

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

PRINTED: 03/22/2010
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 03/11/2010
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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	F 000		
F 167 SS=B	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A standard health survey was conducted 03/09/10 through 03/11/10 and a Life Safety Code survey was 03/09/10. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the survey results were located in an area accessible for the residents.</p> <p>The findings include: Observations of the survey book upon entrance and exit from the facility on 03/09/10, 03/10/10 and 03/11/10 at 8:00am and 5:30pm each day revealed the survey book to be located between two sets of locked doors that required a keypad code or the assistance of a staff member.</p>	F 167	<p>1.) Survey results were moved at the receptionist desk to an area accessible from the hall where they will always be available to the residents.</p> <p>2.) Residents will be reminded at each resident council meeting by the Activity Director, where the survey results are located. This will be documented in the resident council minutes.</p> <p>3.) The location of the survey book and its contents will be checked each month by the receptionist, and the receptionist's findings shall be reported to Administrator.</p> <p>4.) The Administrator will also check the placement of survey results each month and report findings to monthly QA.</p> <p>Completion date:</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Liselle J. Butterfield* TITLE: *X Administration* (X6) DATE: *3-31-10*

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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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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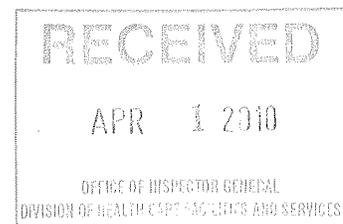
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F 167	Continued From page 1 Interviews during the Quality of Life group meeting on 03/09/10 at 3:30pm revealed thirteen (13) residents were present and all stated they were aware they could read the previous survey results; however, none of the residents knew where the survey results were located. Interview with the Director of Nursing and Social Services on 03/11/10 at 3:45pm revealed the survey book was placed behind locked doors due to wandering residents walking off with the survey binder. They stated they had not thought of the accessibility of the binder and it had never been brought to their attention.	F 167		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to promote care for the residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality for two (2) of twenty-five (25) sampled residents (#24 and #25). Observation of the medication pass on 03/09/10 revealed accuchecks and insulin injections were given to residents in the lounge area and dining room with other residents and family members present. The findings include:	F 241	1./2.) Residents #24 and #25 as well as all other residents will not be given any treatments or injections in a public area where others may be present. 3.) All Nurses and CNAs will be in-serviced regarding privacy and dignity issues as it specifically relates to medication administration. All staff will be asked to report any concerns or issues to the Director of Nursing. The first in-service was given by the Education Nurse on March 25, 2010 and all staff will be in-serviced by April 15, 2010. Privacy issues and appropriate administration of injections will be added to the facility policy and procedures relating to administration of medications.	



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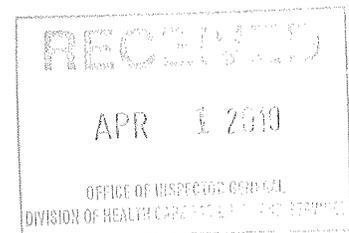
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F 241	<p>Continued From page 2</p> <p>Observation of the medication pass on 03/09/10 at 11:30am revealed Licensed Practical Nurse (LPN) #1 performed the accucheck reading then gave an insulin injection in the abdomen of Resident #24 (admitted with a diagnosis of Insulin Dependent Diabetes Mellitus) while the resident was standing in the lounge area. Several other residents were in the lounge area at the time of the accucheck and insulin injection. Further observation revealed Resident #25 (admitted with a diagnosis of Insulin Dependent Diabetes Mellitus) was seated in the dining area while the accucheck was performed and then was given an insulin injection in the abdomen while still in the dining area. LPN #1 requested a CNA stand beside the resident to provide some privacy because a female resident was seated at the table. However, several residents and family members were present in the dining area and were able to view the resident.</p> <p>Record review of Resident #24 revealed a blood sugar of 253 at 11:30am on 03/09/10 and was administered Humulin R insulin 5 units subcutaneously in the abdomen. Record review for Resident #25 revealed a blood sugar of 252 on 03/09/10 at 11:30am and they received Novolin R insulin 6 Units subcutaneously in the abdomen.</p> <p>Interview with LPN #1 on 03/09/10 at 11:45am revealed she was aware of the lack of privacy provided for the residents while exposing their abdomens during medication administration. LPN #1 stated she was told it was acceptable to give medications to residents in the dining area if the trays had not been served. She acknowledged privacy was not provided by having</p>	F 241	<p>While conducting our resident satisfaction surveys, residents will be asked, by the social service staff, if they have had any privacy issues specifically relating to injections.</p> <p>The nurse identified who improperly administered injections to residents #24 and #25 has been counseled. All nurses will be inserviced regarding privacy and dignity issues</p> <p>4.) All department heads will monitor compliance with this policy on a daily basis and report any non-compliance to the DON and Administrator in the daily QA meeting. Social Service will report findings from the satisfaction surveys at our quarterly QA meetings.</p> <p>5.) Completion Date:</p>	



