

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

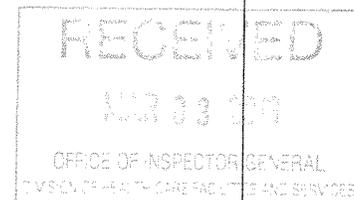
PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

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 C 02/07/2013
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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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(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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F 000	INITIAL COMMENTS An abbreviated survey was initiated on 02/05/13 and concluded 02/07/13 to investigate KY19727. The Division of Health Care substantiated the allegation with deficiencies cited.	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 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. 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 follow the comprehensive care plan for one (1) of three (3) sampled residents and two (2) unsampled residents, Resident #1 for continuous gastric tube (g-tube) feeding. The facility staff failed to ensure a continuous g-tube feeding was administered as ordered. The findings include: Review of the facility's policy Enteral Nutrition, dated December 2011, revealed specific staff members were not identified to implement a resident's care plan. Additionally, the facility policy revealed staff caring for residents with feeding tubes; however the policy did not specify who those specific staff members were.	F 282	1. The nurse notified the physician when she was unable to unstop the clogged g-tube for Resident #1. The nurse followed the physician's order and replaced the g-tube with a temporary tube and resumed the feedings. The physician was aware of the situation and told the surveyor, the Director of Nursing, and the Administrator that there was no negative outcome to the resident as a result of the temporary holding of the feeding. The physician clarified the g-tube order to allow the feeding to be temporarily discontinued for personal care activities throughout the day. The care plan was updated to reflect the current order. Resident #1 is continuing to be cared for in accordance with the care plan and physician's order. CNA #7 was counseled by the Director of Nursing and the Staff Development Coordinator and informed of the scope of practice for CNA staff regarding enteral feedings.	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 3-1-2013
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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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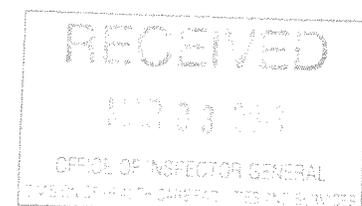
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F 282	<p>Continued From page 1</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 06/04/10 and re-admitted the resident on 01/14/13 with diagnoses of Dementia and PEG tube (g-tube) placement. The facility completed a quarterly Minimum Data Set (MDS) on 01/01/13 and assessed the resident as cognitively impaired with a Brief Interview Mental Status (BIMS) of six (6) and with a g-tube in place.</p> <p>Review of Resident #1's comprehensive care plan for Nutrition, dated 10/11/12 and reviewed by the facility on 01/03/13, revealed the resident received total nutrition through the g-tube and was to receive continuous tube feeding per the physician's order.</p> <p>Observations of Resident #1, on 02/05/13 at 8:50 AM, 9:30 AM, 10:20 AM, 11:00 AM, 1:00 PM, on 02/06/13 at 8:55 AM, 10:30 AM, 2:20 PM, and 02/07/13 at 8:47 AM and 10:45 AM, revealed g-tube feeding running at 35 ml per hour.</p> <p>Interview, on 02/06/13 at 10:45 AM, with Certified Nursing Assistant (CNA) #7 revealed on Sunday 01/27/13 Resident #1's g-tube pump was beeping after lunch and the aide reported it to the nurse. The aide stated she turned off the g-tube pump, at the direction of the nurse, sometime after the lunch meal service. She stated she was unable to remember at what time she turned off the pump. The CNA stated she did not go back to check the resident, the g-tube pump, or with the nurse before the shift change at 3:00 PM.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 02/06/13 at 11:00 AM, revealed she was Resident #1's nurse on 01/27/13 and found the</p>	F 282	<p>2. The facility identified other residents who receive enteral feedings. The physicians' orders for these residents were revised to clarify that enteral feedings could be temporarily held for daily care activities. Care plans were reviewed for these residents and updated to reflect acceptable times when the feedings could be temporarily disconnected. The facility is caring for these residents in accordance with the care plan and the physicians' orders. The Director of Nursing and Staff Development Coordinator held meetings on the day of the surveyor's exit to inform nurses and CNAs of their roles in relation to residents' enteral feedings.</p> <p>3. Nursing administrative staff reviewed and revised the Enteral Nutrition Policy and Procedure 2/26/13. The Medical Director reviewed and approved the revised policy 2/26/13. The revisions clarified that only licensed nursing personnel are to stop, start, disconnect, reconnect, or place on hold any enteral feeding. The Staff Development Coordinator inserviced all licensed nursing personnel on the dates of 2/6/13 - 2/11/13 new policy and procedure revisions including, but not limited to, following physician orders and care plans related to when a resident may be off "continuous enteral feeding". The Staff Development Coordinator inserviced the certified nursing assistants on the dates of 2/6/13 - 2/11/13 regarding their role in relation to enteral feedings. They were informed that only licensed nursing personnel are allowed to stop, start, disconnect, reconnect, or place on hold enteral feedings. They were told that CNAs are to notify the nurse if they observe any problems with enteral feedings.</p>		



