

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

PRINTED: 12/06/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/18/2010
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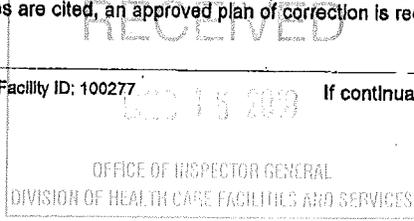
NAME OF PROVIDER OR SUPPLIER  SUNRISE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 80 PHILLIPS LANE HODGENVILLE, KY 42748
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F 000	INITIAL COMMENTS  A standard and abbreviated survey was conducted 11/16/10 through 11/18/10. A Life Safety Code survey was conducted on 11/18/10. Deficiencies were cited with the highest scope and severity of "F" with the facility having the opportunity to correct before remedies would be imposed.	F 000		
F 279 SS=D	Complaint KY00014803 was investigated and found to be substantiated with no regulatory violation cited.  483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced	F 279	The last PASSR Level II for Resident #2 was dated 5/16/2003. It was completed as a result of a significant change in condition referral on 5/14/03. It clearly states that Resident #2 requires NF placement for medical needs that cannot be provided for in a less restrictive setting, e.g. ICF/MR or community placement. (This resident is non-communicative and has G-tube for total nutrition.) It also states, no specialized services are recommended. The Inappropriate PASSR Referral Notification Form is attached to the PASSR II of 6/26/2002 stating: No further action required by their agency. The care plan does not address community integration because this was not and is not a long term goal since this resident's admission. Resident #2 does receive specialized services weekly.	12/17/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Deane Roberts RN BSN* TITLE: *D.O.N Assist Admin* (X8) DATE: *12/15/10*

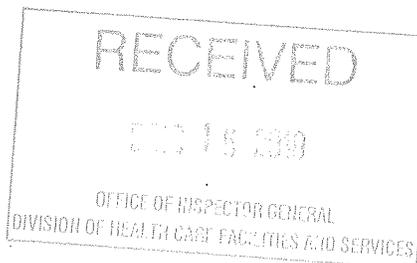
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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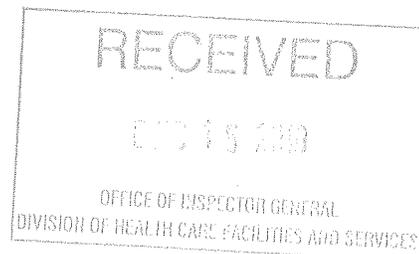
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F 279	Continued From page 1 by: Based on record review, interview and observation it was determined the facility failed to develop a comprehensive plan of care for two (2) of twenty-four (24) sampled residents (#2 and #15). The facility failed to address the specialized services for community reintegration identified through the PASRR level II assessment for Resident #2, and failed to integrate the facility care plan with the hospice care plan for Resident #15.  The findings include:  Review of the facility's policy on Referral of Residents for Community Support Services with no date revealed the facility would ensure the resident received necessary additional help while in the nursing home. The resident's needs would be determined, the appropriate referral would be made, and the Social Services Director would follow up to determine if the appropriate services had been provided. In addition, the policy on Special Needs revealed the Social Worker would determine the resident's individual needs and plan for meeting the resident's special needs in the resident's care plans and notes.  Record review for Resident #2 revealed an admission date of 04/27/07 with diagnoses of Mild Mental Retardation, Adult Failure to Thrive and Aphasia. Review of the Level I PASRR revealed it was completed on 06/21/02 and updated on 04/27/07. The Level II PASRR dated 09/24/02, 10/03/02 and 05/14/03 indicated the resident required specialized services to be provided by the facility. The resident was to receive aggressive measures to regain some independence with functioning and community	F 279	The Social Services Director has notified the agency who provides such and their plan of care will be attached to the resident's comprehensive POC by 12/17/10. The SSD will ensure that this POC is carried out. Hosparus Agency was notified on 11/19/10 to obtain a copy of their POC and progress notes for Resident #15. The resident's plan of care is now updated to include documentation of the integrated plan of care. The charts of all residents receiving Hosparus or Specialized Services will be reviewed by 12/17/10 to assure that they are up to date and their plans of care address any Hosparus or Specialized Services that the resident may be receiving. The Social Services Director and Nursing Staff have been re-educated regarding CMS regulation and the need for documented, integrated plans of care for all residents receiving Hosparus or Specialized Services from outside agencies. The agencies have been notified of this deficiency to problem solve regarding the need for increased communication and documentation of their provided services. The Administrator or designated person will review the plans of care within 30 days after admission or when the services are contracted to assure compliance is met.	



