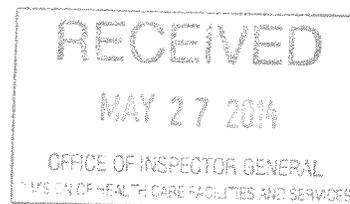


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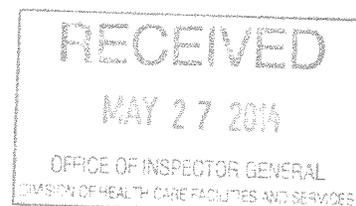
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHABILITATION, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
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F 497	<p>Continued From page 33</p> <p>reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of training records, it was determined the facility failed to provide evidence of ongoing in-service education for one (1) of five (5) nurse aides training records reviewed.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing, on 04/24/14 at 5:00 PM, revealed there was no current policy to reflect the required training for Nursing Assistants.</p> <p>Review of CNA #2's training records revealed the CNA had been hired on 12/20/12. The facility's computerized program which contained each employee's training hours revealed a zero for each course offered for CNA #2. Review of several computerized records revealed no evidence CNA #2 had obtained the required twelve (12) hours of ongoing education to ensure the continued competency of CNA #2.</p> <p>Interview with the Staff Development Coordinator (SDC), on 04/24/14 at 5:00 PM, revealed the</p>	F 497	<p>Criteria 2: An audit was completed on 05/05/14 by the SDC for all SRNA staff to determine that inservice hours are current/up-to-date and comply with the 12 hour annual requirement.</p> <p>Criteria 3: The facility tracking process for SRNA inservice education has been revised to provide quarterly reviews of hours for quick identification of SRNA staff who are behind in completion. This will be monitored by the SDC.</p> <p>Criteria 4: The CQI indicator for the monitoring of staff inservice education compliance will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the SDC.</p> <p>Criteria 5: 05/26/14</p>	05/26/14



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F 497	Continued From page 34 computer gave him a list of staff each month who have not taken the courses listed, and he contacts each individual to complete. The SDC revealed the computer showed no educational classes for CNA #2, and stated it could be a computer glitch, but he could not ensure the nurse aide had the required classes. Interview with the Director of Nursing, on 04/24/14 at 6:00 PM, revealed she was not aware of any audits being done for each CNA education records, and relied on the computer to determine any discrepancies.	F 497			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure physician orders were	F 514	Criteria #1 The orders for resident #5 were reviewed and clarified by the Unit Manger to address the prescribed use of Ativan as completed on 05/02/14. Criteria #2 The orders for all residents have been reviewed by the Clinical Educator on 4/30/14 to determine that all MD orders have been accurately and completely transcribed. Clarification orders were obtained for any discrepancies identified. Criteria #3 - All licensed nurses have received inservice education by 5/26/14 by the SDC on the need to thorough review and accurately transcribe all physician orders.		



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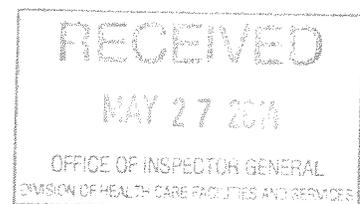
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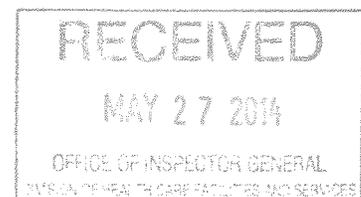
F 514	<p>Continued From page 35</p> <p>transcribed accurately in the medical record for one (1) of twenty-four (24) residents. Resident #5. The facility staff received an order for Ativan 0.5 ml every hour on 3/23/14 for Resident #5; however, the facility failed to transcribe the order onto the Medication Administration Record (MAR).</p> <p>The findings include:</p> <p>Review of the facility's policy titled Medication Orders (not dated), revealed physician's orders were administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. According to the Medication Order policy, the nursing staff was to record verbal medication orders on the telephone order sheet and on the MAR. The following steps were initiated to complete documentation and receive the medications: clarify the order, fax the medication order to the provider pharmacy, transcribe the newly prescribed medication to the MAR, and document each medication order entered on the appropriate form with date, time, and signature.</p> <p>Review of the Staff Development Memo "Physicians Orders" (posted 04/04/14) revealed the night shift Charge Nurse was responsible for checking physician orders from the previous day. According to the memo, the 3rd shift charge nurses were responsible for checking physician's orders from the previous day: check that the orders were documented on the MAR, Care Plan, Progress notes, Medlab, and entered, if applicable, on to the calendar; and initial the top of each order, staple them to the 24-hour report, and place both in to the Unit Manager's mailbox at the end of the shift.</p>	F 514	<p>Criteria #4 The CQI tool for the monitoring of accuracy of transcription orders will be utilized monthly X 2 months and then quarterly thereafter, under the supervision of the DON.</p> <p>Criteria #5 05/27/14</p>	05/27/14
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F 514	<p>Continued From page 36</p> <p>Review of the facility education form titled Changeover Process, revealed the nursing staff was to compare the new monthly order sheet with old MARs and Treatment Administration Record's (TARs) and verify the last 30 days telephone orders were accurately reflected on the new monthly order sheet.</p> <p>Review of the clinical record for Resident #5 revealed the facility admitted the resident with diagnoses of Carcinoma in Situ of Prostate, Urinary Obstruction, Hydronephrosis w/nephrostomy, Hypertension, Diabetes Mellitus Type 2, Coronary Artery Disease, and a history of C-Difficile Infection. The physician ordered Ativan 0.5 milliliters (ml) sublingual (SL) every hour for restlessness on 03/23/14. However, review of the record did not reveal an order for Ativan 0.5 ml on the March or April, 2014 MARs.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 04/24/14 at 2:25 PM, revealed nurses were responsible for taking the physician telephone order, transcribing the order to the resident's chart and MAR, faxing the order to the Pharmacy, and documenting it on the resident's care plan. LPN #2 stated the original new order was filed in the physician folder for signature and the copy was given to the nurse on the next shift during verbal report/changeover. LPN #2 stated 3rd shift (11 PM-7 AM) was responsible for printing the 24-hour shift report and giving the printed copy to the North Unit Manager (UM) daily for verification of resident orders. She revealed the nurse assigned to monthly MAR changeover was expected to review/compare the MAR to the previous month and all written physician orders since the last month's MAR.</p>	F 514		



