

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

PRINTED: 03/17/2011  
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  01/19/2011
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056	
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F 000	INITIAL COMMENTS	F 000		
F 279 SS=D	<p>AMENDED SOD An Annual Health and Life Safety Code survey including complaint investigation KY #15239 was initiated on 01/18/10 and concluded on 01/19/10. The survey was found not to meet the minimum regulatory requirements and a statement of deficiencies was issued with the highest S/S at an "F".</p> <p>The Complaint Survey KY#15239 was Unsubstantiated.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced</p>	F 279	<p>F 279</p> <ol style="list-style-type: none"> <li>The care plans of Residents #15 and 16 were reviewed and updated by our MDS nurses and Hosparus on 02/07/11 to produce an accurate and comprehensive care plan.</li> <li>We have a new resident admitted with Hosparus. We will make sure that the care plan from Hosparus is fully integrated with ours.</li> <li>We spoke with Hosparus personnel regarding their involvement in resident's care plans and the need to produce a fully integrated care plan for each resident. Hosparus will begin entering their goals and approaches into our care plans kept at the nurse's station. Hosparus personnel will also communicate any additions or changes they make in a care plan to a MDS nurse or charge. Social Service will notify Hosparus of upcoming care plan meetings.</li> </ol>	

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

TITLE

(X6) DATE

*X Leslie J. Butterfield*

*X Administrator*

*X 2/09/11*

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

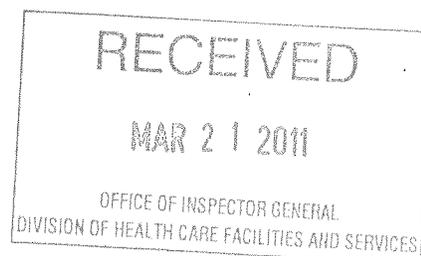
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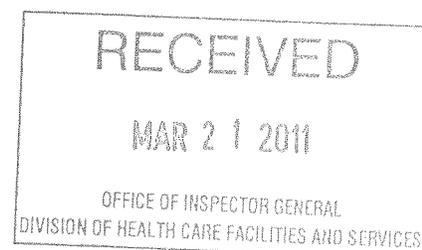
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F 279	Continued From page 1 by: Based on observation, interview and record review, it was determined the facility failed to develop a comprehensive care plan for three (3) of twenty-four (24) sampled residents (Residents #15, #16 and #19).  The findings include:  Record review of a Hosparus contract faxed to the facility on 01/18/11 revealed a Hosparus agreement entered into and effective as of December 2, 2008 with Friendship Manor states "Hospice and Facility will jointly develop and agree upon a Plan of Care which is consistent with the hospice philosophy and is responsive to the unique needs of Patient and his or her expressed desire for hospice care." "Specifically, the Plan of Care includes: (i) Facility Services; (ii) an identification of the Hospice Services, including interventions for pain management and symptom relief, needed to meet Patient needs, and the related needs of Patient's family; (iii) a detailed statement of the scope and frequency of such Hospice Services; (iv) measurable outcomes anticipated from implementing and coordinating the Plan of Care."  Record review on 01/19/11 for Resident #15 revealed an admission date of 06/22/10 with diagnoses of Bladder Cancer, Congestive Heart Failure and Chronic Total Occlusion of Coronary Artery. Resident #15 was admitted to Hosparus on 07/28/10. The quarterly MDS dated 09/13/10 did not mention hospice involvement. Record review on 01/19/11 revealed the Friendship Manor Plan of Care of Resident #15 contained only two mentions of hospice. There was no mention of the scope and services and visit	F 279	4. To ensure compliance, the DON will see that Hosparus resident's care plans are reviewed as soon as possible after each Hosparus visit but no less than once each month. Finding will be reported to our monthly QA committee.  1. A MDS nurse, on 01/20/11, updated the plan of care for Resident #19.  2. All other residents receiving oxygen will have their care plans reviewed and will be revised if needed.  3. Nurses will be inserviced on 02/10/11, by our staff development nurse, on updating care plans to include significant orders and events.  4. A designee of the Director of Nursing (DON) will QA 6-8 care plans per week to ensure that new events are care planned. DON will report finding to monthly QA meeting.	2/28/11