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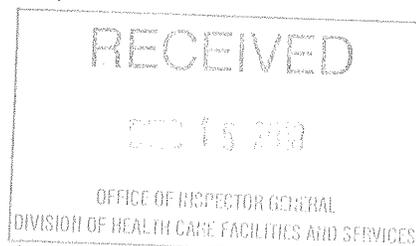
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F 279	Continued From page 2 integration was strongly indicated.  Review of the comprehensive plan of care did not reveal a care plan to address the community integration by the facility. Continued review of the Social Services notes dated 08/06/09, 10/29/09, 12/30/09, 02/15/10, 08/05/10, and 10/29/10 revealed the resident had a Respite worker from a community agency that worked with the resident weekly. However, there was no further information as to what type of active program was being provided to the resident. Review of the care plan notes dated 01/04/10 indicated the resident was attending morning groups and was mostly brought out to spirituals. The care plan note dated 02/15/10 indicated the resident received 1:1 visits and would resume attending spirituals. A care plan note dated 05/06/10 revealed the resident's family member was there daily in the morning and decides what morning groups the resident will attend. The resident had been coming out to spirituals and received 1:1 visits and people watches from his room. The care plan note dated 08/05/10 indicated the resident had been coming out to spirituals with the family member and was being read to in the resident's room. The care plan note dated 10/28/10 indicated the resident was brought out to groups as much as possible. The family member decided what the resident did and did not come to and had little interest in activities.  Observations of Resident #2 on 11/16/10 at 12:15pm revealed the resident lying in bed. At 1:50pm the resident remained lying in bed. At 2:45pm the resident was up in a wheelchair at bedside. At 3:30pm the resident was taken to an activity of "movin and groovin", of which the resident did not participate, but looked around the	F 279	Those resident's charts will then be reviewed quarterly by the MDS coordinator to assure proper documentation is obtained and maintained from outside agencies. Compliance reports will be submitted to the Administrator at the quarterly QA meeting and will be ongoing.	



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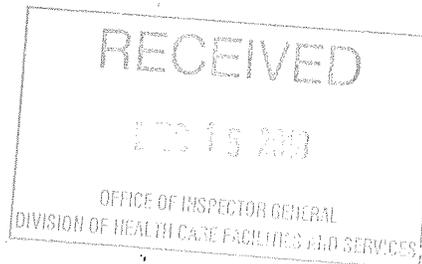
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F 279	<p>Continued From page 3</p> <p>room. At 4:55pm Resident #2 was sitting in the wheelchair in the room. On 11/17/10 at 8:00am the resident was up in a wheelchair in the room.</p> <p>Interview with the Director of Nursing on 11/18/10 at 3:20pm revealed the Social Services Director was responsible for the results of the PASRR level II for follow through.</p> <p>Interview with the Social Services Director on 11/18/10 at 3:45pm revealed she called the community agency and the resident fit the criteria for assistance. She met with the family and resident to determine the resident's needs. It was decided the resident no longer needed transportation and the family would take the resident to visit the father. The resident now has a Respite worker who visits with the resident weekly. They take walks, toss a ball and play in the leaves. They spend approximately 12 hours a month. All documentation is taken back to the agency office and had not been produced in 2 years, even after request by the Social Services to do so. However, Social Services have not shared this concern with the Administrator. In addition, the case worker attends care plan meetings but does not sign that they have attended or provide any documentation. The active treatment would be on the plan of care in activities if it is recreational and Social Services care plan if mental health. This resident's active treatment is recreational. Review of the plan of care by Social Services confirmed the active treatment was not care planned. Review of the care plan notes by the Social Services confirmed there was no documentation regarding the active treatment for reintegration into the community. The Social Services further stated they did not know if the resident had been reassessed to not</p>	F 279		