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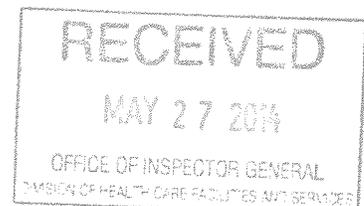
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F 514	<p>Continued From page 37</p> <p>Interview with LPN #6, on 04/24/14 at 3:23 PM, revealed she had received new hire training on transcription of physician orders. She stated she recalled receiving an order on 03/23/14 for Resident #5 for Ativan 0.1 ml SL every hour for restlessness and assumed that she had transcribed the order to the MAR. She revealed telephone physician orders were written on the 3-part order sheet, faxed to the pharmacy and transcribed to the MAR and resident's Care Plan. She also stated any new physician orders obtained during the day were given to the on-coming shift nurse during verbal report/change over. She stated in order to ensure accuracy, monthly MARs were reviewed/compared to previous month's MAR and handwritten physician orders.</p> <p>Interview with the North Unit Manager (UM), on 04/24/14 at 2:40 PM, revealed the nurse receiving a physician telephone order was responsible for ensuring the medication order was transcribed to the MAR. She stated the nurse taking the Ativan 0.5 ml order failed to transcribe the order to Resident #5's MAR. In addition, she revealed the 3rd shift nurse and the North UM were also responsible for daily review of physician orders to verify/ensure accuracy. She further stated the nurse assigned monthly change over failed to verify and ensure accuracy of Resident #5's MAR. She indicated failure to follow the facility system for documentation of physician orders resulted in Resident #5's order for Ativan 0.5 ml not being transcribed on the MAR for March and April, 2014. The UM stated failure to transcribe Resident #5's medication order was considered a medication error which required completing a facility medication error report and subsequent</p>	F 514		
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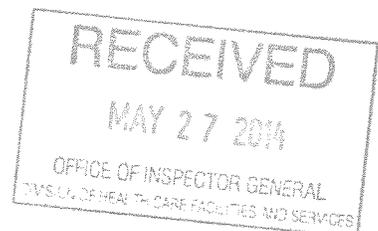
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F 514	<p>Continued From page 38 review at the facility's Quality Assurance (QA) Meeting.</p> <p>Interview with the Director of Nursing (DON), on 04/24/14 at 3:20 PM, revealed the nursing facility had identified there was a problem with physician order transcription errors. There are no past policies, and no policy for writing telephone orders, although they had identified there was a problem they had provided no training. She stated the Staff Development Coordinator had developed educational material for the MAR month to month change over process and had placed the information in the nurse's communication book for review. She also stated the MAR change over education had been reviewed during the March, 2014 monthly nurses' meeting. She indicated the Staff Development Coordinator had begun resident chart audits on the South Unit, but had not conducted audits on the East or North Units. She stated she was unaware Resident #5's Ativan 0.1 ml order had not been transcribed on to the MAR. She further stated the nurse who did monthly change over orders should have verified accuracy of the MAR and the UM should have completed an audit. She stated processes were not in place for physician order transcription/verification and she had identified there was a problem. She further revealed that this was a recent problem and the facility had not yet implemented monitoring plans of action.</p>	F 514		
F 520 SS=F	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and</p>	F 520	<p>Criteria 1: -The facility completed a CQI meeting on 05/22/14 under the supervision of the Administrator. -The QA committee reviewed</p>	