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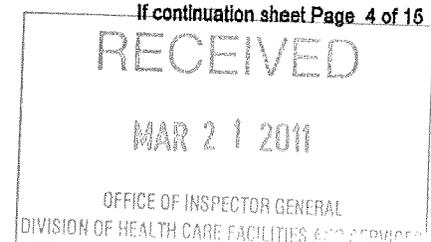
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F 279	<p>Continued From page 2</p> <p>frequency that Hosparus nurse, social worker and chaplain would provide.</p> <p>Record review for Resident #16 revealed an admission date of 09/22/10 with diagnoses of Renal Failure, Dementia and Hypertension. Resident #16 was admitted to Hosparus on 10/30/10. The facility plan of care had no mention of hospice involvement. The Hosparus plan of care has not been updated since 10/30/10.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 01/19/11 at 6:40pm revealed she was unaware of the hospice contract content and did not know the facility staff should be integrating the hospice plan of care with the facility plan of care.</p> <p>Interview with Director of Nursing (DON) on 01/19/11 at 6:40pm revealed she was unsure how to integrate the care plans between hospice and the facility. She stated Hosparus team members are invited to care plan meetings but was unaware how often those meetings are attended by Hosparus staff.</p> <p>Review of the comprehensive plan of care on 01/19/11 revealed the care plan failed to address the physician order for oxygen for resident #19. On 10/29/10 the physician ordered oxygen at 2 liters per minute by nasal cannula, which may be titrated to maintain an oxygen blood saturation of greater than ninety (90) percent.</p> <p>Interview with LPN #5 on 01/19/11 at 6:30pm revealed no documentation could be found to address the order for oxygen on the resident's care plan.</p>	F 279			



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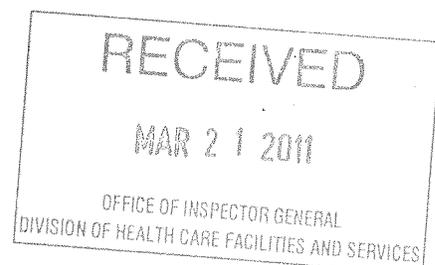
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F 279	Continued From page 3	F 279		
F 282 SS=D	<p>Interview with the Assistant Director of Nursing (ADON) on 01/19/11 at 6:55pm revealed the care plan process includes new "significant" orders received are to be added to the care plan.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to follow interventions for care planning related to the use of a Hoyer lift for one (1) of twenty four (24) sampled residents (Resident #8).</p> <p>The findings include:</p> <p>Review of the policy regarding the use of Mechanical Lifts on 01/19/11 revealed 1) An assessment of the ability of the resident to assist in the transfer process is performed by nursing staff or therapy staff, as well as the cognitive ability of the resident to cooperate with the transfer process is made by the nursing staff; 2) Method of transfer is care planned by the nursing staff; 3) Two staff members must be present during transfers made utilizing mechanical lifts; and 4) Staff are to follow method of transfer care planned for each individual resident.</p> <p>Review of the complaint investigation and record for Resident #8 on 01/18/11 revealed the resident was being transferred by Certified Nurse Aide</p>	F 282	<p>F 282</p> <ol style="list-style-type: none"> <li>1. Resident #8 is properly being transferred by mechanical lift using two people.</li> <li>2. Friendship Manor has been closely monitoring the use of mechanical lifts since June 2010 for all residents.</li> <li>3. Our mechanical lift policy was reviewed and our Staff Development Nurse provided in-services to CNAs and nurses in June of 2010.</li> <li>4. We are still monitoring compliance and will continue to discuss mechanical lift issues at our monthly QA meeting.</li> </ol>	06/2010



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F 282	Continued From page 4 (CNA) #3 to a Geri-chair on 06/13/11 per Hoyer lift, when the strap which hooks over the top of the lift slipped off, causing the resident to slide to the floor. In addition, review of the x-ray report revealed a slight compression fracture of T12, of indeterminate age and the resident had no issues with pain. The investigation also revealed that CNA #3 was transferring the resident with one assist, even though the plan of care revealed the resident should be transferred with two assist.  Interview with CNA #3 on 01/19/11 at 9:45am revealed she had cared for the resident for eight years and never had a problem with the lift. She revealed the incident happened so fast, the fall could not have been prevented even with two people; however, she was aware of the care plan requirement for the assist of two people, and stated, "I am so comfortable with the use of the Hoyer lift, and did not think about the strap slipping off".  Interview with the Director of Nursing (DON) on 01/19/11 revealed residents are screened by therapy for use of the lift, and the care plan is always developed to designate the number of staff required. The DON stated that two people are always required for Hoyer lift transferring, and CNA #3 has been trained to use two people when using the Hoyer lift.	F 282		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

