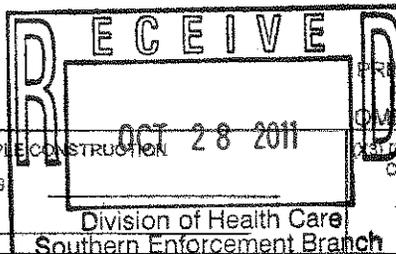


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 10/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185257 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>10/06/2011 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>CEDARS OF LEBANON NURSING CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>337 SOUTH HARRISON STREET<br>LEBANON, KY 40033 |
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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 |
|--------------------|---|---------------|--|----------------------|
| F 000              | INITIAL COMMENTS<br><br>A standard health survey was conducted on 10/04-06/11. Deficient practice was identified with the highest scope and severity at "E" level.<br><br>An abbreviated standard survey (KY17083) was also conducted at this time. The complaint was substantiated with related deficiencies.  | F 000         | The preparation and execution of this plan does not constitute admission or agreement by the provider, of truth of the facts alleged or conclusions set forth in the statement of deficiency. The plan of correction is prepared and executed solely because it is required by the Federal and state law.  |                      |
| F 164<br>SS=D      | 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS<br><br>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.<br><br>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.<br><br>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.<br><br>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. | F 164         | F-164<br>It is the policy and culture of this facility to provide for the personal privacy for all of the residents of Cedars of Lebanon Nursing Center.<br><br>1. The resident was immediately provided privacy by Staff Development Nurse. The contract Rehab Speech Language Pathologist (SLP) was removed from the facility and replaced.<br><br>2. The Facility immediately performed evaluations on the rehab providers cases and all other residents in the facility to determine if other residents had been affected by the deficient practice. No other residents were found affected by practice.<br><br>3. All staff were reeducated through the use of in-services conducted on 10/17/11-10/18/11, which detailed the proper procedure for providing privacy, maintaining dignity, understanding the needs of residents while performing care for a resident in their environment. (See Exhibit # 1, Privacy and Dignity In-service sign in sheet for rehab and Exhibit # 1A Privacy and Dignity In-service sign in sheet for facility) |                      |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><i>Robbie Eustrom</i> | TITLE<br><i>Administrator</i> | (X6) DATE<br><i>10/28/11</i> |
|--|-------------------------------|------------------------------|

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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| F 164  | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to provide visual privacy for one of seventeen sampled residents (Resident #11).<br><br>The findings include:<br><br>Review of the facility's policy titled Privacy and Confidentiality (effective date 10/01/07) revealed residents had a right to personal privacy during medical treatments and privacy of the resident's body would be maintained during examinations and treatments.<br><br>Review of the record revealed the facility admitted Resident #11 on 05/20/11, with diagnoses of Down's Syndrome, Severe Mental Retardation, Seizure Disorder, and Dysphagia. Review of the Quarterly Minimum Data Set (MDS) dated 08/11/11, revealed Resident #11 required extensive assistance to total assistance from staff for all activities of daily living.<br><br>Observation on 10/05/11, at 9:35 AM, revealed Resident #11 in his/her room and in plain view from the nurses' station. Continued observation revealed a Speech/Language Pathologist (SLP) entered Resident #11's room. The SLP attached small electrodes to Resident #11's neck to initiate a treatment of Vital Stimulation (an external electrical current to stimulate the muscles responsible for swallowing). Further observation revealed the SLP failed to ensure personal privacy was provided during the treatment and | F 164  | F-164 Continued<br><br>4.A quality instrument will be utilized by Director of Nursing or ADON to evaluate residents privacy considerations by the staff while performing care that privacy curtains are pulled together appropriately, doors are closed (See Exhibit # 2, privacy/dignity monitor).<br>If there are any indications that a residents privacy may be jeopardized the DON/ADON will remind and provide appropriate one on one education with the staff member before an incident occurs. The DON/ADON, will provide the quality forms weekly for evaluation and review with the Continuous Quality Committee (Morning Stand Up). This process will continue on a weekly basis for the period of not less than one month, longer if less than 100% compliance is met, The quality evaluation will continue to be performed three times per week at random by the DON or ADON for the period of not less than one month until 100 % compliance is maintained. |                      |   |

