

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

PRINTED: 05/08/2013  
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  04/25/2013
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NAME OF PROVIDER OR SUPPLIER  SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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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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<p>F 000 INITIAL COMMENTS</p> <p>A standard health survey was initiated on 04/23/13 and concluded on 04/25/13 and a Life Safety Code survey was initiated on 04/23/13 and concluded on 04/23/13 with deficiencies cited at the highest scope and severity of an "F", with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>This was a Nursing Home Initiative survey with entrance to the facility on Tuesday, 04/23/13 at 7:00 AM.</p> <p>F 151 483.10(a)(1)&amp;(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to allow one (1) of twenty-four (24) sampled residents to exercise his or her rights as a resident of the facility. A staff member held onto the wheelchair back, which restricted the forward movement of Resident #11, and told the resident he/she could not lie down when Resident #11 attempted to self-propel his/her wheelchair toward the resident room and requested to lie down.</p>	<p>F 151</p> <p>F 000</p> <p>1. Resident #11 was assessed on 4/26/13, 4/29/13, 5/01/13, and 5/02/13 by the Social Services Director and the Social Services Assistant. No signs or symptoms of psychosocial distress were identified. Resident #11's care plan was reviewed to ensure that residents personal preferences are individualized and acknowledged in the plan of care. (Resident #11's resident rights are being protected and her personal preferences are being honored. Resident #11 is being assisted by staff to bed as she requests. Staff are not restricting the movement of wheelchairs of resident #11.)</p> <p>F 151</p> <p>2. An audit was completed by 5/31/13 of the Behavior Management Program and all resident care plans including behavioral care plans to ensure that all residents' personal preferences that have been identified are acknowledged on the residents' plan of care and specific behavior management interventions are appropriate. All residents' resident rights are being protected</p>
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CLINICAL DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE NHA	(X6) DATE 5/17/13
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Deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued participation.

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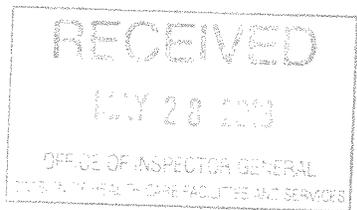
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F 151	<p>Continued From page 1</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Resident Rights, revised 02/13, revealed residents had the right to be free of interference and coercion from the facility when exercising his/her rights.</p> <p>Review of the facility's record for Resident #11, detailed an admission date of 03/08/10 and diagnoses of: Concussion (Head Trauma) with Post-Concussion Syndrome; Abnormal Gait; Muscle Weakness; Depression; and Anxiety. Review of the Minimum Data Set (MDS), dated 03/18/13, revealed the facility assessed the resident at a thirteen (13) of fifteen (15) on the Brief Interview for Mental Status evaluation which indicated Resident #11 was cognitively intact.</p> <p>Review of the Behavioral Assessment, dated 11/29/12, for Resident #11 detailed the resident received psychotropic medications for the treatment of Anxiety, Depression, and Agitation. The Behavioral Assessment identified Resident #11's behaviors as: cursing at staff; kicking at staff; lying about staff; and refusal of care. It further detailed staff interventions to include: keep the resident near the nursing station; provide an explanation of outcomes/rationale to the resident; and provide a time frame for which the resident could return to bed.</p> <p>Observation, on 04/25/13 at 8:50 AM, revealed Resident #11 was sitting in a wheelchair in the common area around the nursing station with a safety helmet on his/her head, and stated, "I am going to lay down, my head hurts." CNA #10 moved behind Resident #11's wheelchair and held the hand grips to restrict the forward</p>	F 151	<p>and all residents' personal preferences are being honored. All residents are being assisted by staff to bed per their request. Staff are not restricting the movement of wheelchairs of residents.</p> <p>Staff are following the interventions as documented in resident's behavior plan and documenting behaviors as appropriate.</p> <p>3. Facility staff have been re-inserviced on 5/31/13 by the Social Services Director and Administrator on resident rights as a resident of the facility and a citizen of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. A post test is being given to ensure understanding.</p> <p>The Social Services Director and Staff Development Coordinator are reeducating all nursing staff on the Behavior Management Program including interventions and documentation of behaviors. A post test is being given to ensure understanding.</p> <p>4. The Social Services Director and the Social Services Assistant will interview ten residents per month times six months to ensure resident</p>	
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F 151 Continued From page 2

movement of Resident #11. CNA #10 told Resident #11 that he/she could not lay down because the Adult Day Care workers would soon arrive to transport the resident and stated the workers would not take the resident if he/she was in bed. Resident #11 continued to use her lower extremities in an attempt to propel forward toward his/her room, and reached behind the wheelchair and pinched and pulled at CNA #10's fingers in an attempt to release the grip of the CNA. Resident #11 told CNA #10, "Let go!" and cursed at the CNA. CNA #10 asked LPN #7, who was at the nursing station what she should do, as she continued to hold the wheelchair. LPN #7 directed another CNA to go find the nurse for Resident #11 and to ask for direction, as CNA #10 continued to restrict the forward movement of the resident. RN #4 advised CNA #10 to allow Resident #11 to return to bed, and to get the resident up in thirty (30) minutes for Adult Day Care.

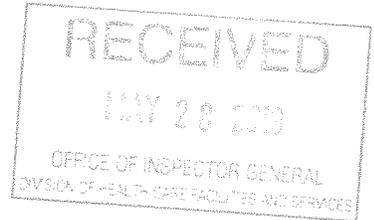
Interview, on 04/25/13 at 1:20 PM, with CNA #10 revealed the staff try to keep Resident #11 up in a wheelchair after breakfast until the Adult Day Care workers arrive for transportation. CNA #10 said earlier on this day, she held the wheelchair back to keep Resident #11 from returning to bed. CNA #10 said that she had observed other staff members to intervene with Resident #11 by holding the wheelchair back to keep the resident from returning to bed after breakfast. CNA #10 said Resident #11 responded with "violence" when staff attempt to restrict the movement of the resident's wheelchair. CNA #10 said Resident #11 pinched and attempted to pull her fingers from the chair, and cursed at her as she held the wheelchair back. CNA #10 was not able to state

rights are being protected and their personal preferences are being honored.

The Social Services Director and the Social Services Assistant will audit the Behavior Management Documentation weekly times four weeks, then monthly times five months to ensure compliance with following the program.

The results of these audits will be forwarded to the Quality Assurance Committee for further review and recommendations.

5. June 7, 2013



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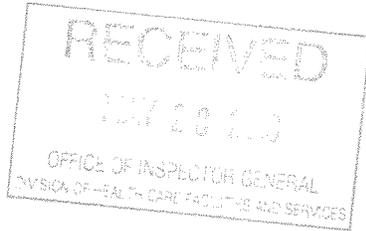
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F 151 Continued From page 3  
the appropriate staff interventions to address the specific behaviors of Resident #11 as documented in the behavior plan.

F 151

Interview, on 04/25/13 at 1:45 PM, with LPN #7 revealed she observed CNA #10 restricting the forward movement of Resident #11 by holding the wheelchair back on this day. LPN #7 said she had witnessed other staff members to hold the wheelchair back to restrict the forward movement of Resident #11. LPN #7 stated it was not appropriate for staff to restrain the forward movement of any resident because the residents had a right to move freely within the facility in accordance with the facility policy for Resident Rights. LPN #7 stated she did not direct CNA #10 to release the wheelchair back of Resident #11 because she did not usually work this unit.

Interview, on 04/25/13 at 2:56 PM, with LPN #4 revealed Resident #11 became combative when staff requested the resident to do something he/she did not want to do. LPN #4 stated he did not witness CNA #10 holding the wheelchair back to restrict the movement of Resident #11 on this day. LPN #4 said it would not be appropriate for staff to hold the wheelchair back to restrict the movement of a resident and stated that action would cause anyone to become angry. LPN #4 stated Resident #11 likely became combative as a result of the wheelchair back being held. LPN #4 stated Resident #11 demonstrated negative behaviors on a daily basis and said he did not think the staff access the Behavior Plan for Resident #11 due to the frequency of her behaviors. LPN #4 did not know if there was a specific Behavior Plan for each resident with negative behaviors and said staff used to chart



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F 151 Continued From page 4  
them in a Behavior Book, and said currently the behaviors were only charted on the Medication Administration Record.

F 151

Interview, on 04/25/13 at 4:30 PM, with the Director of Nursing (DON) revealed Resident #11 had behaviors that were triggered when the resident was requested to do something he/she did not want to do. The DON stated Resident #11 had experienced many falls which resulted in head trauma at the facility. The DON stated the staff attempt to keep Resident #11 out of bed as much as possible to maintain the safety of the resident because the resident would attempt to transfer from the wheelchair to the bed without assistance. The DON stated it would not be appropriate for staff to hold the wheelchair back to restrict the movement of any resident, and stated that CNA #10 should have used a diversionary tactic with Resident #11 instead. The DON stated Social Services was responsible for maintaining the Behavior Plan binder, and said she was not responsible to review the Behavior Plans.

F 151

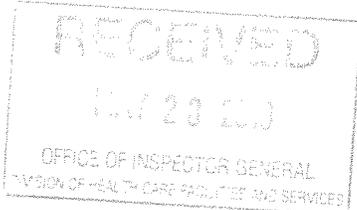
Interview, on 04/25/13 at 5:15 PM, with the Administrator revealed residents in the facility had a right to get up or lie down whenever the resident wished to do so, which was reflected in the facility's policy for Resident Rights. The Administrator stated when CNA #10 held the wheelchair back to restrain the movement of Resident #11, the effect on the resident could cause the resident to feel helpless and would impinge on the resident's rights.

F 221

221 483.13(a) RIGHT TO BE FREE FROM  
SS=D PHYSICAL RESTRAINTS

F 221

1. Resident #11 was assessed on by 4/26/13, 4/29/13, 5/01/13, and 5/02/13 by the Social Services Director and the Social Services Assistant. No signs or symptoms of



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F 221 Continued From page 5

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, it was determined the facility failed to allow one (1) of twenty-four (24) sampled residents and eight (8) unsampled residents to exercise his or her rights as a resident of the facility. The staff forcibly held the wheelchair back preventing the forward movement of Resident #11 when attempts were made to self-propel his/her wheelchair into the resident's room.