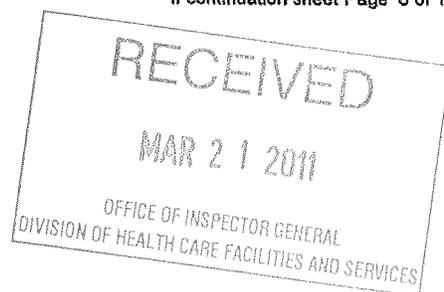


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F 371	Continued From page 5  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. The reach-in refrigerator did not have an internal thermometer, milk cartons that were covered with ice were taken across a container that had ice for consumption and food was being prepared in close proximity of area where a convection oven was being cleaned. The clean dietary cart was left opened and unattended in the North Dining area while meal trays were being served, leaving meal trays open to air and unprotected.  The findings include:  Review of the facility Dining Environment policy revealed: Friendship Manor will provide a safe dining environment for residents during every meal.  Observation on 01/18/11 during initial tour at 8:55am revealed the reach-in refrigerator did not have an internal thermometer. The staff standing nearby did not have an explanation as to why the thermometer was not there. In the freezer was a box of frozen cod that was opened and not dated or resealed. There was a dietary aide that was preparing carrots across the aisle from another dietary aide who was cleaning the convection oven.	F 371	F 371  1 & 2. The reach in refrigerator had a functioning external thermometer gauge that gives a reading of the internal temperature. The Dietary manager has placed an internal thermometer in the refrigerator so we will now have two readings of the internal temperature. All coolers and freezers have been inspected to ensure an internal thermometer is present. Immediately upon being made aware, the frozen cod was resealed and dated.  3. A policy was written, by the Dietary Manager, stating that all coolers and freezers will have internal thermometers and that the temperature will be recorded daily. Another policy was written that states that at the end of their shift, the head cook will inspect coolers and freezers for proper food storage. Opened food items found not to be sealed, labeled and dated will be discarded. Dietary Consultant will inservice dietary staff on these policies by 02/25/11.  4. Our Dietary Consultant, Marie Seese R.D., will add internal thermometers and proper food storage and dating of food to her monthly QA check list. Dietician's monthly QA results are given to the Dietary Manager and Administrator.	

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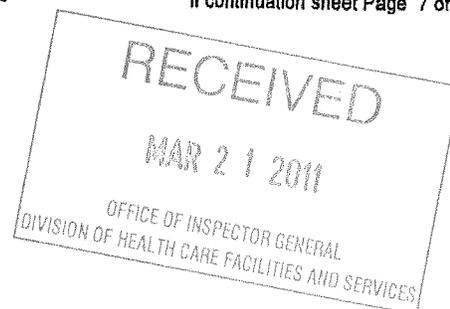


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F 371	<p>Continued From page 6</p> <p>Observation on 01/19/11 during tray line at 11:40am revealed dietary staff placed a pan of milk cartons in ice behind another container of ice that was to be used for resident consumption. Observation revealed a dietary aide reach back for a milk carton and bring it over the ice for consumption, dropping ice and dripping water into the ice for consumption. Further observation revealed a dietary aide dropping a container of milk into the ice for consumption and then continued to use that ice for residents.</p> <p>Interview on 01/19/11 at 11:40am with the Dietary Manager revealed she was aware the ice dripping from the milk carton causing cross contamination when dropped into the ice for consumption.</p> <p>Interview on 01/19/11 at 4:30pm with the Dietary Manager revealed she was aware that opened food in the freezer should be dated and resealed to insure food was kept at its optimum nutritional value. She stated she was unaware of food preparation being done in such close proximity to someone cleaning the oven. She reported she would speak to her staff about that not being a good practice since cleaning agents could splash into food prepared for residents.</p> <p>Observation on 01/18/11 at 12:00pm-12:10pm revealed the clean dietary cart door remained open and unattended during the meal pass on the North Wing.</p> <p>Observation on 01/19/11 at 11:55am-12:05pm revealed the clean dietary cart door remained open and unattended during the meal pass.</p> <p>Interview on 01/19/11 at 6:00pm with Certified Nurse Aide (CNA) #1 revealed the clean dietary</p>	F 371	<p>1 &amp; 2. Ice was discarded immediately and replaced with clean ice. The Milk cartons were then placed in front of the ice.</p> <p>3. The Dietary Manager will write a new policy and procedure for dropping the temperature of the milk before serving which will eliminate the need of milk cartons sitting in ice. The Dietary Manager will write a policy stating that nothing can cross ice that is to be used for consumption. An inservice will be given for the dietary department, by Marie Seese R.D., on cross contamination by 02/25/11.</p> <p>4. Marie Seese R.D. will monitor new procedure during her monthly QA visits. She reports her finding to the Dietary Manager and the Administrator.</p> <p>1 &amp; 2. Maintaining clean equipment in the dietary department is very important in providing a sanitary environment. Spills and prep areas will continue to be cleaned with an approved solution that prevents the spread of germs. Routine cleaning of equipment, such as the convection oven will no longer be cleaned during meal preparation.</p>	