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| F 164   | Continued From page 2<br>the resident remained in plain view. The SLP assisted the resident to drink during the Vital Stimulation and provided oral care all in view of staff and visitors that were in the hallway or near the nurses' station. The resident responded by making incoherent sounds as though having some discomfort with the treatment.<br><br>An interview conducted on 10/06/11, at 9:10 AM, with the SLP revealed Vital Stimulation was provided to activate/strengthen the throat muscles responsible for swallowing. The SLP stated the treatment could produce discomfort as the electrical current stimulated/squeezed the muscles. The SLP stated the intensity of the treatment should be adjusted according to the resident's reaction or if the resident was able to verbally express the discomfort. The SLP stated the intensity of the treatment for Resident #11 required lowering because the resident made incoherent sounds. The SLP stated privacy should be provided during any treatment and she just failed to close the door. The SLP was unaware a privacy curtain was available for the resident in the first bed located nearest the door. | F 164   | F-164 Continued.<br><br>The Administrator will then poll five random residents to monitor dignity and privacy, once weekly for one month until 100% compliance is maintained. (See Exhibit #2, privacy and dignity monitor) and report findings to the Quality Assurance Committee for determination if further action plans are needed. | 10/28/2011           |   |
| F 241<br>SS=D   | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review,   | F 241   | F-241<br><br>1.The signage was immediately removed by Staff Development Nurse. The contract Rehab Speech Language Pathologist (SLP) was removed from the facility and replaced.  |                      |   |

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| F 241  | <p>Continued From page 3</p> <p>and review of facility policy, the facility failed to promote care in a manner that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality for one of seventeen sampled residents (Resident #11).</p> <p>The findings include:</p> <p>Review of the facility's policy titled Resident's Rights/Federal Law (dated 10/2007) revealed residents had a right to personal privacy and confidentiality of his/her personal and clinical records.</p> <p>Review of the record revealed the facility admitted Resident #11 on 05/20/11, with diagnoses of Down's Syndrome, Severe Mental Retardation, Seizure Disorder, and Dysphagia. Review of the Quarterly Minimum Data Set (MDS) dated 08/11/11, revealed Resident #11 was severely impaired in daily decision-making and required extensive to total assistance for all activities of daily living.</p> <p>Observation on 10/05/11, at 9:00 AM, revealed a sign was taped to the wall above Resident #11's bed. The sign listed the resident's name, room number, and had in large bold letters that were highlighted: "Patient is A Silent Aspirator" and "Patient does not cough or choke when food/liquid enters the airway. Sit upright at 90 degrees. Stay upright for at least 30 minutes after taking anything by mouth." Further observation revealed the sign was dated 07/20/11, and signed by the Speech/Language Pathologist (SLP).</p> <p>Interview on 10/06/11, at 9:10 AM, with the SLP</p> | F 241  | <p>F-241 Continued</p> <p>2. The Director of Nursing immediately performed evaluations on the rehab providers cases and all other residents to determine if other residents had been affected by the deficient practice. No other residents were found affected by practice.</p> <p>3.All staff were reeducated through the use of in-services conducted on 10/17/11-10/18/11, which detailed the proper procedure for providing privacy, maintaining dignity, understanding the needs of residents while performing care for a resident in their environment. (See Exhibit # 1 and 1A, Privacy, and Dignity In-service)</p> <p>4.A quality instrument will be utilized by Director of Nursing or ADON to evaluate residents privacy considerations by the staff while performing care that privacy curtains are pulled together appropriately, doors are closed (See Exhibit # 2, privacy/dignity monitor).<br/>If there are any indications that a residents privacy may be jeopardized the DON/ADON will remind and provide appropriate one on one education with the staff member before an incident occurs. The DON/ADON will provide the quality forms weekly for evaluation and review with the Continuous Quality Committee (Morning Stand Up).</p> |                      |   |