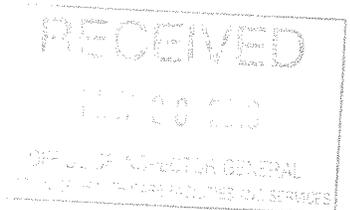
The findings include:

Review of the facility's record for Resident #1, revealed the facility admitted the resident on 03/08/10 with diagnoses of: Concussion (Head Trauma) with Post-Concussion Syndrome; Abnormal Gait; Muscle Weakness; Depression; and Anxiety. Review of the Minimum Data Set (MDS), dated 03/18/13, revealed the facility assessed the resident at a thirteen (13) of fifteen (15) on the Brief Interview for Mental Status evaluation which Indicated Resident #11 was cognitively intact.

Review of the Behavioral Assessment, dated 11/29/12, for Resident #11 detailed the resident received psychotropic medications for the treatment of Anxiety, Depression, and Agitation.

F 221 psychosocial distress were identified. On 5/24/13, C.N.A. #10 and LPN #7 was re-educated by the Staff Development Coordinator on the residents right to be free of restraint imposed for purposes of discipline or convenience, and not required to treat the residents medical symptoms. Resident #11 is free of physical restraint.

- By 5/31/13, the Director of Nursing, Assistant Director of Nursing, Unit Manger, Restorative Nurse Manager and Staff Development Coordinator re-assessed and completed a physical restraint assessment on all residents with a physicians order for a physical restraint to ensure all restraints in the facility are being used for the residents' individual medical symptoms. No other issues were identified..
- Nursing staff were re-educated by the Administrator and Social Services Director by 5/31/13 on the residents right to be free of restraint imposed for purposes of discipline or convenience, and not required to treat the residents' medical symptoms. A post test is being given to ensure understanding.
- All residents with physical restraints will be reviewed in the weekly at risk meeting to



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F 221 : Continued From page 6

The Behavioral Assessment identified Resident #11's behaviors as: cursing at staff; kicking at staff; lying about staff; and refusal of care. In addition it detailed staff interventions to include: keep the resident near the nursing station; provide an explanation of outcomes/rationale to the resident; and provide a time frame for which the resident could return to bed.

Observation, on 04/25/13 at 8:50 AM, revealed Resident #11 was sitting in a wheelchair in the common area around the nursing station with a safety helmet on his/her head, and stated, "I am going to lay down, my head hurts." CNA #10 moved behind Resident #11's wheelchair and held the hand grips to restrain the forward movement of Resident #11. CNA #10 told Resident #11 that he/she could not lay down because the Adult Day Care workers would soon arrive to transport the resident and stated the workers would not take the resident if he/she was in bed. Resident #11 continued to use her lower extremities in an attempt to propel forward toward his/her room, and reached behind the wheelchair and pinched and pulled at CNA #10's fingers in an attempt to release the grip of the CNA. Resident #11 told CNA #10, "Let go!" and cursed at the CNA. CNA #10 asked LPN #7, who was at the nursing station what she should do, as she continued to hold the wheelchair. LPN #7 directed another CNA to go find the nurse for Resident #11 and to ask for direction, as CNA #10 continued to restrain the forward movement of the resident. RN #4 advised CNA #10 to allow Resident #11 to return to bed, and to get the resident up in thirty (30) minutes for Adult Day Care.

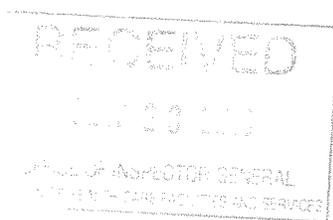
ensure the current restraint is appropriate and used to treat the resident's medical symptoms.

Walking rounds will be completed daily for four weeks t, Monday through Friday, then weekly times six months by the Director of Nursing, Administrator, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator, Restorative Nurse Manager or Social Service Director on each unit to ensure staff are not restraining residents against their wishes.

The Director of Nursing or Assistant Director of Nursing will audit the residents with a physical restraint weekly for four weeks and then monthly for six months to ensure the resident is restrained for their individual medical symptom.

The results of these audits will be forwarded to the Quality Assurance Committee for further review and recommendations.

5. June 7, 2013



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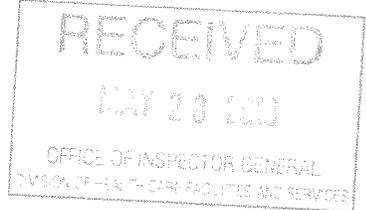
F 221 Continued From page 7

Interview, on 04/25/13 at 1:20 PM, with CNA #10 revealed that she witnessed other staff who intervened with Resident #11 and held the back of the wheelchair to keep the resident from returning to her room/bed. CNA #10 stated she worked at the facility for four (4) months and was trained to keep Resident #11 out of bed after breakfast. CNA #10 stated that she was trained by other staff, and had witnessed other staff members to keep Resident #11 out of her room/bed by holding the back of his/her wheelchair. CNA #10 defined a restraint as a means to keep a resident from a particular activity which was used to maintain the safety of a resident. CNA #10 stated she had never considered holding the wheelchair back to be a resident restraint, but stated that she could see how the action could be considered a restraint. CNA #10 said she should have returned the resident to bed as the resident requested, then advised the nurse of the resident's return to bed.

Interview, on 04/25/13 at 4:00 PM, with the Social Services Director (SSD) revealed the facility plan was to encourage Resident #11 to stay out of bed until time to go to Adult Day Care, and stated this was consistent with the family's request for the facility to encourage the resident to attend Adult Day Care on a daily basis. The SSD stated it was not appropriate for the staff to hold the wheelchair back to restrain the movement of Resident #11 because that would constitute the use of restraint by the facility.

Interview, on 04/25/13 at 5:15 PM, with the Administrator revealed a restraint was defined as a method to restrict the resident's movement used to maintain the resident's safety. The

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F 221 Continued From page 8  
Administrator stated that LPN #7, who witnessed CNA #10 holding the wheelchair back, should have advised CNA #10 to return the resident to his/her room as the resident requested. The Administrator stated the action of CNA #10 who held the wheelchair back was not appropriate because the action was an incident of resident restraint.

F 221

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  
SS=E

F 241

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.

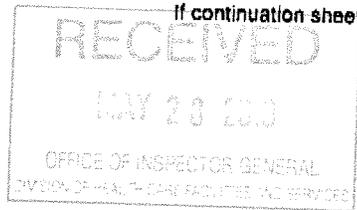
1. Resident #11 was assessed on 4/27/13 by the Social Services Director and the Social Services Assistant. No signs or symptoms of psychosocial distress were identified. Resident #11's care plan was reviewed to ensure that residents personal preferences are individualized and acknowledged in the plan of care.

6/07/13

Resident #16 was assessed for signs/symptoms of psychosocial distress on 4/29/13 by the Social Services Director. No signs/symptoms noted.

Resident # 1 and Un-sampled residents A and B were assessed for signs/symptoms of psychosocial distress on 4/29/13 by the Social Services Director. No signs/symptoms noted. Care plans were updated as appropriate. The facility is providing care for resident #11, # 16 and all other residents in a manner that maintains or enhances dignity, self-esteem, and self-worth.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, and review of the facility's policy, it was determined the facility failed to promote care in an environment and manner that maintained or enhanced each resident's dignity for three (3) of twenty-four (24) sampled residents, Resident #1, 11, and 16, and two of eight (8) unsampled residents, Resident A and B. Staff detained Resident #11 against the resident's will, and was not allowed to make decisions regarding personal preferences. Staff failed to provide visual privacy while toileting for Resident #16. Staff spoke to Resident #1, and Unsampled Residents A and B disrespectfully with use of cursive language, failed to answer resident calls for staff assistance in a timely manner, and failed to respect resident privacy by failure to knock before resident rooms were entered.



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

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FORM APPROVED  
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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  04/25/2013
NAME OF PROVIDER OR SUPPLIER  SUNRISE MANOR NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD 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	

F 241 Continued From page 9

The findings include:

Review of the facility's policy regarding Your Rights as a Resident in a Long-Term Care Facility, revealed residents were treated with consideration, respect, and with full recognition of dignity and individuality, including privacy in treatment and in care of personal needs. Resident had the right to full information, in advance, and to participate in planning and making any changes in care and treatment. Residents were not to be detained against their will.

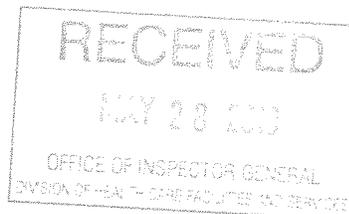
Observation, on 04/25/13 at 8:50 AM, revealed Resident #11 was sitting in a wheelchair in the common area around the nursing station with a safety helmet on his/her head, and stated, "I am going to lay down, my head hurts." CNA #10 moved behind Resident #11's wheelchair and held the hand grips to restrict the forward movement of Resident #11. CNA #10 told Resident #11 that he/she could not lay down because the Adult Day Care workers would soon arrive to transport the resident and stated the workers would not take the resident if he/she was in bed. Resident #11 continued to use her lower extremities in an attempt to propel forward toward his/her room, and reached behind the wheelchair and pinched and pulled at CNA #10's fingers in an attempt to release the grip of the CNA. Resident #11 told CNA #10, "Let go!" and cursed at the CNA. CNA #10 asked LPN #7, who was at the nursing station what she should do, as she continued to hold the wheelchair. LPN #7 directed another CNA to go find the nurse for Resident #11 and to ask for direction, as CNA

F 241 answered timely. Staff are knocking on doors for permission to enter resident rooms before entering. Residents are being spoken to respectfully and without the use of cursive language.

2. All cognitive residents were interviewed by 5/31/13 by the Social Services Director, Social Services Assistant, Chaplain, Quality of Life Director, or Quality of Life Assistants to ensure the facility is providing 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. No other concerns were identified.

All residents are receiving care in a manner that maintains or enhances dignity, self-esteem, and self-worth. Privacy is being provided while toileting. Call lights are being answered timely. Staff are knocking on doors for permission to enter resident rooms before entering. Residents are being spoken to respectfully and without the use of cursive language.

3. The Social Services Director and Administrator are reeducating all staff by 5/31/13 on promoting dignity to our residents. This includes encouraging residents to make their



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F 241 . Continued From page 10

#10 continued to restrict the forward movement of the resident. RN #4 advised CNA #10 to allow Resident #11 to return to bed, and to get the resident up in thirty (30) minutes for Adult Day Care.