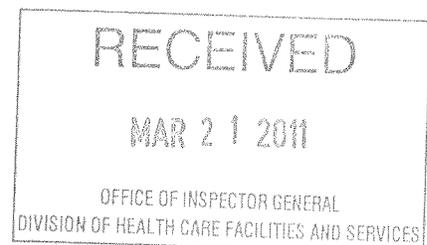
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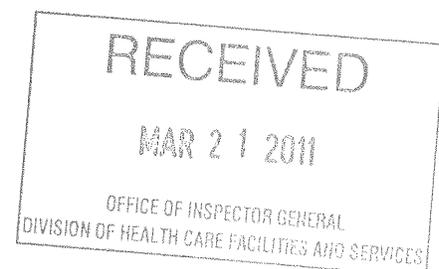
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F 371	Continued From page 7 cart should be kept shut until all trays are passed. She further revealed that by leaving the dietary cart door open the food temperature and safety of the food could be altered.  Interview on 01/19/11 at 6:05pm with CNA #2 revealed the clean dietary cart should be shut after every tray removal. She further revealed that leaving the dietary cart door open could alter the temperature and the safety of the food.  Interview on 01/19/11 at 6:10pm with LPN #1 revealed that the clean dietary cart should be shut after every tray removal. She further revealed that by leaving the clean dietary cart door open and unattended food temperature and food safety could be altered.  Interview on 01/19/11 at 6:12pm with the Dietary Consultant revealed that the clean dietary cart door could remain open during meal pass. She further revealed that by having the clean dietary cart door open food temperature could be affected and that having the dietary cart unattended could alter food safety.  Interview on 01/20/11 at 10:00am with eight (8) unsampled residents and one (1) sampled resident revealed that food was delivered cold sometimes.  Review of the Resident Council Meeting dated 11/04/10 revealed that nurse aides leave the door open to take the food out and food gets cold by the time residents receive it.	F 371	3. A policy will be written that states, no routine cleaning jobs will be completed in food prep areas. Dietary Consultant will inservice dietary staff on the new cleaning policy by 02/25/11.  4. Marie Seese R.D. will monitor new policy during her monthly QA visits. She reports her finding to the Dietary Manager and the Administrator  1 & 2. Food carts throughout facility have their doors closed when not in use.  3. CNAs were inserviced on 01/27/11 regarding keeping the food cart doors closed when not serving trays.  4. Nursing and our Dietary consultants will QA weekly to ensure that residents are receiving their trays in a safe and timely manner. DON will report to monthly QA meeting regarding finding.	2/26/11
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse	F 372		



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F 372	Continued From page 8 properly.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to dispose of garbage and refuse properly as evidenced by the dumpster door left open, trash on the ground around the dumpster, the boxes and leaves in the breezeway and around the back kitchen door.  The findings include:  Observation on 01/19/11 at 12:30pm revealed boxes were stacked up in the breezeway.  Observation on 01/19/11 at 4:30pm during the sanitation tour revealed the dumpster door was open. The ground area around the dumpster had several discarded disposable gloves, paper towels and strips of what appeared to be clear package tape scattered around. There were many empty boxes stacked in breezeway and around the outside entrance door to the kitchen there was a collection of leaves and small pieces of trash.  Interview with the Dietary Manager on 01/19/11 at 4:30pm revealed she was aware that the door to the dumpster should be closed. She stated that her dietary staff was also aware the doors to the dumpster should be closed and they usually kept them closed. She stated that her dietary staff were not the only people to use those dumpsters. The Dietary Manager reported that the boxes would be broken down and put in dumpster after the evening meal service was complete.	F 372	F 372  1. The dumpster doors are being closed and trash is not being left around the dumpster. Boxes near the kitchens back door will be broken down at the end of each shift and the area will be free of leaves.  2. This is the only location for dumpsters. Trash containers around building will also be monitored to ensure all trash is put in containers.  3. CNAs, housekeepers, and dietary staff will be counseled by their respective department heads on the importance of keeping the areas around dumpsters free of trash.  4 Maintenance and Housekeeping departments will QA compliance and will report noncompliance at the next scheduled daily QA / Department Head meeting.	2/18/11
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