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| F 241  | Continued From page 4<br>revealed the signed was posted by the SLP. The SLP stated she had in-serviced staff on the proper feeding techniques required for Resident #11, and had posted the sign over Resident #11's bed to remind staff of the feeding requirements. The SLP also stated she was concerned for the safety of the resident during meals and felt by posting the sign the risk would outweigh the privacy/confidentiality issue.<br><br>Interview on 10/06/11, at 9:30 AM, with the Unit Coordinator (UC) revealed she was not aware of the feeding instructions sheet being posted above Resident #11's bed. The UC stated residents' private information should not be posted.   | F 241  | F-241 Continued<br>This process will continue on a weekly basis for the period of not less than one month, longer if less than 100% compliance is met, The quality evaluation will continue to be performed three times per week at random by the DON or ADON for the period of not less than one month until 100 % compliance is maintained. The Administrator will then poll five random residents to monitor dignity and privacy,once weekly for one month until 100% compliance is maintained. (See Exhibit #2, privacy and dignity monitor)and report findings to the Quality Assurance Committee for determination if further action plans are needed.   | 10/28/11             |   |
| F 253<br>SS=E  | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of the facility policy, it was determined the facility failed to provide effective housekeeping and maintenance services necessary to ensure a sanitary, orderly, and comfortable environment. Water temperatures were below the recommended temperatures on 10/04/11, on the Raley Hall, a footboard was broken with sharp edges exposed in room 145A, the shower chair on the Davis Hall had frayed edges, and three wheelchair armrests were torn and in need of | F 253  | F-253<br><br>1.A. Water Temperatures- Lanham HVAC was immediately notified a inspection revealed faulty piping and mixing valve. These items were immediately repaired. (See Exhibit #3, Lanham refrigeration).<br>B. Footboard located in room 145-A was immediately repaired. (See Exhibit #4, work order for footboard)<br>C. Shower chair located on Davis Hall- Shower chair had already been scheduled for replacement which arrived after survey (See Exhibit #5, shower chair invoice)<br>D. Wheelchair arms located in rooms 104, 125,138 were replaced with new ones immediately. (See Exhibit #6, work order wheelchair arm replacement)<br>E. "Mold like" substance Located in Davis Hall shower- was immediately scrubbed out of existence and sanitized by maintenance. (See Exhibit # 7, work order, cleaning of Davis Hall shower/grout) |                      |   |

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| F 253  | <p>Continued From page 5</p> <p>repair. In addition, the tile grout in the shower room on the Davis Hall had a black "mold like" substance and was in need of cleaning.</p> <p>The findings include:</p> <p>A review of the facility policy Monitoring Water Temperatures (effective 10/01/07) revealed the water temperatures were to be monitored weekly, documented on a log, and water temperatures outside the recommended safe range of 105 degrees Fahrenheit and 120 degrees Fahrenheit would be addressed immediately. However, in accordance with the State Operations Manual, the water temperature should be 100 to 110 degrees Fahrenheit.</p> <p>Observations during the environmental tour on 10/04/11, at 11:05 PM, revealed the water temperatures on the Raley Hall ranged from 88 degrees Fahrenheit to 94 degrees Fahrenheit and were below the State Operations Manual's recommended safe water temperatures of 100 to 110 degrees Fahrenheit. In addition an environmental tour conducted with the Maintenance Director on 10/06/11, at 10:00 AM, revealed the following areas in need of cleaning/repair: A footboard on bed A in Room 145 was broken and sharp edges were exposed; the seat of the shower chair in the Davis shower room was observed to consist of a plastic fabric that was frayed and sharp; the tile grout on the floor and wall in the Davis shower room was observed to be discolored with a black "mold like" substance and was in need of cleaning; and the arm rests on three wheelchairs located in rooms 104, 125, and 138 were in need of repair.</p> | F 253  | <p>F-253 Continued.</p> <p>2.A general wear and cleanliness inspection was conducted at that time(See Exhibit # 8, Monthly general wear inspection form) to determine if any additional residents were affected by the practice. Water temperatures were also monitored throughout the facility to ensure that there were no additional issues with low water temperatures. (See Exhibit # 9, water temperature monitoring form)</p> <p>3. A system review was conducted and the shower areas and general cleanliness was added to the monthly general safety inspection for each room.</p> <p>Policy for obtaining water temperatures was updated and in serviced on 10/06/11.(See Exhibit #10, Water temperature policy update)</p> <p>4.A monthly general wear and cleanliness monitor was added to the safety rounds (See Exhibit #8 Monthly general wear inspection)</p> <p>A water temperature monitor was updated to reflect varying times of obtaining temps, to include second and third shifts. Temps are to be monitored on all shifts by maintenance weekly and reported to Interdisciplinary Team (IDT) daily for any issues and monthly to Quality Assurance.</p> | 10/13/11             |   |