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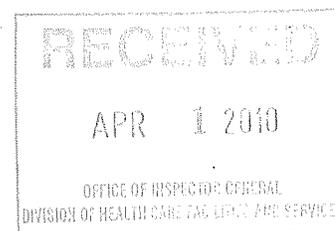
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F 241	Continued From page 3 a CNA stand beside the resident while giving an injection in the abdomen. Interview with the Director of Nursing (DON) on 03/11/10 at 1:25pm revealed the nurse should not have given the insulin injections in an area with other residents and family members present. The DON stated LPN #1 acknowledged it was not an acceptable practice to give injections and perform accuchecks in an area with other residents and family members present. She acknowledged this was a privacy and dignity issue and possibly an infection control issue. The facility policy related to the administration of medication did not address the issue of privacy during medication pass that included providing residents' with injections.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure equipment containing water (Hydrocollator and Aquarium) were plugged into a GFI (Ground Fault Interrupter) plug. The findings include: Observations during the environmental tour on 03/09/10 at 3:00pm revealed a Hydrocollator in the therapy department was plugged into a	F 253	1./2.)The hydrocollator was moved to the therapy kitchen on March 11, 2010 where a GFI plug was located. GFI plugs for the fish tanks were installed and all tanks are now plugged into GFI plugs. 3.) Housekeeping and maintenance will monitor for residents or families that want to set up a new fish tank. Tanks will not be allowed until a GFI plug is installed. A statement will be included in our monthly newsletter regarding fish tanks and the need to have them plugged into a GFI plug.	



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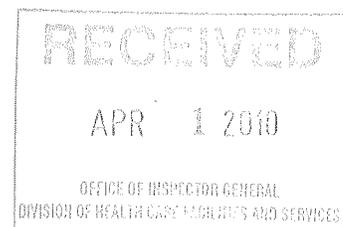
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F 253	Continued From page 4 regular outlet. The Hydrocollator contained heated water. Interview with the Administrator on 03/09/10 at 4:00pm revealed the therapy department moved from another part of the building and did not realize the Hydrocollator was not plugged into a GFI plug. However, there was a GFI plug around the corner near the sink area. In addition, observations on 03/09/10 at 3:00pm revealed an Aquarium holding approximately 60 gallons of water in the lobby area utilized by residents. The aquarium was plugged into a power strip and then plugged into a regular outlet. Interview with the Maintenance Director on 03/11/10 at 2:10pm revealed he did not think the aquarium had to be plugged into a GFI outlet. Observations of the same aquarium on 03/11/10 at 4:00pm revealed the power strip had been plugged into an electrical resister box then plugged into a regular outlet. Interview with the Administrator on 03/11/10 at 4:30pm revealed he had placed the resister box there due to not having a GFI plug. In addition, he did not realize the resister box would not protect from electrical shock or that the aquarium could not be plugged into a power strip.	F 253	Our maintenance staff will inspect facility monthly for compliance and will test all GFI plugs quarterly. Non-compliance will be reported immediately to the administrator. Findings will be reported to the quarterly QA committee. Completed:	3-16-10
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.	F 282	1.) The splints for Resident #6 are now being applied as indicated in the resident's plan of care.	