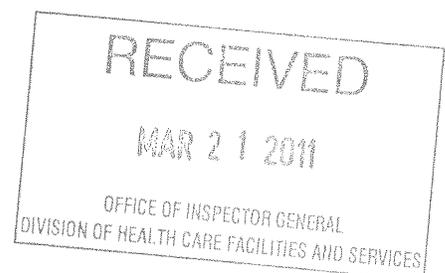


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OMB NO. 0938-0391

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  01/19/2011
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)	(X5) COMPLETION DATE
F 441 SS=D	Continued From page 9 SPREAD, LINENS  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, 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.	F 441	F 441  1. LPN #4 was immediately counseled when issue was brought to our attention.  2. All residents could have been affected by this deficiency.  3. Our Infection Control Nurse will inservice nurses on 02/10/11. CNAs were inserviced on 01/27/11 and will again be inserviced on 02/17/11 regarding proper handling of food and soiled linen to ensure that residents will have a safe dining environment.  4. Our Infection Control Nurse and Dietary Consultants will randomly QA meals at least once a week and will report finding to monthly QA Committee.  1. Residents #17 and 19 have their nasal cannulas properly stored and resident 17's suction catheter is properly stored in a bag.  2. All residents with oxygen equipment will have their nasal cannulas and suction catheters properly stored in approved bags.	

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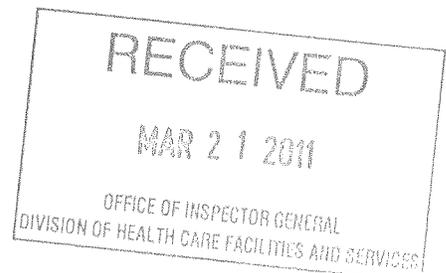
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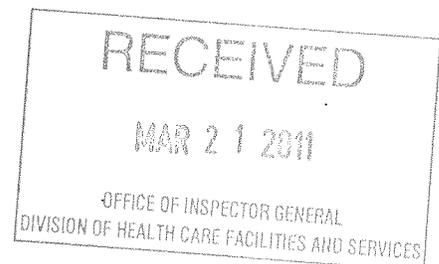
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F 441	Continued From page 10  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to maintain a sanitary environment to prevent the transmission of disease and infection for three (3) unsampled residents as demonstrated by the improper handling of food during meal service, and failure to properly discard nasal secretions in the South Wing dining room. In addition, the facility failed to properly cover and store the nasal cannula for two sampled Residents (#17 and #19), one (1) unsampled resident, and also the cannula attached to the oxygen concentrator in the East Wing dining room. Two (2) suction catheters attached to suction equipment were left uncovered for two (2) unsampled residents. These occurrences created the potential for cross-contamination, transmission of disease and infection.  The findings include:  Record Review of the Infection Control Policy (Revised August 2007) provided by the facility revealed established infection control practices will be observed. A stated objective within the policy is to prevent infections within the facility and monitor the environment to "help prevent and manage transmission of diseases and infections."  Record review of the facility's Infection Prevention and Control policy as it pertains to Dining Environment and the Serving of Meals stated the facility will provide a safe dining environment for residents during every meal, and designated waste disposal as indicated will be used when there is potential and/or direct exposure to body	F 441	3. Our Infection Control Nurse will inservice nurses on 2/10/2011 and CNAs on 2/17/11 regarding their responsibilities in cleaning and storage of equipment such as suction equipment, oxygen equipment and nebulizers.  4. QA will be done by Infection Control Nurse weekly and findings brought to monthly QA meeting.	2/28/11