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| F 253  | <p>Continued From page 6</p> <p>Interview with Certified Nursing Assistants (CNAs) #1 and #2 on 10/04/11, at 11:17 PM and 11:40 PM, revealed the facility did not always have hot water during the third shift. The staff stated if a resident required a bed bath, a pan of hot water could be obtained from the kitchen and mixed with cold water to provide the needed warm water to bathe/provide care for residents. The CNAs stated Nursing staff was aware of the lack of hot water available on the nursing units to provide care.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 10/04/11, at 11:22 PM, revealed the Laundry/Housekeeping staff turns the hot water off before they leave at 10:30 PM, and turns the hot water on when they come in the next morning. The LPN stated showers were provided during the first shift and there had never been an issue with water being too cold during the first shift; however, incontinence care was provided by CNAs during the third shift, and the issue of cold water during that shift had been reported to the Director of Nursing.</p> <p>Interview with the Director of Nursing (DON) on 10/04/11, at 11:45 PM, revealed the third shift nurses had recently made her aware within the past several weeks that the water was cold during the night shift and that she had notified the Administrator of the cold water temperatures on 09/15/11. The DON was not aware Laundry/Housekeeping staff was "turning off" the hot water at night. The DON stated the facility had been working on the "mixing valve," trying to adjust the water temperatures.</p> <p>Interview with laundry aide #1 on 10/05/11, at</p> | F 253  |   |                      |   |

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| F 253   | <p>Continued From page 7</p> <p>10:00 AM, revealed the aide came in at 4:30 AM, and worked until 2:00 PM. The laundry aide said the breaker for the washing machines in the laundry room was in the "off" position at the beginning of the shift at 4:30 AM, and staff had to turn the breaker on to have access to hot water during the shift. The laundry aide also stated she had been at the facility for four years and was taught to turn the breaker off when she left for the day, and would turn the breaker off at the end of the shift at 2:00 PM.</p> <p>Interview with housekeeping aide #1 on 10/05/11, at 3:20 PM, revealed his normal hours were from 2:00 PM to 10:00 PM. The aide stated if a load of laundry needed to be washed he would turn the washing machine breaker on and would turn the breaker off when the laundry was completed.</p> <p>Interview with the Administrator on 10/05/11, at 8:30 AM, revealed he had been made aware by the DON on the morning of 09/15/11, that there was a lack of hot water in the facility. The Administrator reportedly had a repairman work on the water system and the Administrator thought the problem with a lack of hot water had been "fixed."</p> <p>An interview with the Maintenance Director on 10/05/11, at 3:30 PM, revealed water temperatures were monitored weekly in different areas of the building but were not monitored on different shifts. The Maintenance Director stated when the temperatures were outside of the safe range the mixing valve was usually the reason, and a plumber was called in to take care of the problem. The Maintenance Director was unaware the washing machine breaker had</p> | F 253   |   |                      |   |

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| F 253  | Continued From page 8<br>anything to do with insufficient hot water. In addition, although the Maintenance Director was aware the breaker was turned off at night, he was unaware the water from the hot water system was too cold for bathing or the provision of incontinence care during the third shift. In addition, the Maintenance Director was unaware of the torn armrests on the wheelchairs and stated new armrests were available in the facility. The Maintenance Director stated the tile in the Davis shower room was extremely difficult to keep clean and that the footboard in room 145 and the worn/torn shower chair would need to be replaced.   | F 253  |  |                      |   |
| F 322<br>SS=D  | 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, medical record reviews, and review of facility policy/procedure it was determined the facility failed to ensure one of fifteen sampled residents (Resident #6) received the appropriate services to prevent aspiration pneumonia. Resident #6 was observed on 10/05/11, to be lying in bed with the head of the bed elevated approximately 10 degrees while receiving a continuous | F 322  | F-322<br>1. Resident head of bed was immediately moved to 30 degrees, resident was assessed for any potential aspiration and found to be negative. The SRNA was counseled and reeducated immediately. (See Exhibit #11, SRNA counseling form). Kardex was immediately updated to reflect residents plan of care.<br><br>2. All residents that had tubes in place were evaluated and it was determined that no others were affected by the care.<br><br>3. Feeding tube policy was updated to reflect the changes on the Kardex at all times. SRNA and licensed staff in serviced on policy 10/18/11 (See Exhibit # 12, Feeding tube policy and sign in sheet). |                      |   |