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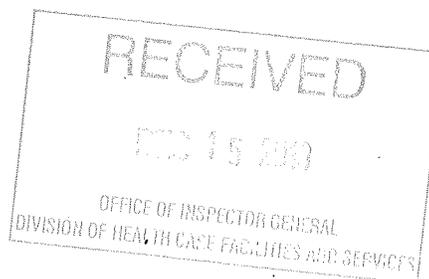
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F 279	Continued From page 4 need community reintegration.  Record review on 11/17/10 revealed Resident #15 was admitted to the facility on 09/14/09 with the diagnoses of Obstructive Hydrocephalus, Cachexia, Spontaneous Ecchymosis, Aphasia, Cerebral Ischemia, Osteoporosis, Hypothyroidism, Dysphagia, Cerebral Vascular Disease, Senile Dementia and Macular Degeneration. Resident #15 was admitted to Hosparus on 09/15/09. The MDS's dated 09/25/09 and 06/17/10 did not have Hospice Care indicated on the MDS form. Hospice involvement was not noted on an MDS form until 09/17/10. Record review on 11/18/10 revealed Hosparus Inc. Nursing Facility Agreement entered into and effective as of December 2, 2008 with Sunrise Manor Nursing Home states "Hospice and Facility will jointly develop and agree upon a Plan of Care which is consistent with the hospice philosophy and is responsive to the unique needs of Patient and his or her expressed desire for hospice care." "Specifically, the Plan of Care includes: (i) Facility Services; (ii) an identification of the Hospice Services, including interventions for pain management and symptom relief, needed to meet Patient needs, and the related needs of Patient's family; (iii) a detailed statement of the scope and frequency of such Hospice Services; (iv) measurable outcomes anticipated from implementing and coordinating the Plan of Care." Record review on 11/17/10 revealed the Sunrise Manor Plan of Care on Resident #15 contained only two mentions of hospice. There was no mention on the scope and services and visit frequency that Hosparus team members would provide. Interview with LPN #1 on 11/18/10 at 2:15pm revealed she thought the integration of the facility	F 279		



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F 279	Continued From page 5 plan of care with the Hosparus plan of care was satisfied by putting a hospice sticker on the chart. When asked if she could find a Hosparus Plan of Care she stated no. Interview with Assistant Director of Nursing (ADON) on 11/18/10 at 2:30pm revealed that Hosparus team members do not attend Care Plan Meetings. When asked how the facility integrates the Plan of Care with Hosparus, the ADON responded that the Plan of Care will indicate that Hosparus comes to see the resident. Interview with Social Service Director (SSD) on 11/18/10 at 3:50pm revealed that Hosparus is invited to attend Care Plan Meetings and that sometimes they come and sometimes they do not. The SSD stated, "To be honest I don't think we integrate with hospice. They do what they do and we do what we do." When asked how important it is to communicate with the hospice Social Worker she stated she was not sure of the importance. When asked if the SSD thought Hosparus activities should be part of the facility Plan of Care, she stated "No, they have their own care plan". The SSD revealed she was unaware that the integration of facility and hospice Plan of Care was part of the contract with Hosparus and a CMS regulation.	F 279		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS  The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 334	Residents #2 and #10 did not experience adverse drug reactions as a result of receiving the flu vaccine. Their attending physician and resident responsible parties have been notified of this situation. All residents' records have been reviewed for allergies and documentation of such is found in the Medical Record Information Sheet, Medication Administration Record, and Treatment Records	12/17/10



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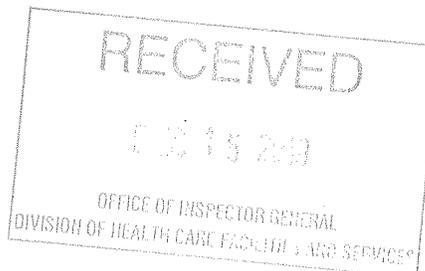
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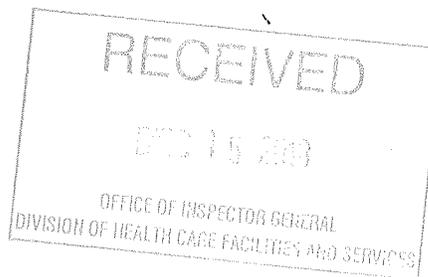
F 334	<p>Continued From page 6</p> <p>annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p>	F 334	<p>along with food allergies noted on the dietary assessment form and dietary tray cards.</p> <p>The Admission/Annual Influenza and Pneumococcal Vaccine consent forms have been reviewed to assure allergies to eggs are documented on this form, The immunization recordkeeping form has been updated to include annual education and consent documentation. This form will be mailed to the resident's responsible party annually in August along with the CDC information sheet currently utilized by the facility that addresses egg allergies. Residents and/or responsible parties will be called if the signed form is not returned by October 1. Documentation of verbal consent and education will be maintained.</p> <p>The Director of Nursing or designated person will be responsible to check for allergies, MD orders, consent forms annually prior to the immunizations being given. An audit tool has been developed for ongoing use to assure nothing is missed in the future.</p>	
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F 334	Continued From page 7  (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.  This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to ensure Residents who received the flu vaccine were not allergic to eggs for two (2) Residents (#2 and #10) of the twenty-four (24) sampled residents.  The findings include:  Review of the facility policy regarding Flu vaccines consent and education dated 3/10 revealed Influenza vaccines are offered annually during the flu season. Consent forms are signed on admission and contain consent for the annual flu vaccine. In addition, the policy stated annual encouragement and education is provided via employee newsletter and resident newsletter.  Review of the Consent form for Influenza and Pneumococcal Vaccines dated 11/20/06 revealed no documentation or reference to allergies to eggs as a contraindication.	F 334		



