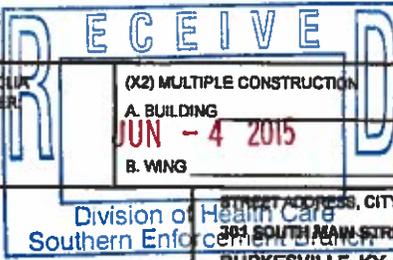


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/28/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING JUN - 4 2015 B. WING	(X3) DATE SURVEY COMPLETED C 05/07/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 391 SOUTH MAIN STREET BURKESVILLE, KY 42717
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS **Amended-	F 000	Plan of Action Cumberland Valley Manor Standard Survey 5/7/15	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.	F 278	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law. F 278 Assessment Accuracy/Coordination A registered nurse must sign and certify that the assessment is completed	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:  TITLE: *Administrator* (08) DATE: 06-07-15

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

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

PRINTED: 05/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2015
NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717		
(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 278	<p>Continued From page 1</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>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 assessments coded on the Minimum Data Set (MDS) accurately reflected the status for two (2) of sixteen (16) sampled residents (Residents #1 and #9). Review of the facility investigations for Resident #1 revealed the facility investigated a fall sustained by Resident #1 on 07/30/14 in which the resident had stated he/she went to sleep and fell out of his/her wheelchair hitting his/her right arm on the wheelchair foot pedal and face and head on the floor. However, the Annual MDS assessment dated 08/01/14 indicated Resident #1 had no falls since the last assessment. Review of Resident #9's Quarterly MDS assessment dated 02/19/15 revealed Resident #9 to be on a Physician Prescribed Weight Loss Regimen. However, review of Resident #9's medical record as well as interviews with staff indicated Resident #9 had a weight loss that was not physician prescribed.</p> <p>The findings include:</p> <p>Interview with the facility Director of Nursing (DON) on 05/07/15 at 2:16 PM revealed the facility did not have a written policy related to accurately completing the Minimum Data Set (MDS) assessment. Continued interview with the DON revealed the facility followed the MDS 3.0 Resident Assessment Instrument (RAI) manual for completing MDS assessments.</p>	F 278	<p>Criteria 1: Corrections have been completed in accordance with the RAI correction process, to the MDS assessments for residents #1, 9 to accurately reflect their fall and weight loss status.</p> <p>Criteria 2: The most recent MDS for all residents have been reviewed by the IDT by 06/11/15 to verify that resident fall and weight loss status are accurately coded. Corrections were completed for any errors identified.</p>		

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

PRINTED: 05/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2015
NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717		
(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 278	Continued From page 2 1. Observation of Resident #1 on 05/05/15 at 1:12 PM revealed Resident #1 to have a fall mat to the left side of his/her bed and Resident #1's bed to be placed against the wall. Observation of Resident #1 on 05/06/15 at 1:20 PM revealed the resident to have a self-releasing alarm-activated belt present on a wheelchair. Review of Resident #1's medical record revealed the facility admitted the resident on 09/15/13, with diagnoses that included Depression, Chronic Obstructive Pulmonary Disease (COPD), Alzheimer's Disease, Anemia, Arthropathy, Lack of Coordination, Muscle Weakness, Difficulty Walking, Anxiety, Insomnia, Hypoxemia, Shortness of Breath, Psychosis, Personal History of Falls, Chronic Pain, and Pneumonia. Further review of Resident #1's medical record revealed the facility had investigated a fall sustained by Resident #1 on 07/30/14 in which the resident had stated he/she went to sleep and fell out of his/her wheelchair hitting his/her right arm on the wheelchair foot pedal and face and head on the floor. Review of Resident #1's Comprehensive Care Plan dated 03/03/15, revealed the resident to be at risk for falls related to limited mobility and impaired balance. Review of the Annual MDS assessment dated 08/01/14 revealed the facility assessed Resident #1 to have no falls since the last MDS assessment was completed. Review of the most recent Significant Change MDS dated 02/23/15, revealed the facility had assessed the Brief Interview for Mental Status (BIMS) score for Resident #1 to be 15 which indicated Resident #1 was cognitively intact.	F 278	Criteria 3: The interdisciplinary MDS team has received in-service education by the DON by 06/02/15 on the need to double check the accuracy of MDS coded items prior to completion and transmission of MDS assessments. Criteria 4: The CQI indicator for the monitoring of accuracy of the MDS assessments will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the DON. (N-19 attached) Criteria 5: June 12, 2015		