Interview, on 04/25/13 at 9:35 AM, with Resident #11 revealed he/she had experienced in the past, staff who held the back of his/her wheelchair to prevent him/her from returning to his/her room. Resident #11 stated he/she wanted to return to his/her room to lie down this morning when CNA #10 prevented him/her from returning to his/her room. Resident #11 said he/she didn't see any reason to complain about his/her being prevented from returning to his/her room because, it happened all of the time around there.

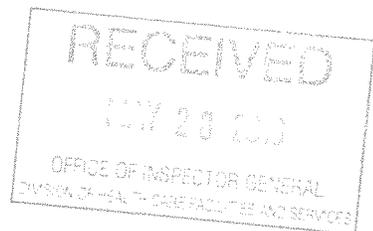
Interview, on 04/25/13 at 10:00 AM, with Resident #16 revealed he/she was concerned about his/her privacy. Resident #16 stated that he/she required staff assistance to the bathroom, and said staff did not close the bathroom door when he/she was assisted to the toilet. Resident #16 stated he/she felt he/she had no privacy in the facility because staff 'barged' into his/her room without knocking.

Interview, on 04/25/13 at 4:50 PM, with the Director of Nursing revealed that Resident #11 should have been allowed to lay down before Adult Day Care and said the failure of staff to recognize the resident's right to choose in his/her own daily activities identified the staff's lack of understanding of resident rights.

own choices, providing privacy while toileting,

F 241 answering call lights timely, knocking on doors and asking for permission to enter resident rooms before entering, speaking respectfully at all times to residents and without the use of cursive language. A post test is being given to ensure understanding.

4. The Social Services Director and Social Services Assistant will interview ten residents per month times six months to ensure care is being provided in a manner that maintains or enhances dignity. Department heads including the Administrator, Chaplain, Director of Nursing, Assistant Directors of Nursing, Quality of Life Director, and Staff Development Coordinator will complete two call light audits at random times weekly times 24 weeks to ensure timely response. Department heads including the Administrator, Chaplain, Director of Nursing, Assistant Directors of Nursing, Quality of Life Director, and Staff Development Coordinator will complete random staff observations on each hall weekly times four weeks, then monthly times five months to ensure staff are knocking on doors and asking for permission to enter rooms. The results of these audits will be forwarded to the Quality



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F 241 Continued From page 11

Assurance Committee for further review and  
F 241 recommendations.

5. June 7, 2013

Observation, on 04/24/13 at 8:07 AM, revealed Certified Nursing Assistant (CNA) #10 walked into Resident Room 2404 without knocking. A resident was present in the room.

Observation, on 04/24/13 at 8:24 AM, revealed Registered Nurse (RN) #1 walked into Room 2404 to give the resident medications without knocking on the door.

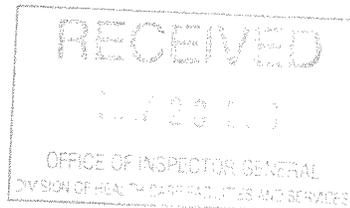
Observation, on 04/24/13 at 8:38 AM, revealed CNA #4 walked into Room 2304 without knocking.

Observation, on 04/24/13 at 8:45 AM, revealed CNA #10 walked into Room 2204 without knocking.

Observation, on 04/24/13 at 9:00 AM, revealed CNA #5 walked into Room 2303 without knocking.

Interview, on 04/25/13 at 9:25 AM, with CNA #4 revealed the purpose of knocking on the door to the resident's room was to let the resident know she was coming in. She stated she did not know the policy related to knocking on resident's doors. She stated she was not trained to knock on the doors and that she never knocked on a resident's door before entering their room.

Interview, on 04/25/13 at 9:30 AM, with CNA #5 revealed she knew the policy of the facility was to knock on a resident's door before entering their room. She stated the reason to knock was to let



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F 241 Continued From page 12 F 241

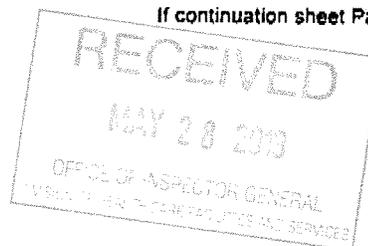
the resident know she needed to enter the room and to get permission to enter because this was the home of the resident. She revealed she had been trained to knock on the resident's door, but had forgotten to knock at times.

Interview during the Quality of Life Assessment Group Interview, on 04/23/13 at 2:00 PM, revealed Resident #1 and Unsampld Resident A and Unsampld Resident B (all members of the resident council) complained call lights were turned off by staff and not answered timely, staff would not knock on their bedroom doors before entering and sometimes the staff would curse which bothered them.

Observation of a second floor nursing unit hallway, on 04/23/13 at 1:50 PM, revealed CNA #13 calling out loudly while walking down the hallway and from approximately forty-two (42) feet to CNA #14, "Wait up, you're hauling ass".

Interview with four (4) residents in rooms in the vicinity of CNA #13's voice revealed none heard CNA #13's expletive.

Interview with CNA #13, on 04/23/13 at 2:45 PM, revealed she did not realize she had used the words "hauling ass" out loud, but she knew it was wrong of her to do so. She stated she had been



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F 241 Continued From page 13

trained by the facility to respect and dignify the residents in their home, but she had let it slip. She also stated she would sometimes 'curse' in front of a resident, but it would just slip. CNA #13 further stated she had not received any disciplinary actions by the facility for cursing in front of the residents.

F 241

Interview with CNA #14, on 04/23/13 at 2:55 PM, revealed she heard CNA #13 tell her she was "hauling ass" and she was aware it was wrong to do so. She stated she had been trained by the facility not to curse or use other expletives in front of the residents in their home, but sometimes she would slip up and curse. She also stated she had not received any disciplinary actions by the facility for cursing in front of the residents. CNA #13 stated she was aware she was to always knock on a resident's bedroom door before entering, but sometimes she forgot.

Interview with CNA #11, on 04/24/13 at 4:10 PM, revealed she was aware some of the staff would turn off residents' call lights and then forget to answer them. She stated she was trained to answer call lights timely, but she was so busy she would not always do so and the residents would have to call again for assistance. CNA #11 stated she was not aware she was to always knock on the resident's bedroom door before entering.

Interview with the Activity Director, on 04/24/13 at 1:00 PM, revealed she was the staff present in the resident council meetings and she was responsible for writing the meeting minutes and addressing resident concerns with Department Heads and the Administrator. She stated she was unaware there were complaints about call

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F 241 Continued From page 14  
lights not being answered timely, about staff not knocking on doors before entering or about staff cursing.

Interview, on 04/25/13 at 2:20 PM, with the Staff Development Coordinator (SDC) revealed the staff are trained that residents have a right to go into their room at any time. The SDC stated the staff were trained on all aspects of resident rights, strategies to maintain resident rights, and that residents should be allowed to make their own decisions. Staff were trained to understand that the facility was the resident's home and that staff should request permission to enter the resident room, by knocking prior to entry.

F 241

Interview with the Director of Nursing (DON,) on 04/24/13 at 4:45 PM, revealed CNA's were trained in orientation by the facility to treat all of the residents with dignity and respect which would include not cursing or using other expletives and answering call lights timely. She stated it was her responsibility to be aware of the residents' complaints.

F 332

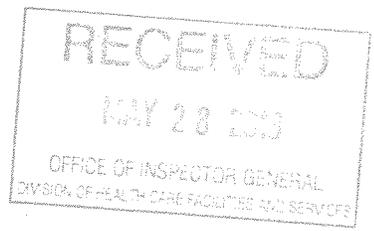
F 332 483.25(m)(1) FREE OF MEDICATION ERROR SS=D RATES OF 5% OR MORE

The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review, review of the facility's policy and PharMerica's 2013 Specialized Long-term Care Nursing Drug

1. Resident #7 was assessed on 4/24/13 by a Registered Nurse. The resident experienced no adverse effects. The MD was notified on 4/24/13 by the Director of Nursing. RN #1 was educated on 4/24/13 by the Staff Development Coordinator, on G-tube medication administration.
2. All other residents receiving medications through a PEG tube or Dobhoff tube were determined to be at risk. A review of these 11

4/27/13



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F 332 Continued From page 15

Handbook, it was determined the facility failed to ensure the medication pass was completed with an error rate of less than five (5) percent. There were five (5) medication errors out of forty-two (42) opportunities observed for a medication error rate of 11.9%

The findings include:

Review of the facility's policy regarding Medication Administration-Naso-Gastric Tubes, Gastrostomy and Jejunostomy Tubes, Effective 12/2010, revealed when administering medications through a gastrostomy tube (G-tube), liquid medications were to be administered first, followed by those medications that needed to be diluted.

Observation, on 04/24/13 during the 8:00 AM medication pass, revealed Registered Nurse (RN) #1 prepared and administered medications to Resident #7. RN #1 placed each crushed medication and the opened Nexium capsule in individual medication cups. One at a time she put the medications into the syringe attached to the gastrostomy tube. None of the medications had been diluted with water. After each crushed medication was put in the syringe, it was followed by water. The same occurred with the Nexium. The medications were noted to stick to the inside of the syringe. RN #1 moved the syringe back and forth to assist the medication in going down. When the medication administration was completed, there was a marked amount of medication stuck to the inside of the syringe.

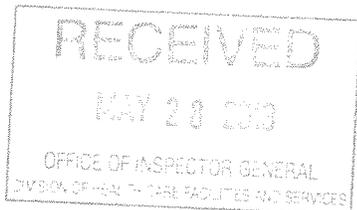
Review of the Medication Administration Record (MAR) dated April 2013 for Resident #7 revealed

charts was completed by 5/31/13 by the

F 332 Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager or Restorative Nurse Manager to ensure that the resident has not been experiencing any adverse affects for the last month. No adverse affects were identified.

The Director of Nursing and Assistant Directors of Nursing identified other residents receiving medication through enteral feeding devices. These residents are receiving medications per physician order and per policy for residents with G tubes.

- The Staff Development Coordinator had all licensed staff re-educated by 5/31/13 on administering medications through enteral feeding devices. The Staff Development Coordinator will complete a Medication Administration Competency with all licensed staff except for prn staff that have not worked in over one pay period by 6/06/13 to ensure proper technique.
- The Staff Development Coordinator, Director of Nursing, Assistant Director of Nursing, Unit Manager or Restorative Nurse Manager will complete a medication pass observation with one nurse per week times four weeks for



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F 332 Continued From page 16  
 Physician's Orders for the following medications to be given via the G-tube during the 8:00 AM medication pass: Lopressor 50 mg; Multivitamin Tablet One (1) tablet; Nexium 40 mg; Citrus Calcium with Vitamin D Tablet 200/250 mg, give two (2); and Tylenol 325 mg, two (2) tablets.