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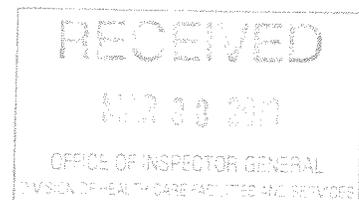
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F 282	<p>Continued From page 2</p> <p>g-tube pump turned off when she began her shift at 3:00 PM. The nurse stated she did not know how long the pump had been turned off. The LPN stated the CNAs were allowed to place a g-tube pump on hold to provide resident care and then turn the pump back on. The LPN stated she had difficulty getting the g-tube flowing again, due to a clog in the tubing, and stated the resident went without nutrition or medicine about five (5) hours until a new catheter was placed, per MD order.</p> <p>On 02/06/13 at 11:25 AM and 02/07/13 at 10:40 AM, interview with LPN #2 revealed she had last given Resident #1 medication and flushed the g-tube around 12:00 PM. The LPN stated she did not remember the g-tube pump beeping or asking the CNA to turn it off. The nurse stated with the g-tube pumped turned off, the resident did not receive the continuous g-tube feeding per the care plan. She stated the resident should not go without g-tube feedings or medicine via the g-tube as required for the resident's care.</p> <p>Interview with the Staff Development Coordinator, on 02/07/13 at 11:00 AM, revealed nurses received training on g-tubes one on one if a resident enters the facility with a new type of g-tube. The Staff Development Coordinator stated in her role she did not monitor if resident care plans were followed for g-tubes. She stated the nurses and Director of Nursing (DON) were responsible to monitor resident g-tube care plans. She stated if Resident #1's care plan for continuous g-tube feeding was not followed, the resident could become dehydrated or not receive needed calories.</p> <p>Interview, on 02/07/13 at 11:35 AM, with the DON</p>	F 282	<p>The Staff Development Coordinator inserviced ancillary staff on the dates of 2/6/13 - 2/11/13 who routinely visit residents' rooms, ie., housekeeping, maintenance, laundry, activities, that they are to notify the nurse if they observe any problem with the resident's enteral feeding.</p> <p>4. All certified nursing assistants , licensed staff and ancillary staff completed a competency test to validate their understanding of their role related to enteral feedings on the dates of 2/6/13 - 2/11/13. QA audits have been initiated to validate proper care for residents in regard to enteral feedings to determine that care plans and physicians' orders are being followed. This will continue to be completed daily by the Staff Development Coordinator or administrative nursing staff 2/27/13 - 3/27/13. Then the audit will be ongoing by the charge nurses daily in the daily QA process. The results of the audits will be presented to the Quality Assurance Committee daily for whose members will review and determine further actions that need to be taken.</p> <p>5. March 1, 2013</p>	3-1-2013	