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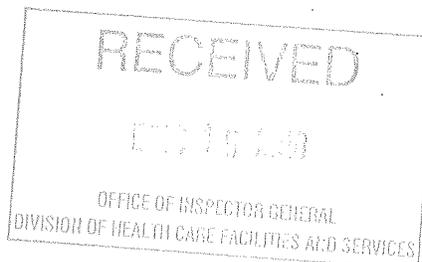
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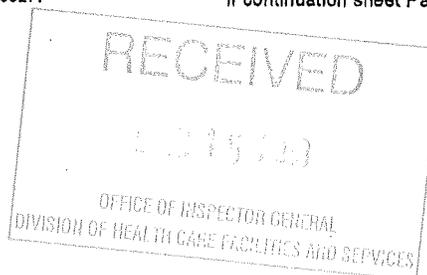
F 334	<p>Continued From page 8</p> <p>Review of the Inactivated Influenza Vaccine, What you need to know, 2010/11 dated 08/10/10 instructed the individual to tell the healthcare provider if you have any severe allergies. Allergic reactions to Influenza vaccine are rare. Influenza vaccine virus is grown in eggs. People with a severe egg allergy should not get influenza vaccine.</p> <p>1) Record review for Resident #2 revealed an admission date of 04/27/07 and diagnoses of Mild Mental Retardation, Diabetes, and Chronic Cystitis. The medical record was marked allergic to eggs. The physician orders dated 10/01/10 indicated an allergy to eggs. The pharmacy review dated 09/22/10 indicated an allergy to eggs. The hospital discharge summary dated 11/08/10 indicated an allergy to eggs. The hospital transfer sheet dated 11/08/10 indicated an allergy to eggs. The Pneumococcal/Influenza Vaccination Screening and Order form from the hospital dated 11/04/10 revealed an allergy to eggs and was contraindicated due to the resident had the flu with the last four weeks.</p> <p>Review of the consent form signed by the responsible party revealed a signature date of 04/27/07 with no documentation of allergy to eggs.</p> <p>Review of the vaccination record for Resident #2 revealed the flu vaccine was administered to the resident on 10/25/07, 10/29/08, 10/06/09 and 10/26/10.</p> <p>Interview with the Director of Nursing on 11/18/10 at 3:15pm revealed the education and consents are signed on admission only. The flu vaccine is administered annually in October of each year. In</p>	F 334		
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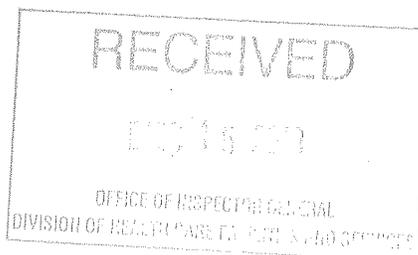
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F 334	<p>Continued From page 9</p> <p>addition, the CDC (Centers for Disease Control) poster "what you need to know" is posted. The Infection Control nurse completes an audit of all residents for consent and allergies. Completes a list of all resident to receive the flu vaccine and administers. The resident's allergies are posted on the physician orders, dietary and medication administration records. Resident #2 should not have received the flu vaccine if they were allergic to eggs. The system should have caught that.</p> <p>2. Resident #10 had a readmission date of 05/07/08 with diagnoses of Chronic Obstructive Pulmonary Disease, and Congestive Heart Failure. Review of the resident's last annual comprehensive assessment dated 01/13/10 revealed the resident had received the flu vaccine offered by the facility. Review of the Immunization Record revealed Resident #10 had received the flu vaccine on 11/03/10, however review of the last Vaccination authorization dated 2007 revealed the resident had a know sensitivity or allegery to eggs and was answered no to the question regarding receiving the flu vaccine annually in the fall of the year.</p> <p>Interview with the Director of Nursing (DON) on 11/18/10 at 3:00pm revealed consent forms are signed on admission and given to the family. She stated the flu vaccine is not given if the resident is sensitvite to or has allergies to eggs. She also revealed the facility checks annually for physician orders to make sure no residents are allergic or have sensitivity to eggs. Interview also revealed Resident #10 should not have received the flu vaccine and should have been caught on the checks.</p> <p>Further interview with the Director of Nursing revealed the Assistant Director of Nursing/</p>	F 334		