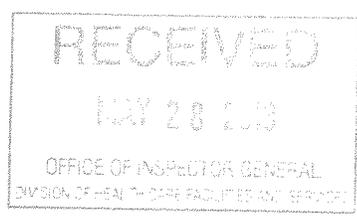
residents with G tubes, then two nurses per F 332 month times five months. The results of these observations will be forwarded to the Quality Assurance Committee for further review and recommendations.

5. June 7, 2013

Review of PharMerica's 2013 Specialized Long-term Care Nursing Drug Handbook revealed Nexium could be given by gastric tube. The instructions specified to open the capsule and place the intact granules into a 60 ml catheter-tip syringe and mix with 50 ml of water. The instructions then stated to replace the plunger and shake vigorously for 15 seconds. The medication was to be administered immediately after preparation and the tube flushed with additional water.

Interview, on 04/24/13 at 3:15 PM, with RN #1 revealed she was "flustered" and did not put water in with the medications which had been placed in the medication cups. She stated she usually puts the water in with the medications to dissolve the pills. She stated the facility policy was to give each medication separately and to dissolve the medication in water. However, she stated she did not do this five (5) times in a row during the medication administration for Resident #7.

Interview, on 04/25/13 at 9:15 AM, with Licensed Practical Nurse (LPN) #4 revealed to administer medications down a G-tube, they would be crushed first and then water added to dissolve the medication. He stated after the medication was administered, the tube would then be flushed with water. LPN #4 revealed if medication was not



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F 332 Continued From page 17  
diluted with the water, the tube could clog and the medication not go down resulting in the resident not receiving their medication.

F 332

Interview, on 04/24/13 at 9:50 AM, with the Signature Nurse Consultant revealed the standard nursing practice to administer medications down a G-tube was to dilute the medication in water before administration.

Interview, on 04/24/13 at 9:52 AM, with the Director of Nursing (DON) revealed staff who administered medications should be familiar with those medications. She revealed mixing water with G-tube medications was a standard practice. Continued interview revealed the medication pass was monitored by audits and competencies. She stated Staff Development did the check offs for the nurse competency on medication administration.

Interview, on 04/24/13 at 2:35 PM, with Staff Development revealed there was an In-service on 03/15/13 which covered medication administration through a G-tube and RN #1 had attended. However, the medication administration by RN #1 via G-tube that was observed during the med pass was inappropriate. Staff Development revealed the skills check list for the nurses did not include administering medications via G-tube. She revealed she did not know who monitored the medication administration because she was new to her position.

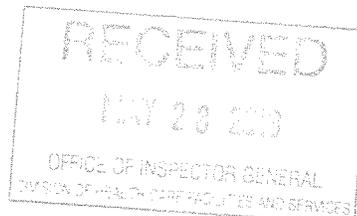
F 368

F 368 483.35(f) FREQUENCY OF MEALS/SNACKS AT SS=F: BEDTIME

F 368 On 4-23-13 dietary staff and nursing staff present were educated by the Director of

*4/27/13*

Each resident receives and the facility provides at



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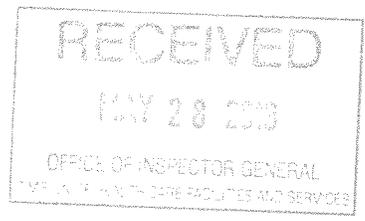
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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<p>F 368</p>	<p>Continued From page 18</p> <p>least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to offer all residents on four (4) of four (4) nursing units (who did not receive labeled house supplements) with snacks at bedtime daily.</p> <p>The findings include: Review of the facility's policy regarding Nourishments, dated 12-2010, revealed all residents received nourishments and snacks. House supplements/snacks would be offered to residents at 10:00 AM, 2:00 PM, and HS (bedtime).</p> <p>Interview with Resident #1, Unsampled Resident C and Unsampled Resident D during the Quality of Life Assessment Group Interview, on 04/23/13</p>	<p>F 368</p>	<p>Nursing, Dietary Manager, Assistant Director of</p> <p>Nursing, Restorative Nurse Manager and/or Staff Development Coordinator on offering HS snacks to all residents. On 4-23-13 resident#1 and un-sampled residents C and D were offered an HS snack at bedtime by the nursing department.</p> <p>2. On 4/23/13 dietary staff and nursing staff present were educated by the Director of Nursing, Dietary Manager, Assistant Director of Nursing and/or Staff Development Coordinator on offering HS snacks to all residents. On 4-23-13 HS snacks were offered to all residents by the nursing department.</p> <p>3. The Staff Development Coordinator, Director of Nursing, Dietary Manager, Assistant Director of Nursing and/or Restorative Nurse Manager completed education by 5/31/13 to all nursing staff and dietary staff on offering snacks to residents in the evening when the dietary staff deliver a nourishment cart to each. The Dietary Manager re-educated all dietary staff on 5/31/13 on providing nourishment carts, with a variety of snacks, to each nurses station every evening at 8pm. Effective 5/31/13, the nourishment cart will be offered 3 times a day to all residents. All residents with a physicians</p>	
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F 368 Continued From page 19  
 at 2:00 PM, revealed they did not get snacks in the afternoon or at bedtime at this facility.

Observation of the two (2) nursing units on the first floor of the facility at 3:00 PM and 3:10 PM respectively on 04/24/13 revealed labeled dietary house supplements (snacks) were delivered to those identified residents by Certified Nursing Assistant (CNA) #11. Observation of the two (2) nursing units on the second floor of the facility at 3:35 PM on 04/24/13 revealed CNA #12 delivered the snacks to those resident's with labeled snacks.

Interview with CNA #11, at 4:30 PM on 04/24/13, revealed she passed the 3:00 PM labeled snacks to those residents identified and she did not offer a snack at that time or at bedtime to any of the residents who did not have a labeled snack. She stated she had an orientation at the facility, but she did not remember having been told to pass snacks to all of the residents at 3:00 PM or at bedtime.

Interview with CNA #12, at 4:40 PM on 04/24/13, revealed she passed the 3:00 PM labeled snacks to those residents identified and she did not offer a snack at that time or at bedtime to any of the residents who did not have a labeled snack. She also stated she had an orientation at the facility, but she did not remember having been told to pass snacks to all of the residents at 3:00 PM or at bedtime.

Interview with Licensed Practical Nurse (LPN) #5, on 04/24/13 at 5:00 PM, revealed the labeled snacks were usually delivered to the nursing station at 3:00 PM each day and it was the CNAs'

order for a fortified snack will continue come out on the nourishment cart individually labeled.

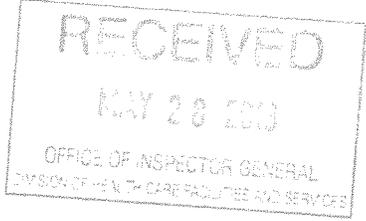
4. The Dietary Manager will audit the nourishment cart five days a week times eight weeks, then weekly times 24 weeks to ensure that a variety of snacks are offered to all residents.

The Director of Nursing, Assistant Director of Nursing, Administrator, Staff Development Coordinator, Restorative Nurse Manager or Manager on Duty will audit the snack pass once daily, Monday through Friday for 4 weeks and then monthly for 6 months to ensure snacks are being offered to all residents.

The Social Services Director, Chaplain, Administrator, Dietary Manager or Director of Nursing will interview 10 residents per month for 6 months to ensure snacks are being offered and accommodate their wants and needs.

The results of these audits will be forwarded to the Quality Assurance Committee for further review and recommendations.

5. June 7, 2013



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F 368 Continued From page 20  
responsibility to deliver those snacks to the residents. She stated the residents without labeled snacks were not offered snacks to her knowledge and the CNAs did not document regarding snacks delivered to any of the residents.

F 368

Interview with the first floor Assistant Director of Nursing (ADON), on 04/24/13 at 5:15 PM, revealed it was her understanding the CNA's should offer all of the residents a bedtime snack and they should have been trained by the facility to do so. She stated she was unaware all of the residents did not receive a bedtime snack.

Interview with the Director of Nursing, on 04/24/13 at 5:30 PM, revealed all of the residents in the facility should be offered snacks by the CNA's and they were trained in orientation to do so per the facility policy. She stated she was unaware the residents were not offered snacks but it was her responsibility to monitor all of the residents' care.

F 441

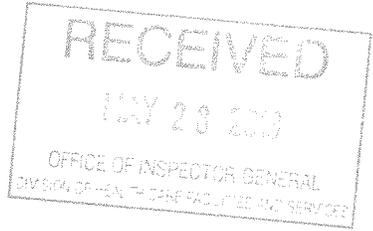
F 441 483.65 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS

1. On 4/23/13 a sign was placed on resident #9's door to alert the residents that this resident is on droplet precautions. The gowns and mask on top of the cart were discarded on 4/23/13 by the Director of Nursing and a new supply was placed in the residents' infection control cart outside of the residents' room.

Residents #9 and #10 and un-sampled residents #A, B, C, D, E, F, G and H had a nursing assessment completed by 5/28/13 and are exhibiting no signs or symptoms of infection.

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

- (a) Infection Control Program  
The facility must establish an Infection Control Program under which it -
- (1) Investigates, controls, and prevents infections in the facility;
  - (2) Decides what procedures, such as isolation,



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F 441 Continued From page 21  
should be applied to an individual resident; and  
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

- (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
- (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
- (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

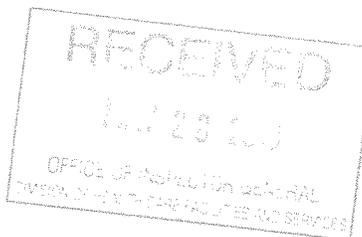
This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to maintain an Infection Control Program to provide a safe and sanitary environment for two (2) of twenty-four (24) sampled residents (Residents #9 and 10) and eight (8) of eight (8) unsampled residents, (Unsampled Residents A, B, C, D, E, F, G and H). Housekeeper's did not follow isolation precautions when cleaning these resident's rooms.

Housekeepers # 3 and #4 were re-educated on F 4414-25-13 on infection control policies and procedures regarding isolation and personal protective equipment by the staff development coordinator.