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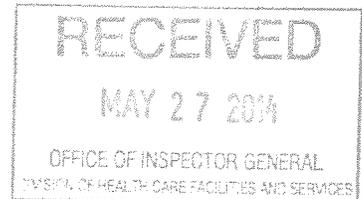
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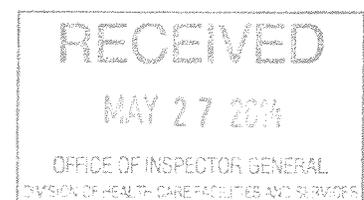
F 520	<p>Continued From page 39</p> <p>assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Quality Assurance (QA) Meeting signature sheet, it was determined the facility failed to meet at least quarterly as required. Interview with the Administrator and Director of Nursing (DON) revealed the last QA meeting was held on 12/11/13. The facility's QA Committee had not met in March or April 2014. In addition, the facility failed to provide a policy and procedure for the Quality Assurance Program and failed to ensure policy and procedures governing the care of the residents were completed, implemented and available for staff use. The QA Committee failed</p>	F 520	<p>and finalized the facility policies for CQI, Staff Training, Room Temperature Levels, Comprehensive Care Plans, Medication Storage, Infection Control-Standard Precautions, and Lost Items.</p> <p>Criteria 2: -The Administrator has developed a calendar for the remainder of 2014 with CQI meetings schedule quarterly in June, September and December. -The QA committee has begun reviewing and finalizing all facility policies.</p> <p>Criteria 3: -The facility QA team will receive inservice education by 5/22/14 by the Administrator on the need to conduct meetings a minimum of quarterly, and the schedule of meetings for June, September and December of 2014.</p> <p>-The facility staff are receiving inservice education on the facility policies/procedures as they are finalized by the QA committee, as provided by the SDC beginning on 05/22/14.</p>	
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F 520	<p>Continued From page 40</p> <p>to develop, implement and monitor action plans to ensure resident grievances were acted upon and resolved regarding palatable food and resident personal laundry being returned to them. (Refer to F252, and F364)</p> <p>The findings include:</p> <p>The facility did not provide a policy for Quality Assurance.</p> <p>1. Review of the signature sheet for the QA meetings revealed since the last standard survey, the QA committee had met three times, 8/29/13, 11/20/13, and 12/11/13. The facility could not provide evidence the QA committee had met since 12/11/13, over four months.</p> <p>Interview with the Administrator and DON, on 04/24/14 at 2:00 PM, revealed the Administrator had only been at the nursing facility for two (2) weeks. The DON revealed the last QA meeting was held on 12/11/13 and there had been no QA meeting since then. She did not give a reason why a QA meeting had not been held. The Administrator stated he was trying to get to know the residents and did not realize the QA committee had not met since December 2013.</p> <p>Interview with the DON, on 04/24/14 at 1:30 PM revealed there were no past policies. Policies that had been developed were currently under review. Even though they had identified there was a problem they had provided no specific staff training.</p> <p>Interview with the Director of Nursing, on 04/24/14 at 5:00 PM, revealed there was no current policy to reflect the required training for</p>	F 520	<p>Criteria 4: The CQI indicator for the monitoring of the CQI process will be utilized quarterly under the supervision of the Administrator to determine completion of quarterly meetings.</p> <p>Criteria 5: 05/26/14</p>	05/26/14	