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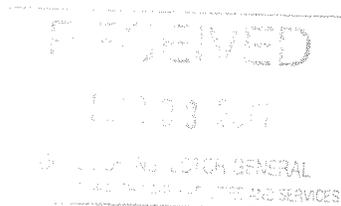
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F 282	Continued From page 3 revealed Resident #1's care plan was not followed for continuous g-tube feeding when it was turned off for an extended period of time. The DON stated she did not monitor if resident care plans are being followed and stated she took it for granted the nurses followed the care plan. She stated the purpose of the comprehensive care plan was to direct the resident's care. The DON stated it was not good practice for Resident #1's g-tube to be turned off for several hours. On 02/07/13 at 12:00 PM, interview with the Administrator revealed nursing was responsible to implement the care plans for g-tubes for residents. The Administrator stated Resident #1's care plan for continuous g-tube feeding was not followed with the g-tube pump off for several hours. He stated if Resident #1 did not receive continuous g-tube feeding for an extended period time, the resident could have a negative outcome.	F 282			
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. 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 ensure appropriate gastric	F 322	1. The nurse notified the physician when she was unable to unstop the clogged g-tube for Resident #1. The nurse followed the physician's order and replaced the g-tube with a temporary tube and resumed the feedings. The physician was aware of the situation and informed the surveyor, the Director of Nursing, and the Administrator that there was no negative outcome to the resident as a result of the temporary holding of the feeding. The physician clarified the g-tube order to allow the feeding to be temporarily discontinued for personal care activities throughout the day.		



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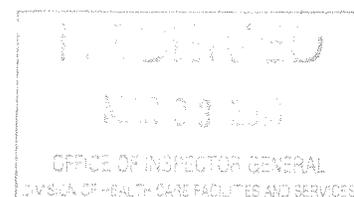
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F 322	<p>Continued From page 4</p> <p>(g-tube) services for one (1) of three (3) sample residents and two unsampled residents, Resident #1. An unlicensed facility staff turned the g-tube feeding pump off after the pump began beeping.</p> <p>The findings include:</p> <p>Review of the facility's policy Enteral Nutrition, dated December 2011, revealed nutrition through enteral feeding would be provided to residents as ordered by the physician. Additionally, staff caring for residents with g-tubes would be trained how to recognize and report complications, such as clogging of the g-tube, potential adverse effects, and risk of aspiration.</p> <p>Observation, on 02/05/13 at 8:50 AM, 9:30 AM, 10:20 AM, 11:00 AM, 1:00 PM and 02/06/13 at 8:55 AM, 10:30 AM, 2:20 PM, and 02/07/13 at 8:47 AM, and 10:45 AM, revealed Resident #1 had a g-tube feeding pump running at 35mi per hour.</p> <p>Interview, on 02/05/13 at 1:15 PM and 02/07/13 at 10:17 AM, with Certified Nursing Assistant (CNA) #1 revealed if a resident's g-tube pump was beeping the nurse should be notified. The aide stated CNAs were not trained to turn off a g-tube pump. She stated she was trained the nurses were responsible for the g-tube pumps. The CNA stated the facility's policy for staff who care for residents with g-tubes does not specify nurses. She stated as a CNA she does care for residents with g-tubes; however, the aides are not responsible for the items listed in the policy.</p> <p>Interview with CNA #2, on 02/05/13 at 1:40 PM and 02/07/13 at 10:05 AM, revealed the aides do</p>	F 322	<p>The care plan was updated to reflect the current order. Resident #1 is continuing to be cared for in accordance with the care plan and physician's order. CNA #7 was counseled by the Director of Nursing and the Staff Development Coordinator and informed of the scope of practice for CNA staff regarding enteral feedings.</p> <p>2. The facility identified other residents who receive enteral feedings. The physicians' orders for these residents were revised to clarify that enteral feedings could be temporarily held for daily care activities. The care plans were reviewed for these residents and updated to reflect the new orders. The facility is caring for these residents in accordance with the care plan and the physicians' orders. The Director of Nursing and Staff Development Coordinator held meetings on the day of the surveyor's exit to inform nurses and CNAs of their roles in relation to residents' enteral feedings.</p> <p>3. Nursing administrative staff reviewed and revised the Enteral Nutrition Policy and Procedure 2/26/13. The Medical Director reviewed and approved the revised policy 2/26/13. The revisions clarified that only licensed nursing personnel are to stop, start, disconnect, reconnect, or place on hold any enteral feeding. In order to clarify staff members knowledge regarding their role with enteral feedings, the Staff Development Coordinator inserviced all licensed nursing personnel on the on the dates of 2/6/13 - 2/11/13 on the new policy and procedure revisions including, but not limited to, following physician orders and care plans related to when a resident may be off continuous enteral feeding.</p>	