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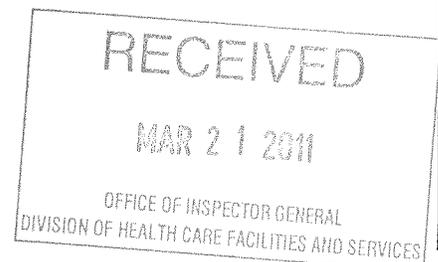
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F 441	<p>Continued From page 11 fluids.</p> <p>Observation of the lunch meal service in the South Wing dining room on 01/18/11 at 12:20pm revealed Licensed Practical Nurse (LPN) #4 removed bread from a wax paper wrapper with her bare hands for one (1) unsampled resident. The same LPN used a bib to clean nasal secretions from one (1) unsampled resident and afterwards placed the bib on the dining table. Additionally, a Certified Nursing Assistant (CNA) on 01/18/11 at 12:30pm in the East Wing dining room removed bread from a wax paper wrapper with her bare hands for one (1) unsampled resident and buttered it for the resident.</p> <p>A telephone interview with LPN #4 on 01/19/11 at 4:10pm revealed she had worked at the facility for one year. She stated when hired the facility provided and she attended Infection Prevention and Control training followed by in-service. She admitted touching one (1) unsampled resident's bread with her bare hands on 01/18/11 during the lunch meal service. She also admitted using a bib to wipe one (1) unsampled resident's nose and then placing the bib on the dining room table. She acknowledged this practice did not follow Infection Prevention and Control policy and could cause cross-contamination and lead to the spread of illness or disease.</p> <p>Interview with the Infection Prevention and Control Nurse on 01/19/11 at 2:30pm revealed LPN #4 received in-service training in Infection Prevention and Control specifically pertaining to the handling of food in a dining room setting.</p> <p>Interview with the Director of Nursing on 01/19/11 at 2:15pm revealed the facility has a policy and</p>	F 441		



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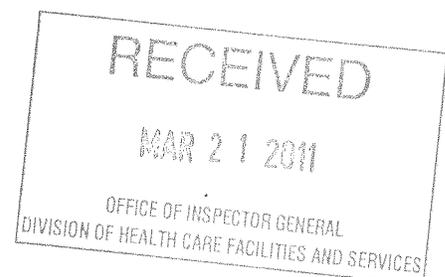
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F 441	Continued From page 12 procedure for infection control and an Infection Prevention and Control Program in place. She stated that if a staff member is not following procedures for proper handling of food during meals, it is not due to a lack of training and education by the facility.  Observation on 01/18/11 at 9:35am and 01/19/11 at 9:30am revealed the suction catheter at the bedside in room 328-B was on the nightstand, uncovered and unprotected.  Observation on 01/19/11 at 6:40pm revealed the suction catheter for Resident #17 was sitting on the nightstand uncovered and exposed, touching the wall. The oxygen tubing was also touching the floor while attached to the resident.  Observation of the East Dining Room on 01/18/11 at 12:30pm and 01/19/11 at 12:05pm revealed a nasal cannula hanging open and exposed on an oxygen concentrator.  Observation on 01/18/11 at 9:35am revealed uncovered nasal cannula tubing in room 328-B. Also, on 01/19/11 at 4:30pm, the oxygen tubing attached to the concentrator in the room of Resident #19 was uncovered, unprotected and touching the garbage can placed next to it.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced	F 465	F 465  1. All residents in rooms 322, 323, 324, 325 and 327 received new toothbrushes, which are properly labeled, on 01/20/11. All wheelchairs and the one Geri-chair were removed from service or repaired by 2/07/11.	