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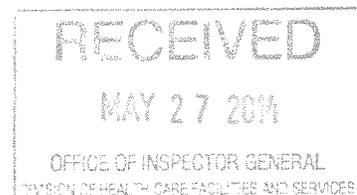
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F 520	<p>Continued From page 41 Nursing Assistants (F497).</p> <p>On 04/24/14 at 3:00 PM, the DON provided a policy for F364 and confirmed there was no title or date on the policy. In addition, the DON stated there had been no formal training yet on new policies</p> <p>The facility could not provide a policy for F156.</p> <p>Review of the polices provided by the facility revealed Room Temperature Level Policy (F257) was not dated. Comprehensive Care Plans Policy (F279) was not dated. Medication Storage Policy (F431) was not dated. Infection Control-Standard Precautions Policy (F441) was not dated. Lost Items Policy (F252) was not dated.</p> <p>2. Review of the Resident Council Minutes for February, March, and April of 2014 revealed reports of missing clothing or articles.</p> <p>Interviews during the Group meeting with Residents #2, #10 and #16 and Unsampled Residents G, H, L and K, on 04/22/14 at 3:00 PM, revealed the facility had received multiple complaints from residents and families regarding lost clothing articles.</p> <p>Interview with the Social Services Director (SSD), on 04/24/14 at 9:40 AM, revealed the facility had a labeling system where all new resident's laundry would be dropped off with the receptionist and sent down to laundry to be labeled. The SSD stated most laundry went down on Friday's and was delivered to resident's the next Tuesday or Wednesday by the laundry attendant</p>	F 520		
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F 520	<p>Continued From page 42</p> <p>Interview with the Housekeeping/Laundry Director, on 04/24/14 at 1:45 PM, revealed there had been staffing problems in the laundry. She had pulled the housekeeping staff to the laundry to work. The Director further stated she had loads of missing items and did not know the process for training laundry staff. She indicated the staff were not double checking the names and she had gone to the owner about the problem.</p> <p>3. Review of the Resident Council Minutes from February and March 2014, revealed grievances were filed as a result of resident dissatisfaction with the food received from the dietary department.</p> <p>Interviews with Resident #5, #8, #10, #16, and #19 and Unsampled Residents, C, D, G, H, I, J, K, L and M, during the meal service, revealed multiple complaints about the taste and temperature of the food and this had been expressed to the Administrative staff without resolution. In addition, a lunch test tray on 4/23/14 validated the residents' concerns.</p> <p>Interview with Dietary Staff #1, on 04/24/14 at 1:35 PM, revealed not enough food was prepared for lunch on 04/23/14 and the delay in the delivery of the trays was upsetting to some of the residents. She further stated the budget had changed and there was less money. She further stated the cook did not measure for large groups of people.</p> <p>Interview with ADM, on 04/24/14 at 1:25 PM,</p>	F 520		
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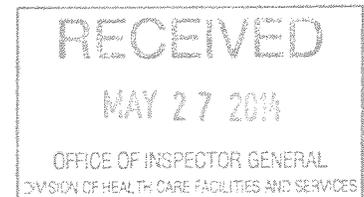
PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2014
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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHABILITATION, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 520	<p>Continued From page 43</p> <p>revealed the meatloaf should not have been served and she would not have eaten the burnt meatloaf either.</p> <p>Interview with DM, on 04/24/14 at 1:50 PM, revealed there was not enough food cooked for the lunch meal, but thought there might have been enough meatloaf for everyone if it had not been burnt.</p> <p>Interview with the Social Services Assistant, on 04/24/14 at 11:00 AM, revealed they received complaints on a daily basis from residents regarding the food.</p> <p>Interview with the North Unit Manager, Licensed Practical Nurse and Certified Medication Technician, on 04/22/14 at 10:10 AM, during tour revealed activities, staffing, cold food, housekeeping, and cold showers had been brought to the attention of the Administration without results.</p>	F 520		
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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056	
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1968, 1984 and 1997</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story with a partial basement, Type III, Protected Construction.</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments on the Ground Floor.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Two (2), Type II generators. Fuel source is diesel.</p> <p>A standard Life Safety Code Survey was conducted on 04/22/14. The facility was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).</p>	K 000	<p>The preparation and execution of this credible allegation of compliance does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. The facility reserves its right to dispute the facts and conclusions in any forum necessary and disputes that any action or inaction on its part created any deficient practice. This Plan of Correction is prepared and executed solely because it is required by federal and state law.</p> <div style="text-align: center; border: 1px solid black; padding: 5px; margin: 10px auto; width: fit-content;"> <p>RECEIVED</p> <p>MAY 27 2014</p> <p>OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES</p> </div>	

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

TITLE

(X6) DATE

x Amy A. Preece

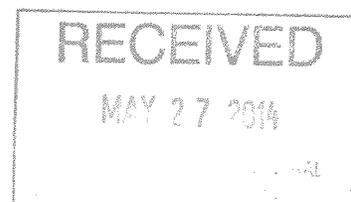
x Administrator 4/23/14

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

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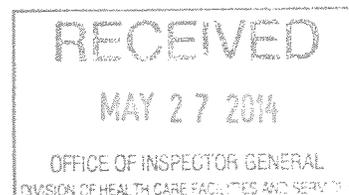
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K 000	Continued From page 1 Deficiencies were cited with the highest deficiency identified at an F level.	K 000		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors, located in a smoke barrier, would resist the passage of smoke in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, approximately forty (40) residents, staff and visitors. The facility has one-hundred and twenty-eight (128) certified beds and the census was one-hundred and seventeen (117) on the day of the survey. The findings include: Observation, on 04/22/14 at 9:38 AM, with the Maintenance Director revealed the cross-corridor doors located in the North East Hall would not completely close when tested, leaving a gap of	K 027	Criteria 1: The cross-corridor doors located in the North East Hall were repaired on 04/25/14 by the maintenance supervisor. These doors now completely close as evidence by audit completed on 04/28/14 by the maintenance supervisor under the supervision of the administrator. Criteria 2: An audit of all smoke barrier doors was completed on 04/25/14 by the maintenance supervisor to determine that the doors completely closed and met all other requirements of this regulation. No needed repairs were identified. Criteria 3: Maintenance Director was in-serviced on the necessity of corridor doors closing properly in the event of an emergency on 04/25/14 as provided by the Administrator. Criteria 4: The QA indicator for the monitoring of corridor doors will be utilized monthly x 2 months and then during the QA meetings on 6/19/14, 9/18/14 and 12/18/14 under the supervision of the Administrator.	