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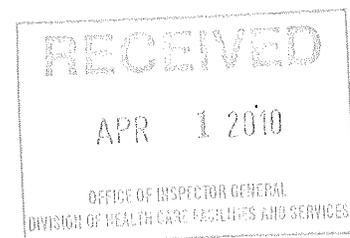
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F 282	Continued From page 5 . This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined the facility failed to follow the plan of care for one (1) of twenty-five (25) sampled residents (#6). Resident #6's plan of care revealed the resident was to have bilateral static knee splints applied from 12:30pm to 3:30pm daily. Observation of Resident #6 on 03/10/10 at 2:20pm revealed the knee splints had not been applied as detailed in the plan of care. The findings include: Observation of Resident #6, admitted with a diagnoses of Cognitive Dysfunction and Osteoarthritis, on 03/10/10 at 2:20pm revealed the bilateral leg splints were not applied as ordered by the physician and detailed in the care plan. Observation of Resident #6 during the skin assessment revealed the resident was in bed with his/her legs bent at the knees. While repositioning the resident during the skin assessment, the resident did not straighten his/her legs. Record review revealed the Minimum Data Set dated 11/19/09 assessed the resident as non-ambulatory with bed mobility, requiring extensive assistance and a cognition of two (moderately impaired). The physician orders dated 03/02/10 revealed the resident was to have bilateral knee splints applied from 12:30pm to 3:30pm daily. The care plan and the CNA care plan also stated the knee splints were to be applied daily form 12:30pm to 3:30pm. Interview with LPN #1 on 03/10/10 at 2:20pm	F 282	2.) All other residents requiring splints were reviewed to ensure that care plans are being followed. 3.) The RNA involved has been re-educated and counseled regarding the need to follow the care plan for each resident. The Education Nurse will conduct training for all Nurses, RNAs, and CNAs regarding the necessity of following each resident's plan of care. 4.) Our education nurse and therapy department staff will weekly check for compliance, regarding splint use, and will inform the QA committee on a monthly basis regarding findings. Completion Date:	4-15-10



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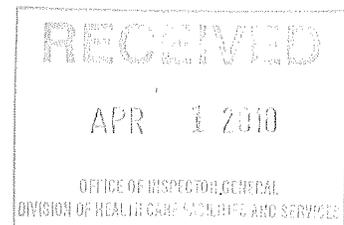
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F 282	Continued From page 6 revealed application of the knee splints is the responsibility of the restorative aide. She was unsure why the knee splints had not been applied to Resident #6. Interview with the Restorative Aide (RA) on 03/11/10 at 9:40pm revealed she had not applied the knee splints on Resident #6 on 03/10/10. She stated she forgot to apply the splints and the resident's contractures could worsen with the splints not placed on the resident.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to ensure residents received medications as ordered by the attending physician for one (1) of the twenty-five (25) residents sampled (#21). Resident #21's attending physician was not notified of a medication that was not available before contacting an outside physician for an order. The findings include: Review of the closed record for Resident #21 revealed on 03/08/10 the resident presented with a temperature of 101.2 degrees Fahrenheit and	F 309	1.) Resident #21 expired on March 10, 2010. 2.) No other residents have been affected by stated deficient practice. 3.) Policy and procedures will be reviewed and revised to address issues that might arise after-hours or on weekends. Contact numbers for the DON and ADON are posted at each nurses station for problems that may arise. All Nurses and CMTs will be in-serviced by our Education Nurse regarding the policy and procedure on acquiring medications after- hours as well as the nursing administration contact phone numbers. New nurses and CMTs will receive this information during their orientation.	



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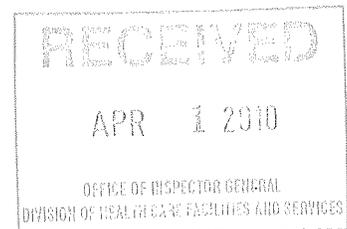
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F 309	<p>Continued From page 7</p> <p>oxygen saturation levels dropped to 82 percent. Per the nurse's note dated 03/09/10 the resident was comfort measures only with family refusal of Hospice care. In addition, the family had refused oxygen be provided to the resident. The physician was notified and ordered Ativan 0.5mg every 6 hours as needed for agitation. Continued review of the closed record revealed a nurse's note dated 03/10/10 that indicated the family member had the nurse call a local pharmacy and order Ativan sublingual under her daughter's DEA number, and the pharmacy would have the medication ready for this physician to pick up. Approximately one (1) hour later the physician brought the Ativan to the facility and a dose was administered to the resident by the nurse.</p> <p>Interview via conference call with LPN #2 on 03/10/10 at 9:10am, and the Assistant Director of Nurses in attendance, revealed the attending physician ordered sublingual; however, when the medication was delivered by the pharmacy it was in pill form. The medication was returned to pharmacy to be replaced with sublingual. The medication was not replaced and the LPN attempted to contact other pharmacies; however, they were closed. The LPN did not call the attending physician's office regarding the unavailability of the medication and did not call the pharmacy to inquire about the medication because they were both closed for the evening. The LPN stated the original order by the attending physician was faxed to the local pharmacy; however, the DEA number of the family member was provided in case it was needed. The LPN further indicated there was nothing posted at the nurse's station to instruct the staff of who to call after hours. The LPN was not aware of the physician's name on the label as she did not read</p>	F 309	<p>A pharmacy incident report will be developed by March 30, 2010 to record problems, such as delivery, that will be used to investigate problems and develop solutions.</p> <p>All Nurses and CMTs will be trained by the Education nurse on new policy or procedures and will be instructed regarding the use and purpose of the pharmacy incident report by April 16, 2010.</p> <p>The nurse identified as not following the appropriate procedures was counseled on March 12, 2010</p> <p>4.) The DON and ADON will randomly ask nurses and CMTs if they understand the policy for acquiring medications after hours. Any non-compliance or misunderstanding will be corrected immediately.</p> <p>The DON will review all pharmacy incident reports and address problems immediately. DON will also present her findings at the monthly QA meeting.</p> <p>Completion Date:</p>	4-16-10