- 2. All residents have the potential to be affected. Housekeepers working in isolation rooms will be observed the week of 5/20/13, by the Housekeeping Director, Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator for following infection control policies while caring for residents on cleaning resident rooms. Any issued identified will be addressed immediately and the Administrator will be notified.
- 3. The Staff Development Coordinator and Environmental Services Director re-educated all housekeeping staff on 5/14/13 and 5/17/13 on following infection control policies when cleaning the rooms of any residents with any isolation precautions. A post test was given to ensure understanding.

The Housekeeping Director was re-educated on 5/14/13 by the Staff Development Coordinator on infection control policies and procedures including isolation policy and procedures and personal protective equipment.



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F 441 : Continued From page 22

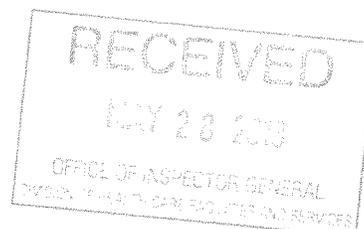
The findings include:

Review of the facility's Infection Control Policy titled Isolation- Categories of Transmission-Based Precautions, revised August 2012, section Gloves and Handwashing revealed that in addition to wearing gloves as outlined under Standard precautions, the staff was to wear gloves when entering the room; while caring for a resident, the staff was to change gloves after having contact with infective material (for example, fecal material and wound drainage); the staff was to remove gloves before leaving the room and perform hand hygiene; and after removing gloves and washing hands, the staff was to not touch potentially contaminated environmental surfaces or items in the resident's room. Section Signs revealed the facility would implement a system to alert staff to the type of precaution residents required. The facility would post the appropriate notice on the room entrance door and on the front of the resident's chart so all personnel would be aware of the precautions, or be aware that they must first see a nurse to obtain additional information about the situation before entering the room.

1. Observation during tour of the facility, on 04/23/13 at 9:30 AM, revealed Resident #9's door to be open with an isolation cart with gowns, gloves, and masks lying on top of the cart. Interview with the Medical Records Director, touring with the surveyor, revealed the resident was in Droplet Isolation, due to a Methicillin Resistant Staphylococcus Aureus (MRSA) infection in the sputum. Additional observations, at 11:05 AM, 1:05 PM, and 2:30 PM, revealed no evidence of signage on the door alerting staff or

4. The Environmental Services Director will complete audits once a week times four weeks, then twice monthly times five months to ensure appropriate infection control procedures are being followed. The results of these audits will be forwarded to the Quality Assurance Committee for further review and recommendations.

5. June 7, 2013



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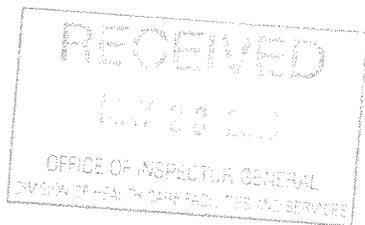
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visitors to the resident's infection. F 441

Review of Resident #9's clinical record revealed an admission date of 04/10/13, with diagnoses of Chronic Airway Obstruction with Acute Respiratory Failure, Methicillin Resistant Staphylococcus Aureus (MRSA) in Sputum, and Pneumonia. The resident was placed on respiratory isolation (droplet) precautions and was in a private room.

However, observation of Housekeeper #3, on 04/25/13 at 1:30 PM, revealed a clean gown was draped over the dirty housekeeping cart outside the resident's room, the housekeeper tied the neck and slipped it over their head and enter the room. Gloves and mask were observed to be worn; however, the housekeeper picked up the trash in the resident's room, and came outside the room, wearing the same gloves, mask, and gown. Housekeeper #3 did not wash her hands. Observation revealed the housekeeper to push the garbage down with her gloved hands, deep into the housekeeping cart trash to make more room for the trash. The housekeeper was also observed to attach a small bag of soiled towels to the side of the linen cart. The Housekeeper went back into the room and proceeded to clean the overbed table, while picking up two drinking glasses and a water pitcher, and moved them to the other side of the overbed table, wearing the same dirty gloves. The housekeeper picked up the resident's urinal and carried it to the bathroom to empty, then returned the urinal to the bedside table. At this time, the housekeeper was observed to use sani-wipes to clean the resident's sink, and walk to the resident's overbed table. Housekeeper #3 picked up the resident's drinking



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F 441 Continued From page 24

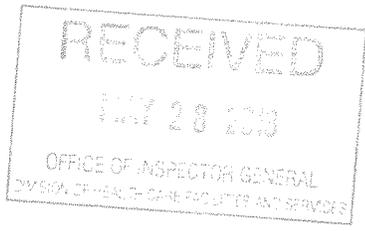
F 441

glass again, and moved it to the other side of the overbed table without washing her hands or changing her gloves.

Interview with Housekeeper #3, on 04/25/13 at 2:30 PM, revealed she should have removed her gown and changed her gloves before coming out of the room, and should have washed her hands before going back into the room. Housekeeper #3 stated she had received training on infection control and how to properly clean the rooms; however, admitted she did not complete the cleaning procedure correctly. The Housekeeper could not give a reason why.

Interview with the Housekeeping Manager, on 04/25/13 at 10:00 AM, revealed airborne precautions are taught on hire, and how far it can be contagious across the room. The Housekeeping Manager stated she knew staff should always put on gown, glove, and mask when going into a room to prevent the spread of infection.

Interview with the Staff Development Coordinator (SDC), on 04/25/13 at 2:30 PM, revealed all newly hired staff gets OSHA training regarding blood borne pathogens, infection control, and standard precautions. The SDC also stated all housekeepers were inserviced yesterday on cleaning procedures for airborne infections. The SDC stated the housekeeper should not have pushed the trash into the outside garbage, and should have removed her gloves and washed her hands before coming out of the room. The SDC stated the housekeeper should also have changed her gloves and washed her hands before handling the resident's drinking glass.



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F 441 Continued From page 25

F 441

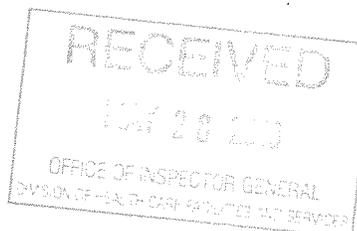
Interview with the Director of Nursing, on 04/25/13 at 2:30 PM, revealed staff should always change gloves and wash hands after transporting anything outside the room. The DON stated she did not like gloves in the hallway.

Interview the Administrator, on 04/25/13 at 3:30 PM, revealed housekeepers are to be trained on the proper procedure for cleaning with droplet precautions. The administrator stated she ensures training is being completed by monitoring staff development by sitting in on some of the trainings, as well as receiving a checklist after each new hire to ensure that all training has been completed.

Review of Housekeeper #3's training record revealed she had received training from the SDC, on 04/24/13, one day prior to the surveyor observations made with Resident #9, on 04/25/13.

2. Review of the clinical record for Resident #10 revealed the facility admitted the resident on 03/19/13 with diagnosis of Tachycardia, Chronic Ischemic Heart Disease, Chronic Kidney Disease, Hypertension, and Bladder Infection. Resident #10 was diagnosed with Clostridium Difficile (C-Diff) on 04/20/13. Review of Resident #10's admission assessment dated 03/28/13, revealed the facility assessed Resident #10 as a level 2 for bowel, which meant frequently incontinent.

Observation of Resident #10's room, on 04/23/13



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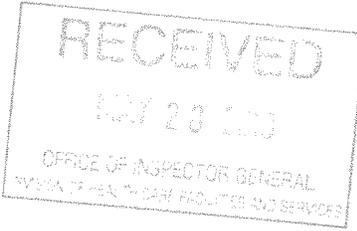
F 441 Continued From page 26 F 441

8:30 AM, revealed Personal Protective Equipment (PPE) on Residents #10's door and a sign that stated for staff and visitors to see the nurse.

Observation of Housekeeper #4, on 04/23/13 8:30 AM, revealed Housekeeper #4 was wearing only gloves while cleaning the bathroom, mopping Resident #10's floors and throwing out Resident #10's trash. Continued observation of Housekeeper #4, on 04/24/13 10:00 AM, revealed Housekeeper #4, was wearing only gloves while cleaning the bathroom, mopping the floor and emptying the garbage.

Review of the training, in which Housekeeper #4 received, on Standard Precautions for Contact Transmission, revealed touching certain germs could cause the spread of disease and sometimes touching an infected person or having direct contact with the germ. Sometimes touching an object that has been handled by an infected person or having indirect contact with the infection.

Interview with Housekeeper #4, on 04/24/13 10:00 AM, revealed when she cleaned a room, she emptied the garbage can, dusted the bedside table and shelves, and cleaned the toilets and sinks. Housekeeper #4 stated she did not place a gown on when she cleaned Resident #10's sink and toilet. Housekeeper #4 stated she did not know what type of isolation Resident #10 was in and that she should have asked the nurse what type of precautions Resident #10 was in.



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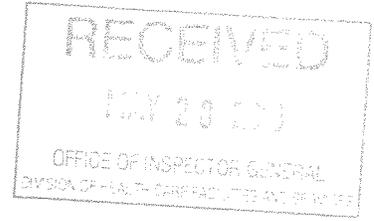
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F 441 Continued From page 27  
Housekeeper #4 stated she did not know what C-Diff was. She thought if she did not come in contact with the resident, she would not need a gown. Further interview with Housekeeper #4 revealed she was not trained on Contact Precautions.

F 441

Interview with the Housekeeping Manager, on 04/24/13 10:19 AM, revealed the housekeeping staff needed to read the sign on the residents door and then put on what was on the residents door. The Housekeeping Manager stated that she taught on air borne precautions and how far to go across the room. The Housekeeper stated she taught her staff about Vancomycin Resistant Enterococcus (VRE) and Methicillin Resistant Staph Aureus (MRSA). The Housekeeping Manager stated she did not know about C-Diff, but she knew it was in the feces. Staff know to gown up when a resident has C-Diff. The Housekeeping Manager stated the housekeeping staff clean the sinks, showers, shower chairs, potty chairs, wheelchairs and toilets. She stated she talks to her staff about how highly contagious VRE, MRSA and C-Diff were. The Housekeeping Manager further stated they put gowns on to prevent the spread of germs to others or themselves.