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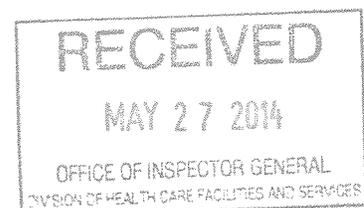
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K 027	Continued From page 2 approximately two (2) inches between the doors in the closed position. The pair of doors could not close completely and resist the passage of smoke in the event of an emergency. Interview, on 04/22/14 at 9:40 AM, with the Maintenance Director revealed he was not aware the pair of doors would not completely close and would not be capable of resisting the passage of smoke in the event of an emergency. The census of one-hundred and seventeen (117) was verified by the Administrator on 04/22/14 at 3:13 PM. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/22/14. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.	K 027	Criteria 5: 05/27/14	05/27/14	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When	K 029	Criteria 1: A door closer has been installed on the following doors: (1) Office Supply Room located in the Main Lobby; (2) Janitor Closet located near the Main Lobby; (3) North Nurses		



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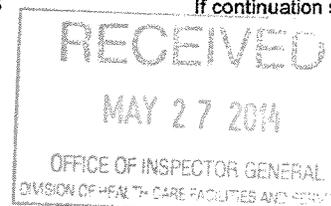
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K 029	Continued From page 3 the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with the National Fire Protection Agency (NFPA) standards. The deficiency had the potential to affect three (3) of seven (7) smoke compartments, and approximately sixty (60) residents, staff and visitors. The facility has one-hundred and twenty-eight (128) certified beds and the census was one-hundred and seventeen (117) on the day of the survey. The findings include: 1. Observation, on 04/22/14 at 8:56 AM, with the Maintenance Director revealed the door to the Office Supply Room located in the Main Lobby, did not have a self-closing device installed on the door. Interview, on 04/22/14 at 8:58 AM, with the Maintenance Director revealed he was aware of the room being used to store combustible items and the requirement for the door to be equipped with a self-closing device. He stated he became aware of the door needing the self-closing device	K 029	Storage Room; and (4) Janitor Closet located near the North Nurses' Station by the Maintenance Supervisor on 05/26/14. Criteria 2: An audit was completed of hazardous areas to ensure door closures were in place and ceilings were sealed by the Maintenance Supervisor 05/16/14 that determined that there were no additional doors requiring self-closing devices to be installed. Criteria 3: The Maintenance Director was in-serviced on what hazardous areas are and the importance of having a door, a self-closer, and separation, by the Administrator on 04/25/14. Criteria 4: The QA indicator for the monitoring of hazardous areas will be utilized monthly X 2 months during the QA meetings on 6/19/14, 9/18/14 and 12/18/14 under the supervision of the Administrator Criteria 5: 05/27/14	05/27/14



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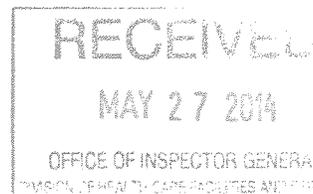
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K 029	Continued From page 4 when he was employed by the facility as the new Maintenance Director. 2. Observation, on 04/22/14 at 9:02 AM, with the Maintenance Director revealed the door to the Janitor Closet located near the Main Lobby, did not have a self-closing device installed on the door. Interview, on 04/22/14 at 9:04 AM, with the Maintenance Director revealed the door to the room was typically closed and locked by the Housekeeping staff. He acknowledged the room was used for the storage of combustible items and should be equipped with a self-closing device. 3. Observation, on 04/22/14 at 9:10 AM, with the Maintenance Director revealed the door to the North, Nurses Storage Room did not have a self-closing device installed on the door. Interview, on 04/22/14 at 9:12 AM, with the Maintenance Director revealed the door to the room was typically closed and locked by the Nursing staff. He acknowledged the room was used for the storage of combustible items and should be equipped with a self-closing device. 4. Observation, on 04/22/14 at 9:15 AM, with the Maintenance Director revealed the door to the Janitor Closet located near the North Nurse's Station, did not have a self-closing device installed on the door. Interview, on 04/22/14 at 9:17 AM, with the Maintenance Director revealed the door to the room was typically closed and locked by the Housekeeping staff. He acknowledged the room	K 029		



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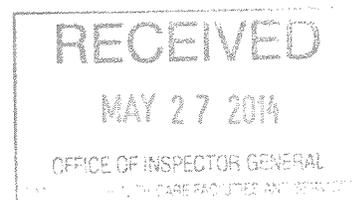
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K 029	Continued From page 5 was used for the storage of combustible items and should be equipped with a self-closing device. The census of one-hundred and seventeen (117) was verified by the Administrator on 04/22/14 at 3:13 PM. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/22/14. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies	K 029		



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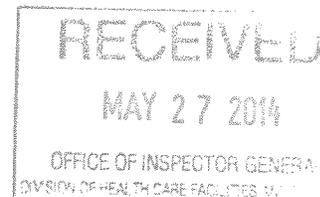
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K 029	Continued From page 6 and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the exits were maintained in accordance with National Fire Prevention Association (NFPA) standards. The deficiency had the potential to affect two (2) of even (7) smoke compartments, approximately sixty (60) residents, staff and visitors. The facility has one-hundred and twenty-eight (128) certified beds and the census was one-hundred and seventeen (117) on the day of the survey. The facility failed to ensure two (2) exits had a durable walking surface to a public right-of-way. The findings include:	K 029		
K 038 SS=E		K 038	Criteria 1: The North and East emergency exit concrete sidewalks have been extended to connect to the paved public right-of-way. Work will be completed by 05/26/14 by a contracted concrete company. Criteria 2: There are no other exits that are affected by this practice. Criteria 3: The Maintenance Director received in-service education on Regulation K038 as provided by the administrator on 04/25/14 regarding access to the public way. Criteria 4: The CQI Indicator for the monitoring of the exits will be utilized monthly X 2 months and then during the QA meetings on 6/19/14, 9/18/14 and 12/18/14 under the supervision of the Administrator. Criteria 5: 05/27/14	05/27/14