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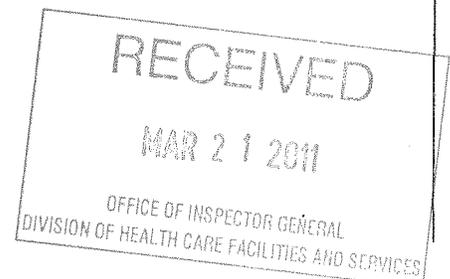
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F 465	<p>Continued From page 13</p> <p>by: Based on observation and interview it was determined the facility failed to maintain services necessary to maintain a sanitary, orderly, and comfortable interior. Four (4) wheelchairs and one (1) Geri-chair had torn arm rest padding and seat cushions. Five (5) resident rooms had communal toothbrush holders holding two or more unprotected toothbrushes.</p> <p>The findings include:</p> <p>Record review of the facility's policy for care of equipment on 01/19/11 revealed the facility was unable to provide a policy to ensure residents' care equipment is cleaned and properly maintained.</p> <p>Observation revealed toothbrushes were stored in an unsanitary manner in cups or holders, unprotected in rooms 322, 323, 324, 325 and 327. The toothbrushes had no identification as to which toothbrush belonged to which resident.</p> <p>Observation on 01/19/11 at 12:15pm on the North Wing revealed the seat cushion on the resident's wheelchair in Room 207 B was cracked, the seat cushion on the resident's wheelchair in 208 B was stained, the arm pads on residents' wheelchairs in Rooms 301 A and 307 B were cracked, the back cushion of a resident's Geri-chair in Room 307 was cracked and worn.</p> <p>Interview on 01/19/11 at 03:30pm with the Director of Maintenance Services revealed the facility had no written policy or system in place to ensure residents' care equipment is clean and properly maintained. The Director of Maintenance Services revealed nursing services</p>	F 465	<p>2. All residents will receive new toothbrushes that will be labeled with names and covered with a protective cap by 02/11/11. All other wheel chairs, Geri-chairs and resident room furniture will be inspected to ensure a comfortable environment.</p> <p>3. New policy and procedure for handling and storage of toothbrushes is being implemented. Toothbrushes with protective caps will be used and will be replaced quarterly and labeled with resident's names. Infection control nurse will QA toothbrushes weekly until we are satisfied the system is working. Chairs are currently inspected quarterly for proper functioning. An individual assigned by the Administrator will begin inspecting resident care equipment monthly for flaws in cushions, fabric or vinyl.</p> <p>4. Results from the Infection Control Nurse and Administrative designee will be presented to the monthly QA committee.</p>	2/28/11



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F 465	Continued From page 14 completes a work order for equipment needing repair and the Director of Maintenance Services reported a pink copy is kept in the maintenance department until the repair is completed, and then the pink copy is destroyed. The Director of Maintenance Services reported the wheelchairs were checked and tagged annually for safety.  Interview on 01/19/11 at 04:15pm with the Director of Nursing (DON) revealed maintenance is responsible for the care of the wheelchairs and cushions. The DON reported it was likely the nurses are responsible to complete a work order, and apologized for not having a better system of communication in place.	F 465			



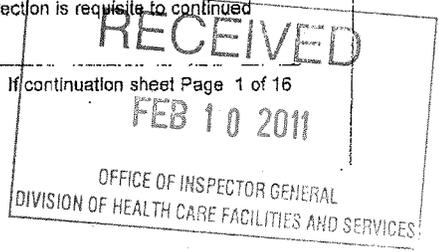
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K 000	INITIAL COMMENTS  A Life Safety Code survey was initiated and concluded on 01/19/11. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observation and interview during the survey on 01/19/11, it was determined the facility failed to ensure the fire barrier walls would resist the passage of smoke/fire to other areas of the facility in the event of a fire. The deficient practice could affect staff and residents. The facility has the capacity for 128 beds and at the time of the survey the census was 125.  The findings include:  Observation on 01/19/11 at 1:56pm with the Maintenance Director, and the Administrator revealed penetrations in the smoke barriers in the	K 025	K 025  1 & 2. All smoke barrier doors and walls will be inspected by the Maintenance Director. All holes, gaps and penetrations will be corrected using "Fire Stop" caulking. All repairs will be completed by 02/28/11.  3. Maintenance Director will retrain maintenance staff on the proper procedure for maintaining smoke barrier wall and doors by 02/28/11. A quarterly inspection by the Maintenance staff of all smoke barrier wall and doors will be included in our maintenance QA schedule.  4. The Maintenance Director will keep documentation of inspections and will provide said documentation to the QA committee.	2/28/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Leslie J. Butterfield* TITLE *Administrator* (X6) DATE *02/09/11*

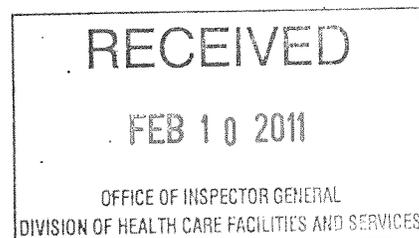
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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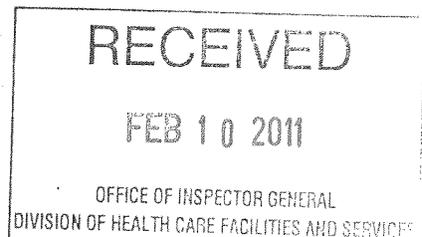
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K 025	Continued From page 1 North Wing  Interview with the Maintenance Director on 01/19/11 at 1:56pm, indicated he had not seen the openings.  NFPA 101 19.3.7.3 Standard: Smoke barriers shall be continuous from an outside wall to an outside wall. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces per NFPA 101 8.3.2. When pipes, conduits, cables, wires, air ducts and similar building service equipment pass through smoke barriers, the space between the penetrating item and the smoke barrier shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or protected by an approved device that is designed for the specific purpose per NFPA 101 8.3.6.1.	K 025			
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-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 19.2.2.6. 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	K 027			