Interview with Staff Development, on 04/24/13 11:16 AM, revealed she trained the housekeeping staff about blood borne pathogens, standard precautions, HIV and hepatitis. They talked about what precautions to take. The Staff Development Coordinator stated they educated the staff to ask the nurse about what precautions the resident



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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  04/25/2013
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NAME OF PROVIDER OR SUPPLIER  SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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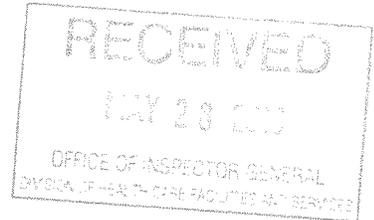
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F 441 Continued From page 28

may be on. They teach about air borne, blood borne, contact transmission and droplet precautions. The Staff Development Coordinator stated they do not teach the housekeeping staff if they do not come in contact with the resident they do not need to wear PPE. If the staff do not wear PPE they can become infected with the organism and infect others. The Staff Development Coordinator stated that when a staff member was oriented to the facility they were to complete an exam on Standard Precautions.

Record review revealed Housekeeper #4 did not take an exam on Standard Precautions.

F 441



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K 000 INITIAL COMMENTS

K 000

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 2009

SURVEY UNDER: 2000 New

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: Two (2) stories, Type II (000)

SMOKE COMPARTMENTS: Six (6) smoke compartments.

FIRE ALARM: Complete fire alarm system with heat and smoke detectors.

SPRINKLER SYSTEM: Complete automatic, wet sprinkler system.

GENERATOR: Type II generator, fuel source is diesel.

A standard Life Safety Code survey was conducted on 04/23/13. Sunrise Manor was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one hundred thirty seven (137) beds with a census of one hundred twenty five (125) on the day of the survey.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from

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

TITLE

(X6) DATE

*[Signature]* X NHA X 5/17/13

iciency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 participation.

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K 000 Continued From page 1  
Fire)

K 000  
K 29

K 029  
SS=D

Deficiencies were cited with the highest deficiency identified at "F" level.

NFPA 101 LIFE SAFETY CODE STANDARD

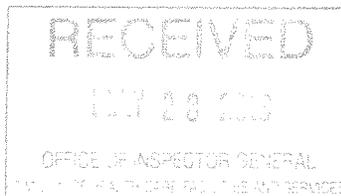
Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for one hundred thirty seven (137) beds with a census of one hundred twenty five (125) on the day of the survey. The facility failed to maintain the integrity of a separation wall between two identified hazardous areas.

The findings include:

Observation, on 04/23/13 between 10:30 AM and 3:00 PM, with the Director of Maintenance revealed the hazard room protecting the fuel fired natural gas water heaters had louvered vents in the wall to another hazardous storage room which paint and other maintenance items were being stored.

1. Paint is not being stored in the water heater room or outer room surrounding the water heater. Hazardous areas are protected in accordance with 8.4. The facility is maintaining the integrity of a separation wall between two identified hazardous areas. *6/07/13*
2. Paint and other family materials are being stored in appropriate locations per Life Safety Code. Hazardous areas are protected in accordance with 8.4. The facility is maintaining the integrity of a separation wall between two identified hazardous areas.
3. The Administrator reeducated facility plant operations staff on 5/21/13 on appropriate storage of paint and other flammable materials and maintaining the integrity of separation walls between two identified hazardous areas.
4. The Administrator or Regional Plant Operations Director will complete monthly audits times six months to ensure paint and other flammable materials are not being stored in the hot water heater areas. The results of these audits will be forwarded to the Quality Assurance Committee for further review and recommendations.



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K 029 Continued From page 2

5. June 7, 2013

K 029

Interview, on 04/23/13 between 10:30 AM and 3:00 PM, with the Director of Maintenance revealed he was not aware the hazardous room for fuel fired natural gas water heaters could not be open to another hazard room with combustible storage.

Reference:

NFPA 101 (2000 Edition).

18.3.2 Protection from Hazards.

18.3.2.1\* Hazardous Areas.

Any hazardous area shall be protected in accordance with Section 8.4. The areas described in Table 18.3.2.1 shall be protected as indicated.

Table 18.3.2.1 Hazardous Area Protection

Hazardous Area Description

Separation/Protection

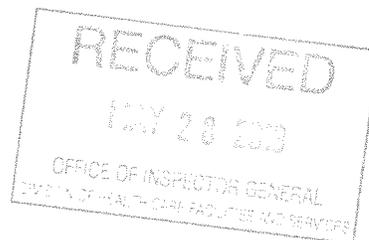
Boiler and fuel-fired heater rooms 1 hour  
Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>) 1 hour

Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard See 18.3.6.3.4

Laboratories that use hazardous materials that would be classified as a severe hazard in accordance with NFPA 99, Standard for Health Care Facilities 1 hour

Paint shops employing hazardous substances and materials in quantities less than those that would be classified as a severe hazard 1 hour

Physical plant maintenance shops 1 hour



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K 029 Continued From page 3  
Soiled linen rooms 1 hour  
Storage rooms larger than 50 ft2 (4.6 m2) but not exceeding 100 ft2 (9.3 m2) storing combustible material See 18.3.6.3.4  
Storage rooms larger than 100 ft2 (9.3 m2) storing combustible material 1 hour  
Trash collection rooms 1 hour

K 029

K 045 SS=D NFPA 101 LIFE SAFETY CODE STANDARD  
Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 18.2.8

K 45

1. Additional lighting has been installed at stairwells C and D to provide the required illumination outside an exit for discharge.

6/17/13

Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness.

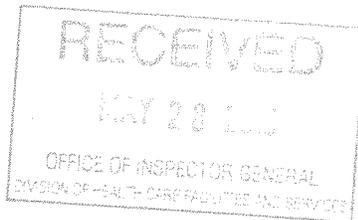
2. Lighting is appropriate at all stairwells to provide the required illumination outside an exit for discharge. Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness.

3. The Administrator has reeducated the facility plant operations staff on 5/21/13 on utilizing appropriate lighting in stairwell areas to ensure the illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness.

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for one hundred thirty seven (137) beds with a census of one hundred twenty five (125) on the day of the survey. The facility failed to provide required illumination outside an exit for discharge.

The findings include:

Observation, on 04/23/13 between 10:30 AM and 3:00 PM, with the Director of Maintenance revealed the exits located in stairwell C, and D did not have a light installed outside to provide the required illumination for exit discharge. The exits



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K 045 Continued From page 4  
were equipped with a light fixture with only one bulb installed.

Interview, on 04/23/13 between 10:30 AM and 3:00 PM, with the Director of Maintenance revealed he was not aware the exits did not have the required illumination for egress lighting.

Reference NFPA 101 (2000 edition)

18.2.7 Discharge from Exits.

Discharge from exits shall be arranged in accordance with Section 7.7.

18.2.8 Illumination of Means of Egress.

Means of egress shall be illuminated in accordance with Section 7.8.

7.7 DISCHARGE FROM EXITS

7.7.1\*

Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.

Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2.

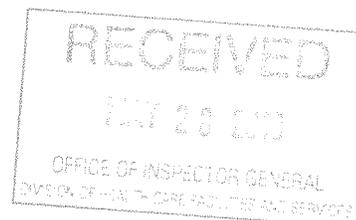
Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6.

Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.

7.7.2

4. The Plant Operations Director will audit the lighting in the facility stairwells monthly times six months to ensure emergency lighting is in accordance with section 7.8 and functional. The results of these audits will be forwarded to the Quality Assurance Committee for further review and recommendations.

5. June 7, 2013



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K 045 Continued From page 5

K 045:

Not more than 50 percent of the required number of exits, and not more than 50 percent of the required egress capacity, shall be permitted to discharge through areas on the level of exit discharge, provided that the criteria of 7.7.2(1) through (3) are met:

(1) Such discharge shall lead to a free and unobstructed way to the exterior of the building, and such way is readily visible and identifiable from the point of discharge from the exit.

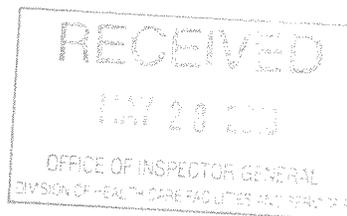
(2) The level of discharge shall be protected throughout by an approved, automatic sprinkler system in accordance with Section 9.7, or the portion of the level of discharge used for this purpose shall be protected by an approved, automatic sprinkler system in accordance with Section 9.7 and shall be separated from the nonsprinklered portion of the floor by a fire resistance rating meeting the requirements for the enclosure of exits (see 7.1.3.2.1).  
Exception: The requirement of 7.7.2(2) shall not apply where the discharge area is a vestibule or foyer meeting all of the following:

(a) The depth from the exterior of the building shall not be more than 10 ft (3 m) and the length shall not be more than 30 ft (9.1 m).

(b) The foyer shall be separated from the remainder of the level of discharge by construction providing protection not less than the equivalent of wired glass in steel frames.

(c) The foyer shall serve only as means of egress and shall include an exit directly to the outside.

(3) The entire area on the level of discharge shall be separated from areas below by construction having a fire resistance rating not less than that required for the exit enclosure.  
Exception No. 1: Levels below the level of



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K 045

discharge shall be permitted to be open to the level of discharge in an atrium in accordance with 8.2.5.6.

Exception No. 2: One hundred percent of the exits shall be permitted to discharge through areas on the level of exit discharge as provided in Chapters 22 and 23.

Exception No. 3: In existing buildings, the 50 percent limit on egress capacity shall not apply if the 50 percent limit on the required number of exits is met.

7.7.3

The exit discharge shall be arranged and marked to make clear the direction of egress to a public way. Stairs shall be arranged so as to make clear the direction of egress to a public way. Stairs that continue more than one-half story beyond the level of exit discharge shall be interrupted at the level of exit discharge by partitions, doors, or other effective means.

7.7.4

Doors, stairs, ramps, corridors, exit passageways, bridges, balconies, escalators, moving walks, and other components of an exit discharge shall comply with the detailed requirements of this chapter for such components.

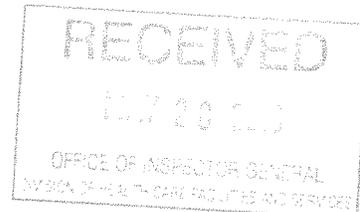
7.7.5 Signs.

(See 7.2.2.5.4 and 7.2.2.5.5.)

7.7.6

Where approved by the authority having jurisdiction, exits shall be permitted to discharge to roofs or other sections of the building or an adjoining building where the following criteria are met:

(1) The roof construction has a fire resistance rating not less than that required for the exit enclosure.



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(2) There is a continuous and safe means of egress from the roof.