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F 334	Continued From page 10 Infection Control nurse is responsible for checking the orders, at which time she makes a list for each unit and coordinates the administration of the injections. The Assistant Director of Nursing (ADON) is responsible for documenting on the Medication Administration Record (MAR), and physician's orders.	F 334		
F 371 SS=D	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, record review and interview it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. The facility failed to ensure staff sanitized their hands properly, followed hand hygiene policy, handled ice intended for residents use free of contamination, changed gloves according to policy and covered their hair completely with hairnets.  The findings include:  Record review on 11/18/10 revealed policy Environmental Sanitation/Infection Control Policy 9.1 Personal Hygiene dated 2006 #5 - Fingernails are well-trimmed, clean and free of nail polish.	F 371	Individual staff were counseled regarding proper hand washing, personal hygiene, hair net compliance and sanitation procedures on 11/18/10. All Dietary staff were re-educated on Environmental Sanitation and Infection Control Policies on 11/18/10. All policies have been posted and staff required to sign off as reading by 12/17/10 for continual reinforcement. Documentation of their knowledge in a post test will be filed in department records. Weekly observation in the kitchen and serving areas are done by the dietician, dietary manager or designated person. Documented follow-up of findings will be done as required. Random monthly audits will be done on both shifts. Environmental Sanitation/Infection Control Audit Tool will be followed and findings submitted to the Administrator.	Ongoing  12/17/10



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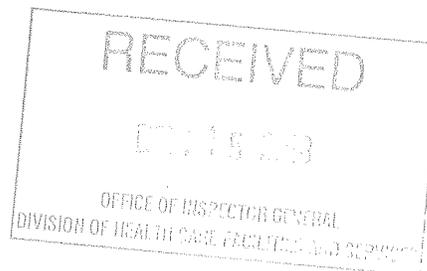
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F 371	<p>Continued From page 11</p> <p>False fingernails are not acceptable.</p> <p>Record review on 11/18/10 revealed policy Environmental Sanitation/Infection Control Policy 9.1 Personal Hygiene dated 2006 #2 - A hair net or head covering that effectively restrains head and facial hair, is worn in food preparation areas. Hair is arranged to prevent contamination of food, equipment and utensils.</p> <p>Record review on 11/18/10 revealed policy Environmental Sanitation/Infection Control Policy 9.29 Cleaning of Floors dated 2006 #9 - Brooms, mop heads and mop handles are stored on hooks, in the designated area, for kitchen use. The mop bucket is washed and turned upside down to dry.</p> <p>Observation on 11/17/10 at 11:20am revealed Dietary Aide #3 washing his/her hands at a wash station then turning around and lifting a garbage can lid to throw away the paper towels. Dietary Aide #3 also had hair coming out from under a hair net while in the kitchen.</p> <p>Observation on 11/17/10 at 11:25am revealed Dietary Aide #1 with dark bluish black fingernail polish.</p> <p>Observation on 11/17/10 at 11:30am revealed Dietary Aide #1 shaking ice off milk and ice cream containers into a container holding ice for resident consumption.</p> <p>Observation on 11/17/10 at 11:40am revealed Dietary Aide #2, after contaminating his/her gloves, changed the gloves without washing his/her hands.</p>	F 371		
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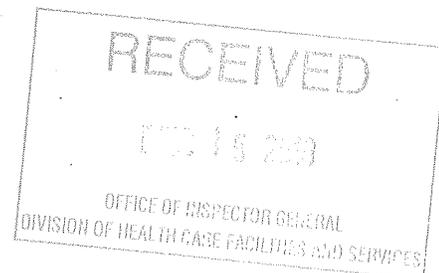
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F 371	<p>Continued From page 12</p> <p>Observation on 11/17/10 at 11:55am revealed Dietary Aide #2, who was wearing gloves, turn around and check information posted on a bulletin board. She touched a sheet of paper posted on the bulletin board and then turned back around and continued serving resident food trays without washing hands and changing gloves.</p> <p>Observation on 11/17/10 at 12:05pm revealed Dietary Aide #3 cleaning her hands with hand sanitizer in the Dining Room and then returned to the kitchen and handled clean dishes without washing her hands with soap and water.</p> <p>Interview with Dietary Manager on 11/18/10 at 2:00pm revealed there is usually an open garbage can near the hand wash sink so the employees do not have to lift a dirty lid to dispose of paper towels used for drying hands. She stated that if ice from around cartons of milk and ice cream falls into the ice container used for resident consumption then the ice in that container would be considered contaminated. The Dietary Manager acknowledged that using hand sanitizing gel is not a substitute for hand washing with soap and water in the dietary area. She revealed the broom is normally not left sitting on floor. She stated she is aware of the no fingernail polish for food handlers and will speak to the staff.</p>	F 371		
F 372 SS=D	<p><b>483.35(i)(3) DISPOSE GARBAGE &amp; REFUSE PROPERLY</b></p> <p>The facility must dispose of garbage and refuse properly.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 372		