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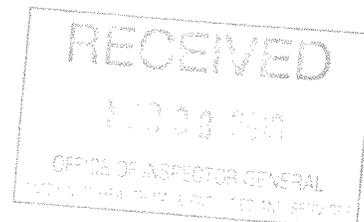
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F 322	<p>Continued From page 5</p> <p>not handle the g-tube pumps. The CNA stated if the pump was beeping the aide should inform the nurse. She also stated the aides do not turn off the beeping pumps. The aide stated she had not received training about the g-tubes or pumps. She stated the facility policy which stated staff caring for residents with feeding tubes could be misinterpreted because as an aide she was a staff who cared for residents with g-tubes.</p> <p>On 02/05/13 at 2:15 PM and 02/07/13 at 9:45 AM, interview with CNA #4 revealed if a resident's g-tube pump was beeping, the aide can place the pump on hold and tell the nurse. The aide stated the hold would last a few minutes and then the pump would begin beeping again. The CNA stated the aides do not provide care of the g-tube; however, she stated she did put the pump on hold to provide care to the resident. The aide stated she was trained to place the pump on hold when providing care. She stated if the pump was turned off it would stop the g-tube feeding and a nurse would need to re-start it.</p> <p>Interview, on 02/05/13 at 2:30 PM, with CNA #5 revealed only the nurse should handle a resident's g-tube and if a g-tube pump was beeping the aide should report it to the nurse. The CNA stated the aides were not trained to place pumps on hold or turn them off.</p> <p>On 02/05/13 at 2:45 PM, interview with CNA #6 revealed aides can put a g-tube pump on hold while providing care to a resident. The aide stated if the pump was beeping, the nurse would need to be informed to fix it.</p> <p>Interview with CNA #7, on 02/06/13 at 10:45 AM</p>	F 322	<p>The Staff Development Coordinator inserviced the certified nursing assistants on the dates of 2/6/13 - 2/11/13 regarding their role in relation to enteral feedings. They were informed that only licensed nursing personnel are allowed to stop, start, disconnect, reconnect, or place on hold enteral feedings. They were told that CNAs are to notify the nurse if they observe any problems with enteral feedings. The LPNs and CNAs addressed in F322 were included in the education. The Staff Development Coordinator instructed ancillary staff on hte dates of 2/6/13 - 2/11/13 who routinely visit residents' rooms, ie., housekeeping, maintenance, laundry, activities, that they are to notify the nurse if they observe any problem with the resident's enteral feeding. The Staff Development Coordinator revised the orientation program to include the facility's employee scope of practice requirement related to enteral feedings.</p> <p>4 All certified nursing assistants licensed staff and ancillary staff completed a competency test to validate their understanding of their role related to enteral feedings of 2/6/13 - 2/11/13. QA audits have been initiated to validate proper care for residents in regard to enteral feedings to determine that care plans and physicians' orders are being followed. This will continue to be completed daily by the Staff Development Coordinator or administrative nursing staff 2/27/13 - 3/27/13. Then the audit will be ongoing by the charginurses daily in the daily QA process. The results of the audits will be presented to the Quality Assurance Committee whose members will</p>		