K 045

7.8 ILLUMINATION OF MEANS OF EGRESS

7.8.1 General.

7.8.1.1\*

Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way.

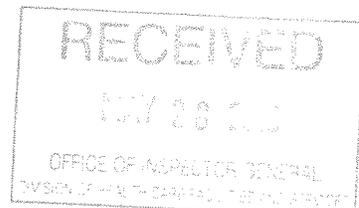
7.8.1.2

Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified.

Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units.

7.8.1.3\*

The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10



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lux) measured at the floor.

Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light.

Exception No. 2\*: This requirement shall not apply where operations or processes require low lighting levels.

7.8.1.4\*

Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.

K 047 NFPA 101 LIFE SAFETY CODE STANDARD

SS=E

Exit and directional signs are displayed with continuous illumination also served by the emergency lighting system in accordance with section 7.10. 18.2.10.1.

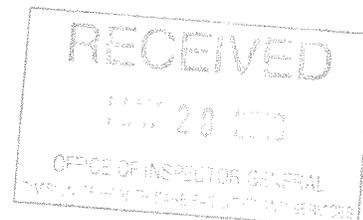
This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for one hundred thirty seven (137) beds with a census of one hundred twenty five (125) on the day of the survey. The facility failed to ensure exits in stairwells were clearly recognizable with proper exit signage.

The findings include:

K 045

K 47

1. Stairwells A & B have exit signs leading people to the outside and indicating which floor they are on. Exit and directional signs are displayed with continuous illumination also served by the emergency lighting system. *6/10/13*
2. All stairwells have appropriate signage to indicate which floor they are on and which way to the outside exit. Exit and directional signs are displayed with continuous illumination also served by the emergency lighting system.
3. The Administrator reeducated facility plant operations staff on 5/21/13 on utilizing appropriate signage for exits and that exit and directional signs are displayed with continuous illumination also served by the emergency lighting system.
4. The Plant Operations Director will audit the stairwells monthly times six months to ensure



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K 047 Continued From page 9  
 Observation, on 04/23/13 between 10:30 AM and 3:00 PM, with the Director of Maintenance revealed the interior of stairwells A, and B did not have an exit sign making the path of egress clearly recognizable.

signage is available and visible. The results of these audits will be forwarded to the Quality Assurance Committee for further review and recommendations.

5. June 7, 2013

Interview, on 04/23/13 between 11:00 AM and 3:00 PM, with the Director of Maintenance revealed he was not aware the interior of the stairwells did not have proper exit signage.

Reference: NFPA 101 (2000 edition)

18.2 MEANS OF EGRESS REQUIREMENTS  
 18.2.1 General.

Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7.

Exception: As modified by 18.2.2 through 18.2.11.

18.2.10 Marking of Means of Egress.  
 18.2.10.1

Means of egress shall have signs in accordance with Section 7.10.

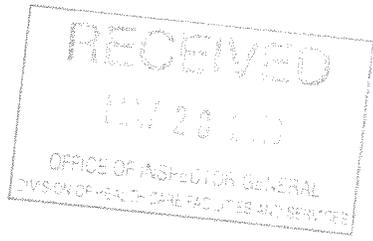
7.10 MARKING OF MEANS OF EGRESS  
 7.10.1 General.

7.10.1.1 Where Required.

Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 42.

7.10.1.2\* Exits.

Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits,



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NAME OF PROVIDER OR SUPPLIER  SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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K 047 Continued From page 10

shall be marked by an approved sign readily visible from any direction of exit access.

7.10.1.3 Exit Stair Door Tactile Signage.  
Tactile signage shall be located at each door into an exit stair enclosure, and such signage shall read as follows:  
EXIT

Signage shall comply with CABO/ANSI A117.1, American National Standard for Accessible and Usable Buildings and Facilities, and shall be installed adjacent to the latch side of the door 60 in. (152 cm) above the finished floor to the centerline of the sign.

Exception: This requirement shall not apply to existing buildings, provided that the occupancy classification does not change.

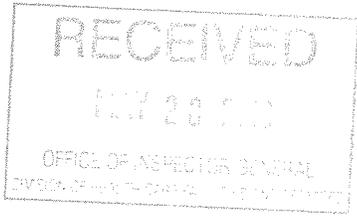
7.10.1.4\* Exit Access.  
Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs.

Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.

7.10.1.5\* Floor Proximity Exit Signs.  
Where floor proximity exit signs are required in Chapters 11 through 42, signs shall be placed near the floor level in addition to those signs required for doors or corridors. These signs shall be illuminated in accordance with 7.10.5.

Externally illuminated signs shall be sized in accordance with 7.10.6.1. The bottom of the sign shall be not less than 6 in. (15.2 cm) but not more than 8 in. (20.3 cm) above the floor. For exit

K 047



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K 047 Continued From page 11

K 047

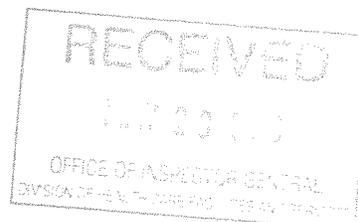
doors, the sign shall be mounted on the door or adjacent to the door with the nearest edge of the sign within 4 in. (10.2 cm) of the door frame.

7.10.1.6\* Floor Proximity Egress Path Marking.  
Where floor proximity egress path marking is required in Chapters 11 through 42, a listed and approved floor proximity egress path marking system that is internally illuminated shall be installed within 8 in. (20.3 cm) of the floor. The system shall provide a visible delineation of the path of travel along the designated exit access and shall be essentially continuous, except as interrupted by doorways, hallways, corridors, or other such architectural features. The system shall operate continuously or at any time the building fire alarm system is activated. The activation, duration, and continuity of operation of the system shall be in accordance with 7.9.2.

7.10.1.7\* Visibility.  
Every sign required in Section 7.10 shall be located and of such size, distinctive color, and design that it is readily visible and shall provide contrast with decorations, interior finish, or other signs. No decorations, furnishings, or equipment that impairs visibility of a sign shall be permitted. No brightly illuminated sign (for other than exit purposes), display, or object in or near the line of vision of the required exit sign that could detract attention from the exit sign shall be permitted.

7.10.2\* Directional Signs.  
A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent.

7.10.3\* Sign Legend.  
Signs required by 7.10.1 and 7.10.2 shall have the word EXIT or other appropriate wording in plainly legible letters.



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K 047 Continued From page 12

K 047

7.10.4\* Power Source.

Where emergency lighting facilities are required by the applicable provisions of Chapters 11 through 42 for individual occupancies, the signs, other than approved self-luminous signs, shall be illuminated by the emergency lighting facilities. The level of illumination of the signs shall be in accordance with 7.10.6.3 or 7.10.7 for the required emergency lighting duration as specified in 7.9.2.1. However, the level of illumination shall be permitted to decline to 60 percent at the end of the emergency lighting duration.

7.10.5 Illumination of Signs.

7.10.5.1\* General.

Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode.

7.10.5.2\* Continuous Illumination.

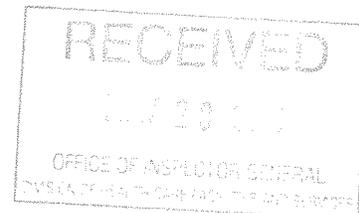
Every sign required to be illuminated by 7.10.6.3 and 7.10.7 shall be continuously illuminated as required under the provisions of Section 7.8.

Exception\*: Illumination for signs shall be permitted to flash on and off upon activation of the fire alarm system.

7.10.6 Externally Illuminated Signs.

7.10.6.1\* Size of Signs.

Externally illuminated signs required by 7.10.1 and 7.10.2, other than approved existing signs, shall have the word EXIT or other appropriate wording in plainly legible letters not less than 6 in. (15.2 cm) high with the principal strokes of letters not less than 3/4 in. (1.9 cm) wide. The word EXIT shall have letters of a width not less than 2 in. (5 cm), except the letter I, and the minimum spacing between letters shall be not less than 3/8



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K 047 Continued From page 13

K 047

in. (1 cm). Signs larger than the minimum established in this paragraph shall have letter widths, strokes, and spacing in proportion to their height.

Exception No. 1: This requirement shall not apply to existing signs having the required wording in plainly legible letters not less than 4 in. (10.2 cm) high.

Exception No. 2: This requirement shall not apply to marking required by 7.10.1.3 and 7.10.1.5.  
7.10.6.2\* Size and Location of Directional Indicator.

The directional indicator shall be located outside of the EXIT legend, not less than 3/8 in. (1 cm) from any letter. The directional indicator shall be of a chevron type, as shown in Figure 7.10.6.2. The directional indicator shall be identifiable as a directional indicator at a distance of 40 ft (12.2 m). A directional indicator larger than the minimum established in this paragraph shall be proportionately increased in height, width and stroke. The directional indicator shall be located at the end of the sign for the direction indicated.

Exception: This requirement shall not apply to approved existing signs.

Figure 7.10.6.2 Chevron-type indicator.

7.10.6.3\* Level of Illumination.

Externally illuminated signs shall be illuminated by not less than 5 ft-candles (54 lux) at the illuminated surface and shall have a contrast ratio of not less than 0.5.

7.10.7 Internally Illuminated Signs.

7.10.7.1 Listing.

Internally illuminated signs, other than approved existing signs, or existing signs having the required wording in legible letters not less than 4 in. (10.2 cm) high, shall be listed in accordance



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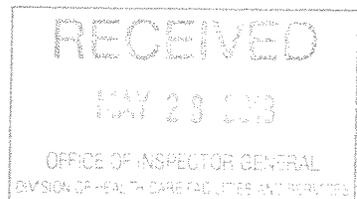
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K 047 Continued From page 14 K 047

with UL 924, Standard for Safety Emergency Lighting and Power Equipment.  
Exception: This requirement shall not apply to signs that are in accordance with 7.10.1.3 and 7.10.1.5.  
7.10.7.2\* Photoluminescent Signs.  
The face of a photoluminescent sign shall be continually illuminated while the building is occupied. The illumination levels on the face of the photoluminescent sign shall be in accordance with its listing. The charging illumination shall be a reliable light source as determined by the authority having jurisdiction. The charging light source shall be of a type specified in the product markings.  
7.10.8 Special Signs.  
7.10.8.1\* No Exit.  
Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows:  
NO  
EXIT  
Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.  
Exception: This requirement shall not apply to approved existing signs.  
7.10.8.2 Elevator Signs.  
Elevators that are a part of a means of egress (see 7.2.13.1) shall have the following signs, with minimum letter height of 5/8 in. (1.6 cm), in every elevator lobby:  
(1) \* Signs that indicate that the elevator can be used for egress, including any restrictions on use  
(2) \* Signs that indicate the operational status of



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**K 047** Continued From page 15  
elevators  
7.10.9 Testing and Maintenance.  
7.10.9.1 Inspection.  
Exit signs shall be visually inspected for operation  
of the illumination sources at intervals not to  
exceed 30 days.  
7.10.9.2 Testing.  
Exit signs connected to or provided with a  
battery-operated emergency illumination source,  
where required in 7.10.4, shall be tested and  
maintained in accordance with 7.9.3.