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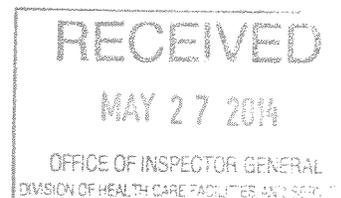
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K 038	Continued From page 7 1. Observation, on 04/22/14 at 9:28 AM, with the Maintenance Director, revealed the North emergency exit was equipped with a concrete sidewalk that extended approximately twenty (20) linear feet from the building, but did not connect to a paved public right-of-way. Interview, on 04/22/14 at 9:30 AM, with the Maintenance Director, revealed he was unaware of the requirement that all emergency exits were required to have a paved walking surface to extend from the exit discharge to a paved, public right-of-way. 2. Observation, on 04/22/14 at 10:09 AM, with the Maintenance Director, revealed the East emergency exit was equipped with a concrete sidewalk that extended approximately twenty (20) linear feet from the building, but did not connect to a paved, public right-of-way. Interview, on 04/22/14 at 10:11 AM, with the Maintenance Director, revealed he was unaware of the requirement that all emergency exits were required to have a paved walking surface to extend from the exit discharge to a paved, public right-of-way. The census of one-hundred and seventeen (117) was verified by the Administrator on 04/22/14 at 3:13 PM. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/22/14. Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained	K 038		



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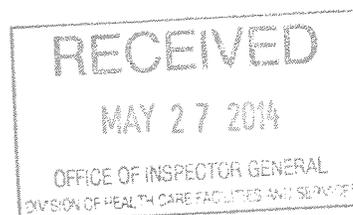
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K 038	Continued From page 8 free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times. 7.7.1* 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.	K 038			
K 045 SS=F	CMS S&C letter 5-38 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.) 19.2.8 This STANDARD is not met as evidenced by:	K 045	Criteria 1: The exit lighting fixtures on the exterior of the North and East hall exits have been changed to a two bulb fixture and arranged so the failure of a single bulb will not leave the exit in complete darkness, by the Maintenance Director on 04/28/14.		



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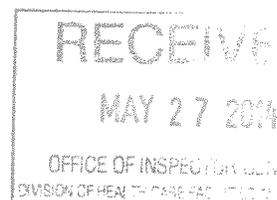
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2014
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
K 045	<p>Continued From page 9</p> <p>Based on observation and interview, it was determined the facility failed to ensure exits were equipped with emergency lighting in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the seven (7) smoke compartments, residents, staff and visitors. The facility has one-hundred and twenty-eight (128) certified beds and the census was one-hundred and seventeen (117) on the day of the survey. The facility failed to provide the required level of illumination outside an exit for discharge.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation, on 04/22/14 at 9:23 AM, with the Maintenance Director revealed the North exit near the Dining Room, did not have exterior egress lighting to provide the required level of illumination at the exit discharges. The exit was equipped with a light fixture containing one bulb. Interview, on 04/22/14 at 9:25 AM, with the Maintenance Director revealed he was not aware of the requirement that exterior light fixtures required for egress were to have two (2) bulbs. 2. Observation, on 04/22/14 at 10:09 AM, with the Maintenance Director revealed the exit at the East Hall, did not have exterior egress lighting to provide the required level of illumination at the exit discharges. The exit was equipped with a light fixture containing one bulb. Interview, on 04/22/14 at 10:11 AM, with the Maintenance Director revealed he was not aware of the requirement that exterior light fixtures required for egress were to have two (2) bulbs. 	K 045	<p>Criteria 2: All exterior exits were audited to ensure two bulb fixtures were in place by the Maintenance Supervisor on 04/28/14.</p> <p>Criteria 3: The Maintenance Director has been in-serviced that lighting for means of egress, should be equipped with more than one bulb and arranged in such a fashion that the failure of one bulb does not result in the area being in complete darkness, by the Administrator on 04/28/14.</p> <p>Criteria 4: The CQI Indicator for the monitoring for exit lighting shall be utilized monthly x 2 months then during the QA meetings on 6/19/14, 9/18/14 and 12/18/14 under the supervision of the Administrator.</p> <p>Criteria 5: 05/26/14</p>



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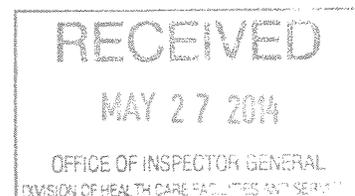
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K 045	Continued From page 10 3. Observation, on 04/22/14 at 10:58 AM, with the Maintenance Director revealed the South exit, did not have exterior egress lighting to provide the required level of illumination at the exit discharges. The exit was equipped with a light fixture containing one bulb. Interview, on 04/22/14 at 11:00 AM, with the Maintenance Director revealed he was not aware of the requirement that exterior light fixtures required for egress were to have two (2) bulbs. The census of one-hundred and seventeen (117) was verified by the Administrator on 04/22/14 at 3:13 PM. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/22/14. Reference NFPA 101 (2000 edition) 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. 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,	K 045		