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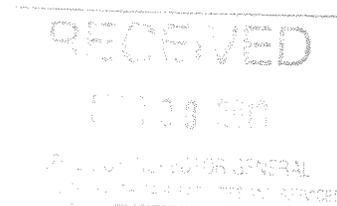
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F 322	<p>Continued From page 6</p> <p>revealed she turned off Resident #1's g-tube pump after the lunch meal service on 01/27/13 and before the shift change at 3:00 PM. The aide stated the resident's pump was beeping and she was told by the nurse to turn the pump off. The CNA stated she did not follow up with the resident, the g-tube pump, or the nurse to ensure the cause of the beeping had been resolved. The CNA stated the aides put g-tube pumps on hold to provide care; however, if the pump made any noise it was reported to the nurse.</p> <p>On 02/05/13 at 11:00 AM, interview with Licensed Practical Nurse (LPN) #1 revealed Resident #1's g-tube pump was turned off when she began her shift on 01/27/13 at 3:00 PM. The nurse stated the aides could put the g-tube pump on hold and turn back on when giving care, and can turn the pump off if directed to do so by the nurse. The LPN stated she found the g-tube clogged and needed to be replaced. The nurse stated if a g-tube pump was beeping it could have been due to a clog, improper flow, or something wrong with the tubing. The LPN stated the day shift nurse should have checked the g-tube pump if it was beeping.</p> <p>Interview, on 02/06/13 at 11:25 AM and 02/07/13 at 10:40 AM, with LPN #2 revealed she did not have any problems with Resident #1's g-tube or pump on the day shift for 01/27/13. The LPN stated she last gave the resident medications and flushed the g-tube around 12:00 PM. The nurse stated she did not remember anyone reporting Resident #1's g-tube pump beeping to her or telling anyone to turn it off. She stated she was unaware Resident #1's g-tube pump was turned off when the second shift nurse took over the</p>	F 322	<p>review and determine further actions that need to be taken.</p> <p>5. March 1, 2013</p>	3-1-2013	



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F 322	Continued From page 7 resident's care. The LPN stated the aides were not to put on hold or turn off g-tube pumps, only nurses were responsible. She stated the facility did not provide training regarding g-tube pumps. The nurse stated the policy for g-tube feedings for staff caring for residents with g-tubes was not worded properly and could be misinterpreted. She stated staff who cared for residents with g-tubes could be CNAs, therapy, or dietary, in addition to nurses. Interview with the Director of Nursing (DON,) on 02/06/13 at 3:05 PM and 02/07/13 at 11:35 AM, revealed if a resident's g-tube pump was beeping the aide should get the nurse to check it. The DON stated the CNAs were not to place a g-tube pump on hold or turn the pump off. She stated the nurses and aides needed more education to ensure they understand the nurses were responsible for resident g-tubes and pumps. She stated it was not in the CNAs scope of practice to place a gtube pump on hold or turn it off. The DON stated there was no g-tube training in place and the CNAs should know the nurses were responsible for the g-tubes and pumps. She stated the policy for staff providing care to residents with g-tubes was vague and that staff could mean anyone. The DON stated if a CNA was not trained, the staff member could misinterpret the policy for who was responsible for the g-tubes. She stated the g-tube pump would beep if there was a problem and if the pump was turned off it would no longer beep or alert the nurse. The DON stated if the CNAs put the g-tube pumps on hold and they are not trained to do so, then it was possible they were not being placed on hold appropriately. The DON stated she monitored that the g-tube pumps were	F 322			



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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
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 322	<p>Continued From page 8 working and clean.</p> <p>On 02/06/13 at 3:55 PM, interview with the Administrator revealed CNAs should go to the nurse if there was a problem with a resident's g-tube or pump.</p> <p>Interview, on 02/07/13 at 11:00 AM, with the Staff Development Coordinator revealed CNAs were trained on safe feeding techniques when assisting residents to eat. She stated the aides were not trained on g-tubes or pumps. The Staff Development Coordinator stated the CNAs responsibility for g-tubes included what to do if a resident needed to get up or lie down, or if the pump was beeping to inform a nurse. She stated the policy for staff caring for residents with g-tubes was vague and was not clear in identifying who the staff responsible were.</p> <p>On 02/07/13 at 12:00 PM, interview with the Administrator revealed he began as the Administrator in October 2012. The Administrator stated he was concerned resident #1's g-tube pump was turned off by a CNA. He stated he was not aware of what training was in place regarding g-tube pumps. The Administrator stated the policy was ambiguous referring to staff in general and did not provide clear guidance to CNAs or nurses.</p>	F 322		