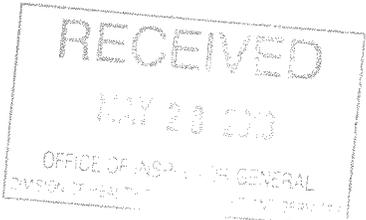
**K 047**

**K 050** NFPA 101 LIFE SAFETY CODE STANDARD  
SS=F  
Fire drills are held at unexpected times under  
varying conditions, at least quarterly on each shift.  
The staff is familiar with procedures and is aware  
that drills are part of established routine.  
Responsibility for planning and conducting drills is  
assigned only to competent persons who are  
qualified to exercise leadership. Where drills are  
conducted between 9 PM and 6 AM a coded  
announcement may be used instead of audible  
alarms. 18.7.1.2

**K 50**

- K 050** Fire drills are being completed quarterly on  
each shift. Fire drills are held at unexpected  
times under varying conditions, at least  
quarterly on each shift. *6/10/13*
2. Fire drills are being completed quarterly on  
each shift. Fire drills are held at unexpected  
times under varying conditions, at least  
quarterly on each shift.
  3. The Administrator reeducated facility plant  
operations staff on 5/21/13 completion of fire  
drills and that they are held at unexpected  
times under varying conditions, at least  
quarterly on each shift.
  4. The Administrator will audit fire drill  
documentation monthly times six months to  
ensure drills were completed at unexpected  
times under varying conditions, at least  
quarterly on each shift.

This STANDARD is not met as evidenced by:  
Based on interview and fire drill record review, it  
was determined the facility failed to ensure fire  
drills were conducted quarterly on each shift at  
unexpected times, in accordance with NFPA  
standards. The deficiency had the potential to  
affect six (6) of six (6) smoke compartments,  
residents, staff and visitors. The facility is certified  
for one hundred thirty seven (137) beds with a  
census of one hundred twenty five (125) on the  
day of the survey. The facility failed to ensure the  
fire drills were conducted quarterly on third (3rd)



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K 050 Continued From page 16 shift.

The findings include:

Fire Drill review, on 04/23/13 at 1:00 PM, with the Director of Maintenance revealed the facility failed to conduct a fire drill in the second (2nd) quarter of 2012 on third (3rd) shift.

Interview, on 04/23/13 at 1:00 PM, with the Director of Maintenance revealed he was hired in the second (2nd) quarter of 2012, and the fire drill schedule started over upon him taking over the position and the second (2nd) quarter fire drill on third (3rd) shift was just overlooked.

18.7.1 Evacuation and Relocation Plan and Fire Drills.

18.7.1.1

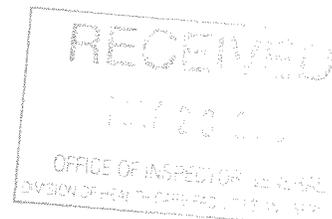
The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center. The provisions of 18.7.1.2 through 18.7.2.3 shall apply.

18.7.1.2\*

Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns,

The audits will be forwarded to the Quality Assurance Committee for further review and recommendations.

5. June 7, 2013



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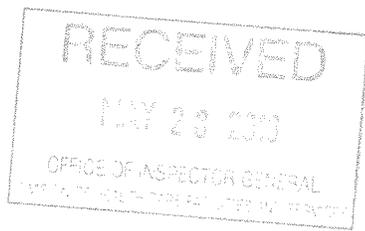
**K 050** Continued From page 17  
maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.  
Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.

**K 056** SS=F  
NFPA 101 LIFE SAFETY CODE STANDARD  
There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.

This STANDARD is not met as evidenced by:  
Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, installed in accordance with NFPA Standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and

- K 050**  
**K 56**
- On 5/15/13, Century Fire Protection was contacted by the Regional Plan Operations Director to obtain a plan and quote and begin work to update the sprinkler systems with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. Upon approval of plans, the work will begin with an estimated completion date of no later than 7/21/13
  - On 5/15/13, Century Fire Protection was contacted by the Regional Plan Operations Director to obtain a plan and quote and begin work to update the sprinkler systems with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. Upon receipt of sprinkler heads, the work will begin with an estimated completion date of no later than 7/21/13. See attached work plan by Century Fire Protection
  - The Regional Plant Operations Director will reeducate facility Plant Operations staff on utilization of appropriate sprinkler systems by 6/01/13.
  - The Quality Assurance Committee (Administrator, DON, ADON's, SSD, Dietary Manager, Plant Operations Director, Medical

*7/21/13  
Completed  
6/12/13  
per letter  
from Compa*



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**K 056** Continued From page 18  
visitors. The facility is certified for one hundred thirty seven (137) beds with a census of one hundred twenty five (125) on the day of the survey. The facility failed to ensure sprinkler heads installed were of the same temperature rating in the same compartment.

Director and Staff Develop Coordinator) will  
**K 056** Review maintenance reports related to replacement of appropriate sprinkler heads to assure that the work was completed and any areas of concern identified are addressed immediately.

The findings include:

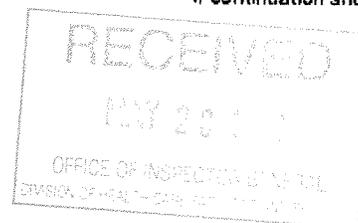
5. ~~7/27/13~~ 6/12/13

Observations, on 04/23/13 between 10:30 AM and 3:00 PM, with the Director of Maintenance revealed sprinkler heads installed in all resident rooms were rated for 155 degrees Fahrenheit, and 175 degrees Fahrenheit. Sprinkler heads installed in corridors and use areas were 155 degrees Fahrenheit, and 200 degrees Fahrenheit. The facility did have heat pump units installed in the ceiling; however the units did not have an emergency heat strip installed to necessitate any special circumstance.

Interview, on 04/23/13 between 10:30 AM and 3:00 PM, with the Director of Maintenance revealed he was not aware of the mixed temperature rating sprinkler heads. Further interview revealed the heat pumps located on the ceiling did not have a heat strip installed and could not understand why the sprinkler heads had been installed with different temperature ratings when there was not a special circumstance to necessitate the need for some sprinkler heads to have a higher temperature rating.

Reference: NFPA 13 (1999 Edition)

2-2.1.1\* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SUNRISE MANOR NURSING HOME  B. WING _____	(X3) DATE SURVEY COMPLETED  04/23/2013
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NAME OF PROVIDER OR SUPPLIER  SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 056 Continued From page 19

K 056

corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.

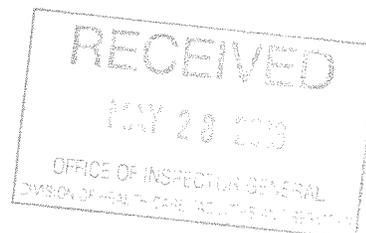
hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:

- (1) Wet pipe system
- (2) Light hazard or ordinary hazard occupancy
- (3) 20-ft (6.1-m) maximum ceiling height

The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.

Reference: NFPA 13 (1999 Edition)

7-2.3.2.4 Where listed quick-response sprinklers are used



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K 056 Continued From page 20  
throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:  
(1) Wet pipe system  
(2) Light hazard or ordinary hazard occupancy  
(3) 20-ft (6.1-m) maximum ceiling height  
The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.

K 056

K 064 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=D  
Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6

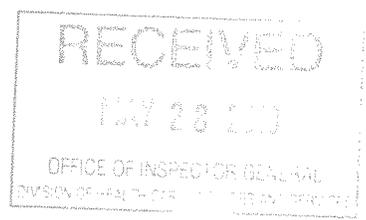
K 64

1. A fire extinguisher has been placed in the employee smoking area. Portable fire extinguishers are provided in all health care occupancies.

6/07/13

K 064

2. Fire extinguishers are placed in all appropriate areas. Portable fire extinguishers are provided in all health care occupancies.



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K 064 Continued From page 21

This STANDARD is not met as evidenced by:  
Based on observation and interview it was determined the facility failed to ensure that fire extinguishers were maintained in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff, and visitors. The facility is certified for one hundred thirty seven (137) beds with a census of one hundred twenty five (125) on the day of the survey. The facility failed to ensure the designated smoking areas had a fire extinguisher.

The findings include:

Observation, on 04/23/13 at 3:04 PM, with the Director of Maintenance revealed the facility's designated smoking area was not equipped with a fire extinguisher.

Interview, on 04/23/13 at 3:04 PM, with the Director of Maintenance revealed he was not aware a fire extinguisher was required to be located in the smoking areas.

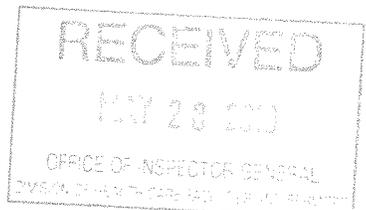
Reference: NFPA 10 1999

4-3.2\* Procedures.

Periodic inspection of fire extinguishers shall include a check of at least the following items:

- (a) Location in designated place
- (b) No obstruction to access or visibility
- (c) Operating instructions on nameplate legible and facing outward
- (d)\* Safety seals and tamper indicators not broken or missing
- (e) Fullness determined by weighing or "hefting"
- (f) Examination for obvious physical damage,

- 3. The Administrator reeducated facility plant operations staff on 5/21/13 the placement of portable fire extinguishers in appropriate areas.
- 4. The Plant Operations Director will audit the facility monthly times six months to ensure fire extinguishers are located in appropriate areas. The results of these audits will be forwarded to the Quality Assurance Committee for further review and recommendations.
- 5. June 7, 2013



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K 064	Continued From page 22 corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place 4-3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 4-3.2 (a), (b), (h), and (i), immediate corrective action shall be taken.	K 064		
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