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K 027	Continued From page 2 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. These doors must close all the way to help prevent fire/smoke from reaching other parts of the building in a fire situation. The deficiency has the potential to affect two (2) smoke compartments, fifty one (51) residents, staff, and visitors.  The findings include:  Observation on 01/19/11 at 2:15pm, with The Maintenance Director, and the Administrator, revealed the smoke doors located in the North Wing had too large of a gap. Interview with the Maintenance Director at that time revealed he was not aware of the size of the gap between these doors.  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. NFPA 101 LIFE SAFETY CODE STANDARD	K 027	K 027  1 & 2. Smoke barrier doors located on the North Wing were repaired on 02/07/11. All corridor doors will be inspected by the Maintenance Director and repaired if required by 02/28/11.  3. The Maintenance Director will inservice his staff regarding the proper operation and maintenance of corridor doors. All corridor doors will be inspected on a monthly basis by one of the maintenance staff.  4. The Maintenance Director will keep documentation of inspections and will provide said documentation to the QA committee.	2/28/11
K 038 SS=F	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

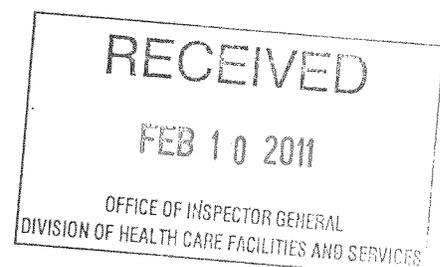


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K 038	Continued From page 3  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain egress requirements, according to NFPA standards.  The findings include:  Observation on 01/19/11 at 11:12am, with the Maintenance Director and the Administrator, revealed a door marked as an exit leading from the East Dining Room could not be opened from the egress side, but the door could be opened from the television room. An interview with the Maintenance Director revealed the horizontal sliding doors were installed to prevent noise from the dining room, during times of special entertainment, from interfering with the residents that are in the television room.  Observation on 01/19/11 at 9:45am, with the Maintenance Director, revealed the use of door guards to keep residents from wandering into another residents' room. These door guards were made of vinyl covering with metal hooks at each end, the door frames had matching eyelets to receive the hooks.  Interview on 01/19/11 at 9:45am with the Maintenance Director revealed they were not aware these type door guards were not permitted on resident doors.	K 038	K 038  1 & 2. The horizontal sliding door at the East Wing Dining Room was modified by a licensed contractor on 02/04/11. The door latch is now accessible at all times from both sides of the door. This situation does not exist anywhere else in our facility.  3. The sliding door will be inspected on a monthly basis by one of the maintenance staff to ensure proper operation.  4. The Maintenance Director will keep documentation of inspections and will provide said documentation to the QA committee.  1 & 2. Most of the door guards were removed on the last day of our survey. The last of the door guards and door hooks were removed from all resident doors on 02/01/11.  3. Mesh Guards with stop signs were ordered on 01/20/11. The new devices are held in place by Velcro strips. The Maintenance Director will train his staff on the proper installation and use of the Velcro guards by 02/28/11.	

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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  01/19/2011
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)	(X5) COMPLETION DATE
K 038	Continued From page 4  Reference: NFPA 101 (2000 edition) 19.2.2.2.4  Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.)  SECTION 7.2 MEANS OF EGRESS COMPONENTS 7.2.1 Doors. 7.2.1.1 General. 7.2.1.1.1 A door assembly in a means of egress shall conform to the general requirements of Section 7.1 and to the special requirements of 7.2.1. Such an assembly shall be designated as a door. 7.2.1.1.2 Every door and every principal entrance that is required to serve as an exit shall be designed and constructed so that the path of egress travel is obvious and direct. Windows that, because of their physical configuration or design and the materials used in their construction, have the potential to be mistaken for doors shall be made inaccessible to	K 038	4. The Maintenance Director will monitor hallways to ensure no other type of door guards are installed without his knowledge. He will report issues at the next scheduled morning Department Head meeting.	2/28/11

