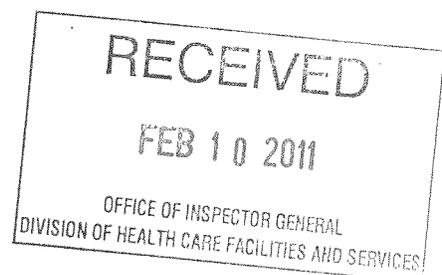


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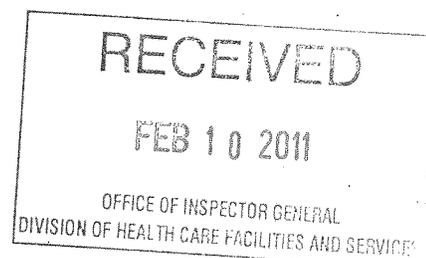
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/19/2011
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR NURSING HOME			STREET ADDRESS, CITY, 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 5 the occupants by barriers or railings. 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings. Reference: NFPA 101 (2000 edition) 7.2.1.14 Horizontal Sliding Doors. Horizontal sliding doors shall be permitted in means of egress, provided that the following criteria are met: (1) The door is readily operable from either side without special knowledge or effort.	K 038		



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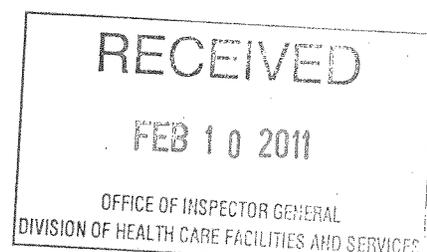
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K 038	Continued From page 6 (2) The force that, when applied to the operating device in the direction of egress, is required to operate the door is not more than 15 lbf (67 N). (3) The force required to operate the door in the direction of door travel is not more than 30 lbf (133 N) to set the door in motion and is not more than 15 lbf (67 N) to close the door or open it to the minimum required width. (4) The door is operable with a force not more than 50 lbf (222 N) when a force of 250 lbf (1110 N) is applied perpendicularly to the door adjacent to the operating device, unless the door is an existing horizontal sliding exit access door serving an area with an occupant load of fewer than 50. (5) The door assembly complies with the fire protection rating and, where rated, is self-closing or automatic-closing by means of smoke detection in accordance with 7.2.1.8, and is installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows.	K 038		
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4,	K 051	PLEASE SEE NEXT PAGE.	



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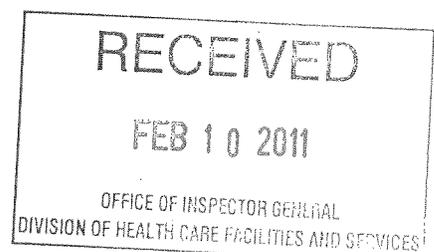
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K 051	<p>Continued From page 7 9.6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the building's fire alarm system as required by the National Fire Protection Association (NFPA) Standard 72. This deficient practice affected one (1) smoke compartment, eighteen (18) residents and staff.</p> <p>The findings include:</p> <p>Observation during the Life Safety Code inspection on 01/19/11 at 10:05am revealed the fire pull initiation device was mounted higher than required 4 1/2 ft. The device is located in the South Wing next to room 118. Interview with the Maintenance Director on 01/19/11 at 10:00am, indicated he did not realize the pull initiation device was mounted too high.</p> <p>Reference: NFPA 72 (1999 Edition) 2-8.1 Mounting. Each manual fire alarm box shall be securely mounted. The operable part of each manual fire alarm box shall be not less than 3 1/2 ft (1.1 m) and not more than 4 1/2 ft</p>	K 051	<p>K 051</p> <p>1 & 2. After being made aware of the regulation for pull stations to be mounted no more than 4 ½ feet high, a facility wide inspection of all pull stations was completed by the Maintenance Director on 01/20/11. Two additional pull stations were found to be too high, one in the South Wing Dining Room and one at the front door of the facility. Simplex/Grinnell was contacted and they completed an assessment for lowering the pull stations on 02/04/11. The pull stations will be lowered by Simplex/Grinnell to under 4 ½ feet by 02/18/11.</p> <p>3 & 4. All further installations of pull stations will be approved by the Maintenance Director.</p>	2/18/11



