed they were not aware of the requirement that built-in, full height, wardrobe units were required to be protected by automatic sprinkler coverage.</p> <ol style="list-style-type: none"> 3. Further observation, on 05/08/13 at 1:55 PM, with the Maintenance Director and Maintenance Assistant revealed the Linen Storage Room, located in the basement, had a storage shelf located within one (1) foot of the sprinkler head. 	K 056	<p>The Maintenance Director will conduct bi-weekly life safety rounds to assure compliance. All results will be reviewed with the Administrator and in the weekly/monthly QA meetings.</p> <p>5. Completion Date: 6-14-13</p>	6-14-13
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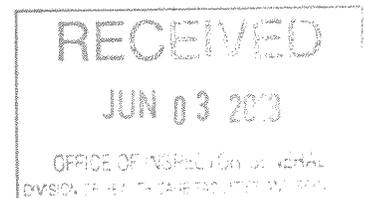
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K 056	<p>Continued From page 6</p> <p>Interview, on 05/08/13 at 1:55 PM, with the Maintenance Director and Maintenance Assistant revealed the top shelf was not used to store linen and acknowledged that the shelf was located within the required clear area of eighteen (18) inches from the sprinkler head.</p> <p>Reference: NFPA 101 (2000 Edition) and NFPA 13 (1999 Edition)</p> <p>Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <p>(1) Sprinklers installed throughout the premises</p> <p>(2) Sprinklers located so as not to exceed maximum protection area per sprinkler</p> <p>(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p>	K 056		
K 147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p>	K 147	<p>1 & 2. Use of a power strip for medical equipment in rooms 120 & 130, and for a commercial hair dryer</p>	



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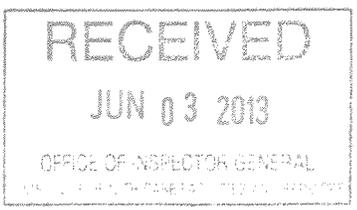
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K 147	<p>Continued From page 7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards and failed to ensure the staff was knowledgeable of the requirements. The deficiency had the potential to affect one (1) of seven (7) smoke compartments on the Ground Floor and each of the two (2) smoke compartments in the basement, all residents, staff, and visitors. The facility has one-hundred and twenty-eight (128) certified beds and the census was one-hundred and eighteen (118) on the day of the survey.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observations, on 05/08/13 between 11:30 AM and 11:35 AM, with the Maintenance Director and Maintenance Assistant revealed medical equipment, an oxygen concentrator and a mini-nebulizer, were plugged into power strips in both resident Rooms 120 and 130. <p>Interview, on 04/30/13 between 11:30 AM and 11:35 AM, with the Maintenance Director revealed he was not aware of the medical equipment being plugged into power strips.</p> <ol style="list-style-type: none"> 2. Further observation, on 05/08/13 at 12:00 PM, with the Maintenance Director and Maintenance Assistant revealed a free-standing commercial 	K 147	<p>in the Beauty Shop was corrected immediately on 5-8-13. One on one instruction to nursing staff and Beauty Shop manager was provided in regards to using power strips.</p> <ol style="list-style-type: none"> 3. A facility tour was conducted by the Maintenance Director and Assistant to evaluate for compliance. All staff will be in-serviced by Maintenance Director on electrical wiring/safety on 6-6-13. Information will be provided to families on use of power strips. 4. The Maintenance assistant complete weekly life safety rounds, any discrepancies will be corrected and report provided to Maintenance Director. The Maintenance Director will conduct bi-weekly life safety rounds to assure compliance. All results will be reviewed with the Administrator and in the weekly/monthly QA meeting. 5. Completion Date 6-14-13 	6-14-13
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 147	<p>Continued From page 8</p> <p>hair dryer, located in the Beauty Shop, was plugged into an extension cord.</p> <p>Interview, on 05/08/13 at 12:00 PM, with the Maintenance Director and Maintenance Assistant revealed they were not aware that an extension cord was being used to power the commercial hair dryer.</p> <p>3. Further observation, on 05/08/13 at 1:50 PM, with the Maintenance Director and Maintenance Assistant revealed a refrigerator and a microwave oven, located in the laundry, were plugged into a power strip.</p> <p>Interview, on 05/08/13 at 1:50 PM, with the Maintenance Director and Maintenance Assistant revealed they were not aware of the refrigerator and microwave oven located in the laundry, were being powered by a power strip.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147		
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