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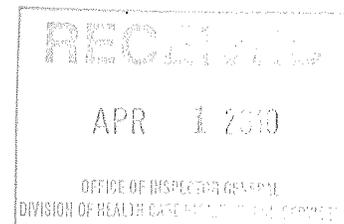
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F 309	Continued From page 8 the label prior to administering the medication to the resident. Review of Resident #21's medications for return to the pharmacy revealed the Ativan (Lorazepam Intenso!) was dispensed in the name of the family member on 03/10/10 and not by the attending physician. Interview with LPN #3 on 03/10/10 at 9:30am revealed it was the policy of the facility to call the attending physician's office and the answering service would have the on-call physician call the facility. In addition, the nursing staff are to call the pharmacy after-hours number and a medication would be sent right away. The physician's number was observed documented in the clinical record and the pharmacy number was posted at the nurse's station.	F 309		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to prepare, distribute and serve food under sanitary conditions. The three (3) kitchen staff were noted	F 371	1./2.) Hair nets are now being worn properly, and insulated plate holders are free of moisture and water droplets before they are used. 3.) Training was given by the dietary manager and dietitian on March 9, 2010 to all staff on duty concerning the proper use of hair nets and the proper procedure for air-drying dishes, pans and utensils. Our procedures for air drying and storing kitchen ware were reviewed and revised on March 31, 2010.	



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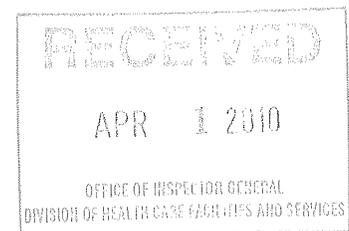
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F 371	<p>Continued From page 9</p> <p>wearing hair coverings that did not fully cover their hair. In addition, fourteen (14) wet plate holders were observed being distributed during the tray line.</p> <p>The findings include:</p> <p>Observation of the kitchen staff on 03/09/10 at 10:45am revealed that even though the three (3) employees had hair coverings on, their hair was only partially covered and loose strands of hair was observed.</p> <p>Observation of the lunch meal service on 03/09/10 at 10:45am revealed fourteen (14) wet plate holders being utilized during tray line and placed on resident trays.</p> <p>Record review of the facility policy on Hair Covering stated that kitchen employees are to cover their hair using facility supplied white bouffant caps, and that the cap must be arranged in such a way that no loose hairs are visible. It also stated that for employees with long hair, it should be restrained first and then covered so that no hair is visible, and two caps may be necessary.</p> <p>Interview with the kitchen chef on 03/09/10 at 2:15pm revealed that hair nets are to be worn at all times to keep loose hair or hair lint from falling into the food. Continued interview revealed that dishes and lids should not be wet. Wet dishes and lids could contain chemicals and/or cause contamination that could cause a resident to become ill.</p> <p>Interview with dietary worker #1 on 03/09/10 at 2:20pm revealed he had received training on</p>	F 371	<p>By April 02, 2010, the dietary manager and dietitian will give an additional in-service to the entire dietary staff concerning the proper use of hair nets as well as the proper procedure for air-drying dishes, pans, and utensils.</p> <p>4.) Compliance will be monitored daily by Dietary Manager and Shift Supervisors. Any non-compliance will be corrected immediately. One of our Dietitian Consultants will monitor compliance of our procedures for air-drying and the proper use of hairnets on a monthly basis.</p> <p>The Dietitian Consultant will report findings to the Q.A. Committee quarterly.</p> <p>Completion Date:</p>	4-15-10	