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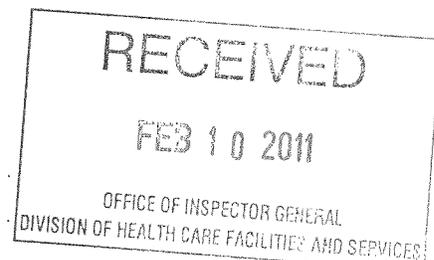
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K 051 K 056 SS=F	Continued From page 8 (1.37 m) above floor level. NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide 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 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, according to NFPA standards. The deficiency could affect all one-hundred and twenty-five (125) residents, visitors and staff. The facility is licensed for one-hundred and twenty-eight (128) beds and the census on the day of the survey was one-hundred and twenty-five (125). The findings include: Observation on 01/19/11 at 10:30am with the Maintenance Director, revealed the canopy over the exit located in the North wing of the facility was over four (4) feet in length, constructed with combustible material, and was not sprinkled. Further observation during the Survey revealed	K 051 K 056	K056 1 & 2. The Maintenance Director contacted Hussing Mechanical, who does all sprinkler work for our facility. An inspection was completed by Hussing and the materials have been ordered and all work will be completed by 02/28/11. We are going to put a sprinkler head at all exits with an overhang even if it is less than 4 feet in length. 3 & 4. In the future any canopies added to the building will be monitored by the Director of Maintenance to ensure all areas of the building are properly sprinkled. Director will inform QA committee when work is complete.	2/28/11	



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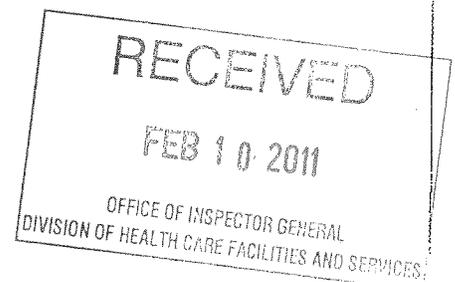
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K 056	Continued From page 9 that another canopy over the South exit and two (2) canopies over the East exits were over four (4) feet in length, constructed with combustible materials, with no sprinklers. Interview with the Maintenance Director on 01/19/11 at 10:30am, indicated that he was not aware that the canopies and overhangs needed to be sprinkled. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure space heaters used in the facility were of the approved type, according to NFPA standards. The deficiency has the potential to affect one (1) of eight (8) smoke compartments, approximately	K 070	K 070 1 & 2. The space heater found in the medical records department was removed immediately. An inspection of all space heaters will be completed by 02/04/11. 3. All space heaters will be inspected and tagged by the Maintenance Department before being used. A log of all space heaters will be kept by the Maintenance Director. All space heaters will be inspected yearly to ensure they are safe to operate and do not exceed 212 degrees F. 4. Log will be made available to the QA committee upon request.	2/18/11



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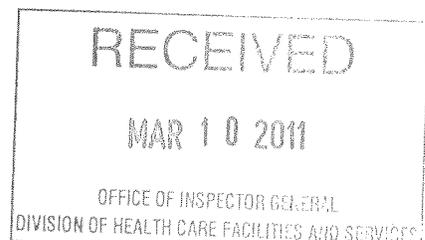
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K 070	Continued From page 10 twenty (20) residents, staff within the compartment and visitors. The findings include: Observation on 01/19/11 at 1:05pm revealed a space heater was being used in the medical records office. The observation was confirmed with the Maintenance Director. Interview on 01/19/11 at 1:05pm, with the Maintenance Director, revealed the facility had no documentation for the heater, documenting its temperature range. Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). NFPA 101 LIFE SAFETY CODE STANDARD	K 070		
K 073 SS=E	No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility,	K 073		