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

PRINTED: 05/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2015
NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717		
(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 278	<p>Continued From page 3</p> <p>Interview with the facility Assistant Director of Nursing (ADON) on 05/07/15 at 2:16 PM revealed she was responsible for the accuracy of Resident #1's Annual MDS assessment dated 08/01/14. Continued interview with the facility ADON revealed either she had made a "miss entry" or it had been an oversight that no falls since the prior MDS assessment had been indicated.</p> <p>Interview with the facility Restorative Nursing Coordinator on 05/07/15 at 2:20 PM revealed she was responsible for completing the falls section of the MDS assessment and had made an oversight by not indicating that Resident #1 had sustained a fall since the previous MDS assessment.</p> <p>Interview with the facility MDS Coordinator on 05/07/15 at 1:44 PM revealed she just "sporadically" checked MDS assessments for accuracy. Continued interview with the facility MDS Coordinator revealed she had not identified any issues with any of the MDS assessments in the facility and she had no way of tracking what MDS assessments she had checked.</p> <p>Interview with the facility Director of Nursing (DON) on 05/07/15 at 2:24 PM revealed she periodically checked the MDS assessments for accuracy but had no way of knowing which MDS assessments she had reviewed. Further interview with the DON revealed the facility Nurse Consultant conducted MDS audits for accuracy on a monthly basis and had not identified any inaccurate MDS assessments.</p> <p>2. Review of Resident #9's medical record revealed the facility admitted the resident on 09/10/14, with diagnoses that included Hypertension, Nausea with Vomiting, Vitamin B12</p>	F 278			

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

PRINTED: 05/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2015
NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717		
(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 278	<p>Continued From page 4</p> <p>Deficiency, Malaise and Fatigue, Esophagitis, Paraplegia, Dysphagia, Acute Pain, Anemia, Urinary Tract Infection, Dementia, Anorexia, Hypopotassemia, and Psychosis. Further review of Resident #9's medical record revealed Resident #9 had a significant weight loss over a period of six months. Resident #9 weighed 145 pounds on 11/03/14 and weighed 128 pounds on 05/05/15. Review of Resident #9's Comprehensive Care Plan dated 09/18/14, revealed the resident to have an alteration in nutrition due to a mechanically altered diet, supplemental therapy, some confusion, history of weight loss, and low meal intake due to a paratracheal mass. Review of Resident #9's most recent Quarterly MDS assessment dated 02/19/15, revealed the facility had assessed the Brief Interview for Mental Status (BIMS) score for Resident #9 to be 6 which indicated Resident #9 had severe cognitive impairment.</p> <p>Interview with the facility Food Service Supervisor (FSS) on 05/07/15 at 1:23 PM revealed she had completed the nutrition section of the most recent Quarterly MDS assessment dated 02/19/15 for Resident #9. Continued interview with the facility FSS revealed it had been an oversight that she had coded the MDS to reflect that Resident #9 had a significant weight loss that was physician prescribed. Further interview with the facility FSS revealed she should have coded the weight loss as not a physician prescribed weight loss regimen.</p> <p>Interview with the facility MDS Coordinator on 05/07/15 at 1:44 PM revealed she just "sporadically" checked the MDS assessments for accuracy. Continued interview with the facility MDS Coordinator revealed she had not identified</p>	F 278			

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

PRINTED: 05/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2015
NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717		
(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 278	Continued From page 5 any issues with any of the MDS assessments in the facility and she had no way of tracking which MDS assessments she had checked.	F 278			
F 281 SS=D	<p>Interview with the facility Director of Nursing (DON) on 05/07/15 at 2:24 PM revealed she periodically checked the MDS assessments for accuracy but had no way of knowing which MDS assessments she had reviewed. Further interview with the DON revealed the facility Nurse Consultant conducted MDS audits for accuracy on a monthly basis and had not identified any inaccurate MDS assessments.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>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 provide services that met professional standards of quality regarding administration of intravenous (IV) fluids for one (1) of sixteen (16) sampled residents (Resident #7). Observations on 05/06/15 revealed an unlabeled IV fluids bag that was providing IV fluids to Resident #7. The facility failed to assure the IV fluids bag was labeled according to facility policy and professional standards of practice.</p> <p>The findings include: Review of the facility's policy titled "Intravenous Fluids Administration," dated 02/10/11 revealed all</p>	F 281	<p>F 281 Services Provided Meet Professional Standards The services provided or arranged by the facility must meet professional standards of quality.</p>		