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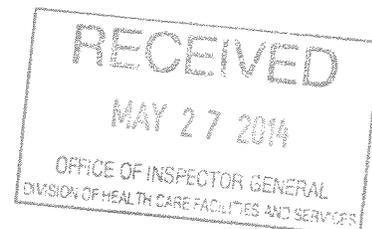
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K 045	Continued From page 11 escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available 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 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	K 045		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 046	Criteria #1: The battery-powered emergency light fixture located at the	



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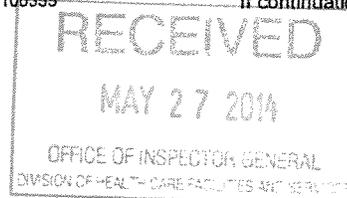
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K 046	<p>Continued From page 12</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide testing of emergency lighting in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the seven (7) smoke compartments, residents, staff and visitors. The facility has one-hundred and twenty-seven (127) certified beds and the census was one-hundred and seventeen (117) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 04/22/14 at 12:05 PM, with the Maintenance Director revealed the battery-powered emergency light fixture located at the emergency generator transfer switch located in the Basement, Electrical Control Room, did not function when the test button was activated.</p> <p>Interview, on 04/22/14 at 12:07 PM, with the Maintenance Director revealed the battery-powered emergency light fixture located at the emergency generator transfer switch had functioned properly when he conducted the monthly ninety (90) second test for March, 2014.</p> <p>The census of one-hundred and seventeen (117) was verified by the Administrator on 04/22/14 at 3:13 PM. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/22/14.</p>	K 046	<p>emergency generator transfer switch located in the basement electrical control room has been repaired and now functions when the test button is activated by the Maintenance Director on 05/20/14.</p> <p>Criteria #2: An audit was done to ensure all other emergency lights with battery backup were functioning, by the Maintenance Supervisor on 05/21/14.</p> <p>Criteria #3: The Maintenance Director was in-serviced on the importance of ensuring emergency lights with battery backup are functioning properly, by the Administrator on 04/28/14.</p> <p>Criteria #4: The QA tool for the monitoring of emergency lighting will be utilized monthly x 2 months and then during the QA meetings on 6/19/14, 9/18/14 and 12/18/14 under the supervision of the Administrator</p> <p>Criteria #5: 05/26/14</p>	05/26/14



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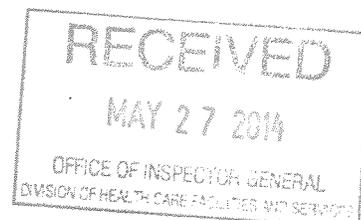
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K 046	Continued From page 13 Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046			



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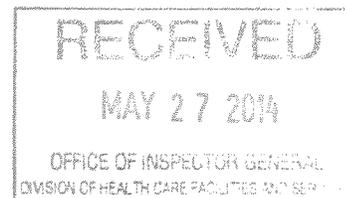
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K 056 K 056 SS=D	<p>Continued From page 14</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>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 in accordance with the National Fire Protection Association (NFPA) Standards. The deficiency had the potential to affect residents, staff and visitors. The facility has one-hundred and twenty-eight (128) certified beds and the census was one-hundred and seventeen (117) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 04/22/14 at 11:52 AM, with the Maintenance Director revealed the storage closet within the Dietary Office located in the Basement Kitchen, was not protected by automatic sprinkler coverage.</p>	K 056 K 056	<p>Criteria 1:A sprinkler was installed in the storage closet on 5/15/14.</p> <p>Criteria 2:All storage closets were audited to ensure complete sprinkler coverage by the Maintenance Supervisor on 05/15/14.</p> <p>Criteria 3: The Maintenance Director has received in-service education on 04/28/14 by the Administrator on the requirement of all enclosed areas of the building to be equipped with sprinkler system.</p> <p>Criteria 4: The QA indicator tool for the monitoring of equipping all enclosed areas of building with sprinkler systems shall be utilized annually and upon renovation.</p> <p>Criteria 5: 05/27/14</p>	05/27/14



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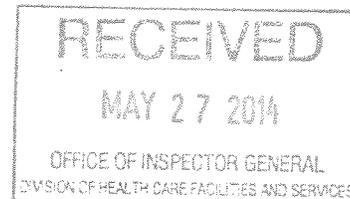
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K 056	Continued From page 15 Interview, on 04/22/14 at 11:54 AM, with the Maintenance Director revealed he was not aware the storage closet was not being protected by automatic sprinkler coverage. The storage closet had been recently constructed within the Dietary office prior to the new Maintenance Director's employment at the facility. The census of one-hundred and seventeen (117) was verified by the Administrator on 04/22/14 at 3:13 PM. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/22/14. Reference: NFPA 101 (2000 Edition) 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Reference: NFPA 13 (1999 Edition) 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.	K 056		
K 066	NFPA 101 LIFE SAFETY CODE STANDARD	K 066	Criteria 1: The appropriate approved ashtray has been placed at the	