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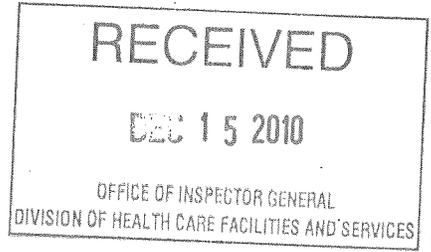
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F 372	Continued From page 13 Based on observation, record review and interview it was determined the facility failed to dispose of garbage and refuse properly as evidenced by a white milky substance leaking from the dumpster and flowing across the parking lot.  The findings include:  Record review of the facility's policy titled Environmental Sanitation/Infection Control Policy 9.51, Cleaning of Trash/Refuse Area #4 dated 2006 revealed all trash bags are leak-proof and are securely closed to avoid any spillage.  Observation on 11/17/10 at 2:00pm, during sanitation tour, revealed the kitchen dumpster with doors closed and lids down. There was a white milky substance running across the parking lot coming from the bottom of the dumpster. The stream was approximately one foot wide and ran across the parking lot about fifteen to twenty feet to a grassy area.  Interview on 11/17/10 at 2:20pm with Dietary Manager revealed there is not supposed to be any leakage from dumpsters and that a bag must have burst causing leakage of the milky substance from the dumpster.	F 372	Policy and Procedure has been updated to include pouring liquids in the disposal prior to placing containers in the trash bags. The monthly cleaning list has been revised to include spraying the outside dumpster area with a hot water hose monthly and PRN.  All staff will complete re-education on Environmental Sanitation and these changes in procedures by 12/17/10.  Observation of dumpster area for proper garbage disposal has been added to the Weekly Environmental Audits and assigned to a specific job description. Random monthly audits will be performed and findings submitted to the Administrator for review.	Ongoing  12/17/10



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K 000	INITIAL COMMENTS  A Life Safety Code survey was initiated and concluded on 11/18/10. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".	K 000		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were maintained according to NFPA standards.  The findings include:  Observation on 11/18/10 at 10:41am, revealed fabric materials having been self made by interweaving the materials together to fabricate a web type design for a gate guard. This was installed on the outside of the door on the metal frame secured on one side by a screw and washer and on the other side was a hook fastener.  The deficiency would prevent exit access readily accessible at all times. This deficiency was found on patient doors 26, 24, 21, 20, 17, 14, 15, 13, 4,	K 038	All door guards were immediately removed from all resident rooms.  Fire retardant stop signs with hook and loop adhesive strips were ordered and have been placed on resident rooms needing door guards. Staff was educated and advised that only fire retardant stop sign door guards are to be used on resident doors to allow quick removal in case of emergency.	12/08/10