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

PRINTED: 05/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/07/2015
NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717	
(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 281	<p>Continued From page 6</p> <p>infusion solutions would be dated, timed, and initiated when hung. The policy further stated the label would include the date, time started, specific additive, amount of additive, and the rate of flow.</p> <p>Observations on 05/06/15 at 9:21 AM revealed an IV fluid bag hanging and connected to Resident #7 that did not have a label affixed to the bag with any resident information including name, date administered, time started, or rate of flow. The IV fluid bag contained approximately 250 milliliters (ml) in the bag. Observation on 05/06/15 at 9:39 AM revealed an IV fluid bag hanging and connected to Resident #7 that had approximately 950 ml of fluid in the bag. The IV bag had a label affixed to the bag with Resident #7's name on it but the label did not include the date or time the bag was initiated, nor the initials of the staff who administered the bag of IV fluids.</p> <p>Review of the medical record for Resident #7 revealed the facility admitted the resident on 01/06/12 with diagnoses that included Anxiety, Constipation, Reflux Esophagitis, after-care for Traumatic Fractured Hip, Anemia, Alzheimer's Disease, and Nausea with Vomiting. Review of the May 2015 Medication Administration Record (MAR) revealed an order for Dextrose 5% and Sodium Chloride 0.45% IV fluids to be infused via IV at 50 cc (cubic centimeters) per hour. Review of the MAR revealed a bag of Dextrose 5% and Sodium Chloride 0.45% was hung at 9:00 AM Eastern Time on 05/05/15.</p> <p>Interview on 05/06/15 at 11:05 AM with Registered Nurse (RN) #2 revealed she was the nurse that administered the IV fluids on 05/06/15 and that a label was not affixed to the IV bag because she could not peel the sticker off the</p>	F 281	<p>Criteria 1:</p> <p>The IV fluid bag for resident # 7 was properly labeled with the time/date initiated and the starting nurse's initials, for the remainder of the survey after the initial identification.</p> <p>Criteria 2:</p> <p>All residents with IV fluid bags have been reviewed by 06/05/15 to verify they are properly labeled with the IV contents, resident name, time/date initiated, and starting nurse's initials as determined by compliance rounds completed by the administrative nursing staff.</p>	

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

PRINTED: 05/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2015
NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717		
(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)	(X3) COMPLETION DATE	
F 281	Continued From page 7 outer bag. RN #2 stated she went back to Resident #7's room and hung a new IV bag, cut the label out of the outer bag, and affixed it to the IV bag with tape. RN #2 stated they are always supposed to label the IV bags. Interview on 05/07/15 at 1:00 PM with the Director of Nursing (DON) revealed that the nurses are supposed to label the IV bags with the rate of flow, name of the resident, and the date the IV fluids were started.	F 281	Criteria 3: In-service education has been provided for licensed nursing staff by the DON/ADON by 06/02/15 on the correct labeling of all IV fluids when initiated. Criteria 4: The CQI indicator for the monitoring of compliance with labeling of IV fluids will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON/ADON. (N-12 attached) Criteria 5: June 12, 2015.		

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

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING #1 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/06/2015
NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1989 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111 (000) SMOKE COMPARTMENTS: Six SUPERVISED AUTOMATIC ADDRESSIBLE FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Two Type II Diesel generators A Life Safety Code Survey was initiated and concluded on 05/06/15. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at a scope and severity of "D".	K 000	Plan of Correction Cumberland Valley Manor Standard Survey 5/05/15 - 5/07/15 Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 072		

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

TITLE

(X6) DATE



Administrator

05-28-15

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

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

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/06/2015
NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	<p>Continued From page 1</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridors were maintained free from obstructions to full instant use in the case of fire or other emergency. This deficient practice affected one (1) of six (6) smoke compartments, staff, and approximately twelve (12) residents. The facility had the capacity for 84 beds with a census of 78 on the day of the survey.</p> <p>The findings include:</p> <p>Observation during the Life Safety Code tour on 05/08/15 at 10:45 AM with the Director of Maintenance (DOM) revealed a table and an aluminum can recycle bin were observed in the corridor of the Ambulance entrance/exit. Corridors were intended for means of egress, internal traffic, and emergency use. These items limited the use of the handrails by occupants of the building when needed.</p> <p>An interview on 05/06/15 at 10:45 AM with the DOM revealed these items were placed there approximately one year ago and that he was not aware the items should not be in the corridor.</p> <p>The findings were revealed to the Administrator</p>	K 072	<p>K072 NFPA 101 Life Safety Code Standard: Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>Criteria 1: The table and recycle bin were removed from the corridor of the ambulance entrance/exit on 05/08/2015.</p> <p>Criteria 2: The entire facility was inspected and no other obstructions to the handrails or means of egress were found.</p>	

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

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/06/2015
NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 2 during the exit conference.	K 072	<p>Criteria 3: Staff have received in-service education on the requirement to keep means of egress continuously free of all obstructions or impediments May 27 – June 10, 2015.</p> <p>Criteria 4: The CQI tool for the monitoring of means of egress will be used monthly X two months and then per the established CQI calendar under the supervision of the Maintenance Director (ES-3 attached).</p> <p>Criteria 5: June 12</p>	