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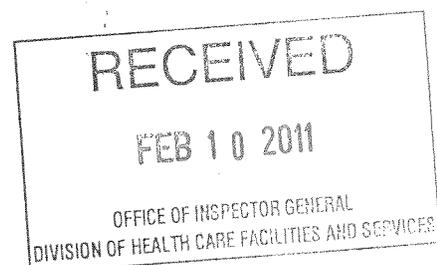
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K 073	Continued From page 11 according to NFPA standards. The deficiency could affect all one-hundred and twenty-five (125) residents, visitors and staff. The facility is licensed for one-hundred and twenty-eight (128) beds and the census on the day of the survey was one-hundred and twenty-five (125). The findings include: Observation and interview with the Maintenance Director on 01/20/11 at 10:00am revealed there were hanging decorations on the doors in various locations throughout the facility. The Maintenance Director indicated that the decorations were treated with a fire retardant spray, but did not have documentation of a written policy. Interview with the Administrator and Maintenance Director on 01/20/11 at 12:55pm, indicated that they did not have a written policy for treating the decorations but would implement a policy for documentation. Reference : NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	K073 1. Residents and families, who had decorations on their door, are being notified and unapproved door decorations will be removed by 02/18/11. 2. All residents could be affected. 3. A letter will go out to all responsible parties, by 02/24/11, informing them of the rules for decorations placed on doors. A new policy and procedure for approving and monitoring door decorations is being implemented. The policy and procedure will be presented to the QA committee on 02/17/11 for approval. 4. The Activities Director will be responsible for monitoring and policing decorations brought in by family members or residents. Issues will be brought to the QA committee to ensure we stay in compliance.	2/24/11
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		



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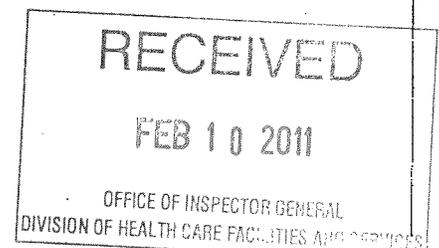
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K 073	Continued From page 11 according to NFPA standards. The deficiency could affect all one-hundred and twenty-five (125) residents, visitors and staff. The facility is licensed for one-hundred and twenty-eight (128) beds and the census on the day of the survey was one-hundred and twenty-five (125). The findings include: Observation and interview with the Maintenance Director on 01/20/11 at 10:00am revealed there were hanging decorations on the doors in various locations throughout the facility. The Maintenance Director indicated that the decorations were treated with a fire retardant spray, but did not have documentation of a written policy. Interview with the Administrator and Maintenance Director on 01/20/11 at 12:55pm, indicated that they did not have a written policy for treating the decorations but would implement a policy for documentation. Reference : NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	K073 1 & 2. Residents and families are being notified and unapproved door decoration will all be removed by 02/18/11. 3. A new policy and procedure for approving door decorations and documenting untagged decoration is being implemented. The policy and procedure will be presented to the QA committee for approval. 4. The Activities Director will be responsible for monitoring and policing decorations brought in by family members or residents. Issues will be brought to the QA committee to ensure we stay in compliance.	2/18/11
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		



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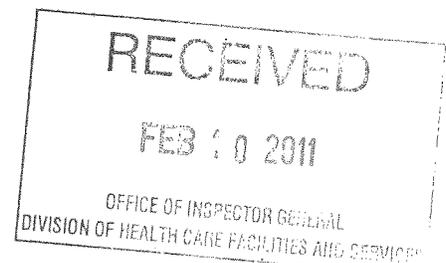
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K 147	Continued From page 12 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficient practice affected three (3) of five (5) smoke compartments, staff and approximately fifty nine (59) residents. The facility has the capacity for 128 beds with a census of 125 the day of survey. The findings include: Observations on 01/19/11, with the Director of Maintenance and the Administrator revealed: 1) A light fixture in a janitor's closet located in the North Wing did not have an approved cover. The unapproved fixture did not meet the minimum requirements for distance from shelving. Interview with the Director of Maintenance and the Administrator, confirmed they were not aware that the light fixture used in the closet had any regulations associated with it. 2) Room #209 had an unapproved extension cord in use. Interview with the Director of Maintenance and the Administrator, revealed the Director of Maintenance does try to stop extension cords from being used but family members of residents bring them in not knowing they cannot be used. 3) Two linen closets located in the North and South Wing had storage in front of electrical panels. Interview with the Director of Maintenance and the Administrator, confirmed the practice of storage in front of electrical panels. They moved the items and said that they would post signs and inform all staff that these areas could no longer	K 147	K 147 1. The light fixture in the janitor's closet located in the North Wing will be replaced. 2. All other closets will be inspected and brought into compliance if needed. 3. A policy will be written and maintenance staff will be informed of the new policy. The installation of any light fixture in the facility must be approved by the Maintenance Director. 4. Once all modifications are complete, the Maintenance Director will show all work, related to the new policy, to the Administrator for final approval. 1. The extension cord in room 209 was removed immediately. 2. All rooms received a walk through inspection on 02/01/11. No additional extension cords were found. 3. All rooms will be inspected for extension cords on a monthly basis by the maintenance staff and results will be documented and presented to the Director. 4. The Maintenance Director will provide documentation to the QA committee upon request.	