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

*Kuane Robertson, Ben*

TITLE

*Don / Asst. Adm.*

(X6) DATE

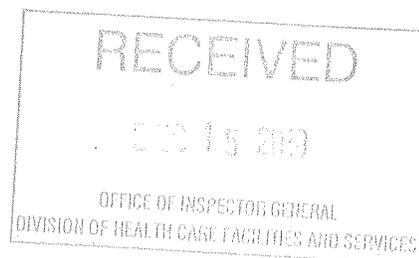
*12/15/10*

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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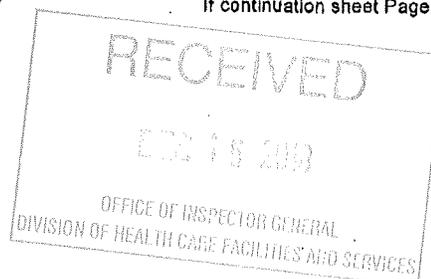
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K 038	<p>Continued From page 1</p> <p>50, 51, 48, 46, 45, 40, 34, 32 and 30. The deficiency affected thirty-six (36) residents. The facility is licensed for one hundred and twenty-two (122) beds and the census the day of the survey was one hundred and twenty (120).</p> <p>Interview on 11/18/10 at 10:41 am with the Maintenance Director revealed they were not aware these type gate guards were not permitted on resident doors.</p> <p>SECTION 7.2 MEANS OF EGRESS COMPONENTS</p> <p>7.2.1 Doors.</p> <p>7.2.1.1 General.</p> <p>7.2.1.1.1 A door assembly in a means of egress shall conform to the general requirements of Section 7.1 and to the special requirements of 7.2.1. Such an assembly shall be designated as a door.</p> <p>7.2.1.1.2 Every door and every principal entrance that is required to serve as an exit shall be designed and constructed so that the path of egress travel is obvious and direct. Windows that, because of their physical configuration or design and the materials used in their construction, have the potential to be mistaken for doors shall be made inaccessible to the occupants by barriers or railings.</p> <p>7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or</p>	K 038	



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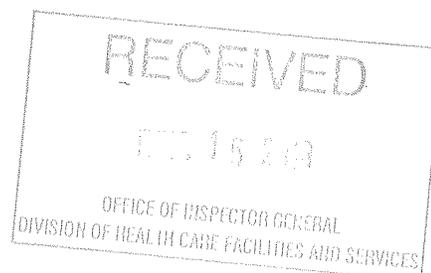
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K 038	Continued From page 2 draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.	K 038		
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the sprinkler system, according to NFPA standards. This deficiency has the potential to affect all	K 061	On 11/19/10, Simplex-Grinnell was contacted for service. During the service call, it was determined that a tamper alarm was needed. Tamper alarm was installed to replace the chain/padlock on wheel. During routine quarterly inspections, Simplex-Grinnell will monitor.	12/31/10



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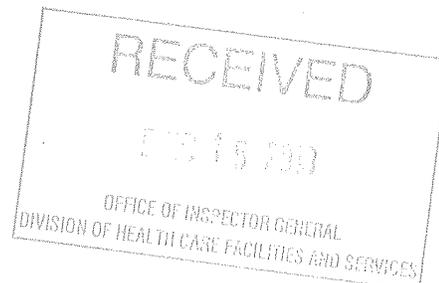
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K 061	Continued From page 3 residents and staff.  The findings include:  Observation on 11/18/10 at 11:50am with the Maintenance Director revealed the post indicator valve was not electronically supervised. The post indicator valve must be electronically supervised to prevent the post indicator valve from being mistakenly turned off and shutting off the outside supply of water to the sprinkler system.  Interview on 11/18/10 at 11:50am with the Maintenance Director, revealed he was unaware of the post indicator valve not meeting the code.  Reference: NFPA 101 (2000 Edition) Supervisory Signals 9.7.2.1 Where supervised automatic sprinkler systems are required by another section of this code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.	K 061		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		



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K 062 SS=D	<p>Continued From page 4</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system according to NFPA standards.</p> <p>The Findings Include:</p> <p>Observation on 11/18/10 at 10:35am revealed storage of records on top of filing cabinets was less than eighteen (18) inches from the sprinkler head. This deficiency would prevent the pattern from fully developing of the sprinkler head.</p> <p>Also the deficiency affected a staff of three (3). The facility is licensed for one hundred and twenty-two (122) and census the day of the survey was one hundred and twenty (120).</p> <p>Interview with the Maintenance Director on 11/18/10 at 10:35am revealed the records would be removed. The Maintenance Director stated they just do not have enough storage.</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge</p>	K 062	<p>All medical record storage boxes were removed from the tops of file cabinets. All other areas were assessed to ensure all items were stored at least 18" from the ceiling.</p> <p>Staff were educated and advised that all items must be stored at least 18" from the ceiling.</p> <p>Environmental Services will monitor all storage and office areas to ensure compliance.</p>	12/06/10