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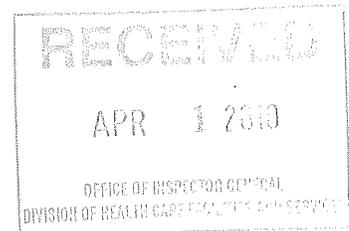
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2010
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056	
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F 371	<p>Continued From page 10</p> <p>infection control. He continued to state he did not know why the plate holders had not been dried the morning of 03/09/10. He stated when the dishes are not dry; they are not to be used because the water can cause bacteria. In addition, dietary worker #1 also stated that hair nets keep hair from getting in the resident's food.</p> <p>Interview with dietary worker #2 on 03/09/10 at 2:25pm revealed the plate holders were to be air dried, and then stored. He stated that the plate holders were wet because he was in a hurry and didn't make sure they were dried before reaching the tray line and stated that bacteria could grow in the water and make resident's sick. Continued interview with dietary worker #2 revealed hair nets should be worn in the kitchen at all times so hair does not get into the resident's food.</p> <p>Interview with the Evening Shift Dietary Supervisor on 03/09/10 at 2:35pm revealed that there was to be no water droplets present on any of the dishes or dish holders because of possible bacteria build up that could result in an illness. He stated the dishes must have been unracked, and put away too soon before they were allowed to completely dry. In addition, the supervisor stated all employees must wear hair nets at all times to keep hair out of the food.</p> <p>Interview on 03/09/10 at 2:45pm with the Dietary/Kitchen Manager revealed the kitchen employees are in-serviced upon hire, and frequently throughout the year on the use of hair nets, and the importance of not using wet dishes/dish holders. She stated that all resident dishes should be completely dried before use. Her plan was to talk with dietary worker #2 again on the importance of completely drying the</p>	F 371		



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F 371	Continued From page 11 resident's dishes and dish holders prior to use. She also stated that hair nets prevent hair from getting in the resident's food. She stated she would also provide the employees with hair pins to keep their hair inside the bouffant.	F 371			



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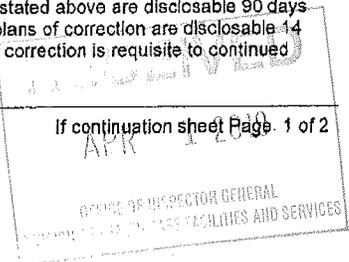
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/09/2010
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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40068
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K 000	INITIAL COMMENTS	K 000		
K 147 SS=E	<p>A state Life Safety Code survey was conducted on 03/09/10 for compliance with Title 42, Code of Federal Regulations, 483.70 (a) (Life Safety from fire, requirements for Long Term Care Facilities) NFPA 101 Life Safety Code 2000 Edition.</p> <p>Deficiencies were cited with the highest scope/severity identified at an "E".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure electrical equipment was used properly.</p> <p>The findings include:</p> <p>Observation during the Life Safety Code Inspection on 03/09/10 at 1:30pm revealed a fish tank located in the Lobby area had a power strip that was being used in place of a Ground Fault Circuit Interrupter (GFCI). In addition, observation on 03/09/10 at 4:00pm revealed the Therapy department's hydrocollator was not plugged into a GFCI.</p> <p>Interview on 03/09/10 at 4:00pm with the Maintenance Director revealed the hydrocollator was moved but they did not think about the GFCI. In addition, they did not know a GFCI was needed for a fish tank.</p>	K 147	<p>1./2.)The hydrocollator was moved to the therapy kitchen on 3-11-10 where a GFI plug was located. GFI plugs for the fish tanks were installed and all tanks are now plugged into GFI plugs.</p> <p>3.) Housekeeping and maintenance will monitor for residents or families that want to set up a new fish tank. Tanks will not be allowed until a GFI plug is installed.</p> <p>A statement will be included in our monthly newsletter regarding fish tanks and the need to have them plugged into a GFI plug.</p> <p>Our maintenance staff will inspect the facility monthly for compliance and will test all GFI plugs quarterly. Non-compliance will be reported immediately to the administrator. Findings will be reported to the quarterly QA committee.</p> <p>Completed:</p>	3-16-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Lessie J. Butterfield* TITLE *Administrator* (X8) DATE *3-31-10*

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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K 147	Continued From page 1 NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces National Electric Code, relating to ground fault protection for electric outlets near sinks in resident rooms. NFPA: 70 210.8 Receptacles installed under the exceptions to 210.8(A)(5) shall not be considered as meeting the requirements of 210.52(G). (6) Kitchens - where the receptacles are installed to serve the countertop surfaces (7) Wet bar sinks - where the receptacles are installed to serve the countertop surfaces and are located within 1.8 m (6 ft) of the outside edge of the wet bar sink.	K 147		