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K 147	<p>Continued From page 13 be used for storage.</p> <p>4) Open junction boxes were observed in the attic of the North Wing.</p> <p>Interview with the Director of Maintenance and the Administrator, confirmed that they were unaware of the open junction boxes in the attic, and would get the covers and install them properly.</p> <p>(1) Reference NFPA 70 (1999 Edition) 410.8 Luminaires (Fixtures) in Clothes Closets. (A) Definition. Storage Space. The volume bounded by the sides and back closet walls and planes extending from the closet floor vertically to a height of 1.8 m (6 ft) or the highest clothes-hanging rod and parallel to the walls at a horizontal distance of 600 mm (24 in.) from the sides and back of the closet walls, respectively, and continuing vertically to the closet ceiling parallel to the walls at a horizontal distance of 300 mm (12 in.) or the width of the shelf, whichever is greater; for a closet that permits access to both sides of a hanging rod, this space includes the volume below the highest rod extending 300 mm (12 in.) on either side of the rod on a plane horizontal to the floor extending the entire length of the rod. FPN: See Figure 410.8.</p> <p>Figure 410.8 Closet storage space. (B) Luminaire (Fixture) Types Permitted. Listed luminaires (fixtures) of the following types shall be permitted to be installed in a closet: (1) A surface-mounted or recessed incandescent luminaire (fixture) with a completely enclosed lamp</p>	K 147	<ol style="list-style-type: none"> The floor area in front of the electrical panels in the North and South Wing Linen Closets have been modified by a Licensed Contractor to help prevent items from being placed in front of the panels. All other electrical panels will be monitored and signs posted to keep areas in front of panels clear. These areas will be placed on our weekly monitoring list and documented. The Maintenance Director will provide documentation to QA committee upon request. <ol style="list-style-type: none"> Junction boxes found open in the attic have been sealed. A complete attic inspection will be completed by 02/28/11. All junction boxes found will be repaired if needed. Upon completion of the inspection, all attic access doors will be secured with plastic tie straps. The attic access doors will be inspected on a walk-through weekly. If the straps have been removed an inspection of that attic area will take place. A policy will be written for our new procedure. Maintenance staff will be inserviced on the new procedure.



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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	
(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 147	Continued From page 14 (2) A surface-mounted or recessed fluorescent luminaire (fixture) (C) Luminaire (Fixture) Types Not Permitted. Incandescent luminaires (fixtures) with open or partially enclosed lamps and pendant luminaires (fixtures) or lampholders shall not be permitted. (D) Location. Luminaires (fixtures) in clothes closets shall be permitted to be installed as follows: (1) Surface-mounted incandescent luminaires (fixtures) installed on the wall above the door or on the ceiling, provided there is a minimum clearance of 300 mm (12 in.) between the luminaire (fixture) and the nearest point of a storage space (2) Surface-mounted fluorescent luminaires (fixtures) installed on the wall above the door or on the ceiling, provided there is a minimum clearance of 150 mm (6 in.) between the luminaire (fixture) and the nearest point of a storage space (3) Recessed incandescent luminaires (fixtures) with a completely enclosed lamp installed in the wall or the ceiling, provided there is a minimum clearance of 150 mm (6 in.) between the luminaire (fixture) and the nearest point of a storage space (4) Recessed fluorescent luminaires (fixtures) installed in the wall or the ceiling, provided there is a minimum clearance of 150 mm (6 in.) between the luminaire (fixture) and the nearest point of a storage space (2) Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D 2. Minimum Number of Receptacles. The number of receptacles shall be determined by the	K 147	4. The Maintenance Director will provide documentation of weekly rounds to QA committee upon request Check lists, policies and all in-services and training will be completed by:	2/28/11

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

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K 147	<p>Continued From page 15</p> <p>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.</p> <p>(3) Reference: NFPA 70 (1999 edition)</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>(4) Reference: NFPA 70 (1999 edition)</p> <p>370.28(c) Covers.</p> <p>All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.</p>	K 147			