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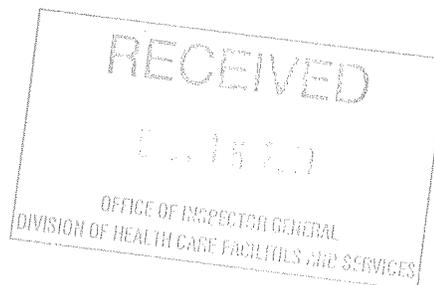
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K 062	Continued From page 5 Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.	K 062		
K 072 SS=F	NFFPA 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  This STANDARD is not met as evidenced by: Based on observation and interview conducted on 11/18/10, it was determined the facility failed to ensure the corridors were maintained free from obstructions in the case of fire and other emergencies. This affects all residents and staff. The census was 120 on the day of the survey with the bed capacity of 122.  The findings include:  Observation on 11/18/10 at 10:30am, with the Maintenance Director, revealed a dirty linen/trash cart on Station 1 short hallway. Further observation at 12:10pm revealed (2) two Hoyer Lifts in the front hallway between Units 2 and 3 and (1) one Hoyer Lift next to room #41 on Station 2.	K 072	All hallways were cleared of excess equipment immediately. Hallways will be kept clear and equipment will be stored in designated areas when not in use. Staff have been educated regarding storage of equipment when not in use. All departments will perform on-going observation to ensure hallways are kept clear of equipment.	12/09/10



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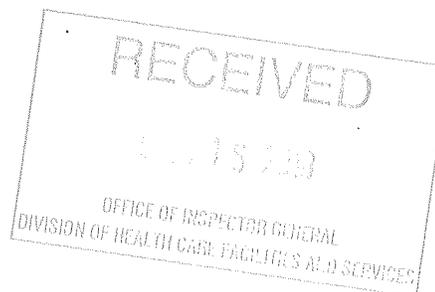
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  11/18/2010
NAME OF PROVIDER OR SUPPLIER  SUNRISE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 80 PHILLIPS LANE HODGENVILLE, KY 42748	
(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 6 Interview with the Maintenance Director on 11/18/10 at 3:00pm indicated that the carts and lifts would be moved.	K 072		
K 147 SS=F	Reference: NFPA 101 (2000 Edition) 7.1.10 Means of Egress Reliability Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to guard against accidental contact of live parts per NFPA Standard.  The findings include:  Observation on 11/18/10 at 10:37am revealed the electrical panel boxes in the corridor across from the Nursing Services Office were not secured. This deficiency was also noted at panel boxes near Nursing Station #2 and Nursing Station #3 with the potential to affect three (3) smoke compartments, staff and thirty eight (38) residents.  Interview on 11/18/10 at 10:37am, with the	K 147	All panel boxes were locked with keys. Additional keys for boxes were placed at Nurse Station 1 with the master keys, and in Dietary, Maintenance and Environmental Services Office in the event of an emergency.  Maintenance Department will perform on-going observation to ensure boxes are locked.	11/19/10



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NAME OF PROVIDER OR SUPPLIER  SUNRISE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 80 PHILLIPS LANE HODGENVILLE, KY 42748	
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K 147	Continued From page 7 Maintenance Director, revealed they were unaware the electrical panels should be secured. They also stated they had lost the keys years ago.  Reference: NFPA 70 (1999 Edition), 110.27 Guarding of Live Parts. (A) Live Parts Guarded Against Accidental Contact. Except as elsewhere required or permitted by this Code, live parts of electrical equipment operating at 50 volts or more shall be guarded against accidental contact by approved enclosures or by any of the following means: (1) By location in a room, vault, or similar enclosure that is accessible only to qualified persons. (2) By suitable permanent, substantial partitions or screens arranged so that only qualified persons have access to the space within reach of the live parts. Any openings in such partitions or screens shall be sized and located so that persons are not likely to come into accidental contact with the live parts or to bring conducting objects into contact with them. (3) By location on a suitable balcony, gallery, or platform elevated and arranged so as to exclude unqualified persons. (4) By elevation of 2.5 m (8 ft) or more above the floor or other working surface. (B) Prevent Physical Damage. In locations where electric equipment is likely to be exposed to physical damage, enclosures or guards shall be so arranged and of such strength as to prevent such damage. (C) Warning Signs. Entrances to rooms and other guarded locations that contain exposed live parts shall be marked with conspicuous warning signs	K 147		



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K 147	Continued From page 8 forbidding unqualified persons to enter.	K 147		