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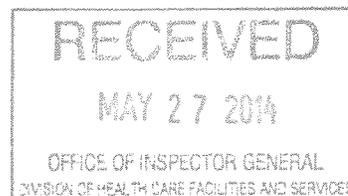
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K 066 SS=D	Continued From page 16 Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the designated outdoor smoking area for the residents was properly equipped for safe smoking, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect residents using the smoking areas and staff. The facility has one-hundred and twenty-eight (128) certified beds and the census was one-hundred and	K 066	designated smoking area for residents by the Maintenance Supervisor on 05/26/14. Criteria 2: All areas where visitors/ employees/residents smoke were audited to determine that appropriate ashtrays were in place by the Maintenance Supervisor on 05/26/14. Criteria 3: On 05/24/14 the Maintenance/Housekeeping personnel have been in-serviced on the approved types of ashtrays that can be utilized in smoking areas by the Administrator on . Criteria 4: The CQI tool for Smoking regulations specific to types of ashtrays will be utilized monthly x 2 months and then during the QA meetings on 6/19/14, 9/18/14 and 12/18/14 under the supervision of the Administrator Criteria 5: 05/26/14	05/26/14



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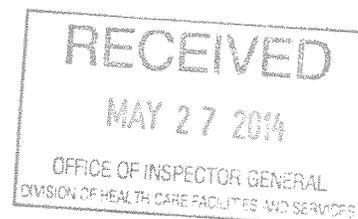
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K 066	<p>Continued From page 17 seventeen (117) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 04/22/14 at 10:31 AM, with the Maintenance Director revealed the designated outdoor smoking area for residents did not have an approved metal container with a self-closing lid to empty ashtrays into or a fire extinguisher available for use in the event of an emergency.</p> <p>Interview, on 04/22/14 at 10:33 AM, with the Maintenance Director revealed he was not aware of the requirement that the designated, outdoor smoking area for residents was to be equipped with an approved metal container with a self-closing lid to empty ash trays into or that a fire extinguisher be available within the designated smoking area. The nearest available fire extinguisher was within the building.</p> <p>The census of one-hundred and seventeen (117) was verified by the Administrator on 04/22/14 at 3:13 PM. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/22/14.</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition)</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location,</p>	K 066		



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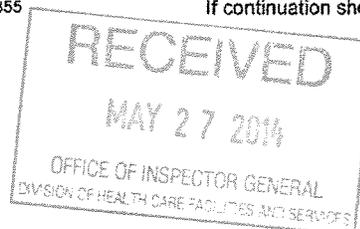
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K 066	Continued From page 18 and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. Reference: S & C Letter: 12-04-NH; Date: November 10, 2011 Smoking Safety in Long Term Care Facilities	K 066		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	Criteria 1: The power strips were removed from Resident room 123 and activities office by the Maintenance Director on 04/25/14.	



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K 147	<p>Continued From page 19</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, approximately thirty-five (35) residents, staff, and visitors. The facility has one-hundred and twenty-eight (128) certified beds and the census was one-hundred and seventeen (117) on the day of the survey.</p> <p>The findings include:</p> <p>1. Observation, on 04/22/14 at 10:41 AM, with the Maintenance Director revealed medical equipment (a mini-nebulizer) was plugged into a power strip located within resident room 123.</p> <p>Interview, on 04/22/14 at 10:43 AM, with the Maintenance Director revealed he was aware of power strips being prohibited for use with medical equipment, but was not aware of the misuse of a power strip within the resident's room.</p> <p>2. Observation, on 04/22/14 at 11:07 AM, with the Maintenance Director revealed a small refrigerator and a microwave oven were plugged into a power strip located within the Activities Office.</p> <p>Interview, on 04/22/14 at 11:09 AM, with the Maintenance Director revealed he was aware of power strips being prohibited for use with appliances, but was not aware of the misuse of a power strip within the Activities Office.</p>	K 147	<p>Criteria 2: An inspection of the facility was done by the Maintenance Director on 05/25/14 to determine that all electrical wiring and equipment is in accordance with this regulation.</p> <p>Criteria 3: The Maintenance Director was in-serviced by the Administrator on 04/25/14 on un-allowed use of extension cords and power strips; open junction boxes and storage in front of electrical panels. The area in front of the electrical panels identified above has been marked on the floor to identify non-storage space.</p> <p>Criteria 4: The QA indicator tool for the monitoring of electrical wiring and equipment shall be utilized monthly X 2 and then during the QA meetings on 6/19/14, 9/18/14 and 12/18/14 under supervision of Administrator.</p> <p>Criteria 5: 05/26/14.</p>	05/26/14	



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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2014
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
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K 147	Continued From page 20 The census of one-hundred and seventeen (117) was verified by the Administrator on 04/22/14 at 3:11 PM. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/22/14. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147			