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| F 322              | <p>Continued From page 9 gastrostomy tube feeding.</p> <p>The findings include:</p> <p>Review of the facility policy/procedure "Feeding Tubes Gastrostomy, PEG, etc." (dated as revised 09/23/08) revealed residents who received tube feedings must have the head of the bed elevated 30 degrees at all times.</p> <p>Review of the physician's orders for Resident #6 dated 03/12/11, revealed the head of the resident's bed was to be elevated 30-45 degrees at all times during feeding and at least 30-40 minutes after the feeding was stopped.</p> <p>Observation of Resident #6 on 10/05/11, from 8:45 AM to 12:15 PM, revealed the resident to be receiving nutrition via a gastrostomy tube. The feeding was delivered via a feeding pump at 50 cc (cubic centimeters) per hour continuously. The head of the resident's bed was elevated approximately 30 degrees. Observations on 10/05/11, at 1:40 PM, revealed Resident #6 in bed receiving the tube feeding at 50 cc per hour. The head of the resident's bed was not elevated and the resident was lying flat.</p> <p>Review of the comprehensive care plan for Resident #6 dated as revised on 04/26/11, revealed staff was required to elevate the head of the resident's bed 30-45 degrees at all times during feeding.</p> <p>Interview on 10/05/11, at 1:40 PM, with State Registered Nursing Assistant (SRNA) #6 revealed SRNA #6 was responsible for the care of Resident #6. The SRNA stated she had</p> | F 322         | <p>F-322 Continued</p> <p>4. Quality Monitor for residents receiving nutrition through enteral or any tube feeding was developed. (See Exhibit # 13, Quality Monitor for residents receiving nutrition through enteral feeding or other tube, the Head of bed is to be at 30 degrees). The Director of Nursing, ADON will perform the audit daily for 7 days until 100 % compliance has been achieved, then three times weekly for three weeks until 100% compliance has been achieved. Then monthly for three months or until 100% compliance is maintained. The Administrator will audit quality monitor for compliance at least weekly utilizing the HOB monitor form.</p> <p>Any suspected discrepancies will be remedied immediately. The quality monitor will be reviewed, reported and discussed with the Quality Assurance Committee for recommendations on monthly basis if needed.</p> | 10/18/11             |

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| F 322  | Continued From page 10<br>repositioned the resident prior to 1:40 PM, and was unaware the head of the resident's bed was not elevated as required.<br><br>Interview with SRNA #5 on 10/05/11, at 1:45 PM, revealed all residents receiving tube feedings were to have the head of the bed elevated 45 degrees at all times. SRNA #5 stated the head of Resident #6's bed was too low and should have been elevated.<br><br>Interview with the Director of Nursing (DON) on 10/05/11, at 1:50 PM, revealed SRNAs were required to consult the resident Kardex for all care needs. The DON stated all care needs for residents were on the Kardex. Upon review of the Kardex the DON stated there was no requirement for the resident's head to be elevated 30-45 degrees on the Kardex but it should have been documented. | F 322  |   |                      |   |
| F 371<br>SS=E  | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of the facility's Dietary Sanitation policy, it was  | F 371  | F-371<br><br>1. The range hood was immediately cleaned and disinfected, relieving the appliance of all dust and debris.<br><br>2. Given the the practice involved the range hood that is part of the food preparation for all residents, it was determined by IDT that all residents had the potential to have been affected. |                      |   |

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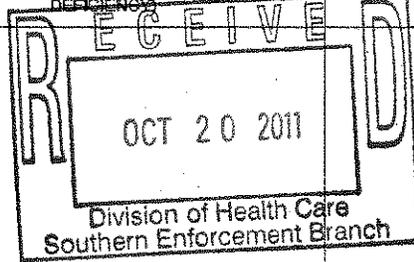
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| F 371  | <p>Continued From page 11</p> <p>determined the facility failed to prepare and distribute food under sanitary conditions. Observations revealed an excessive accumulation of dust on the gas range hood vent cover.</p> <p>The findings include:</p> <p>A review of the facility policy Dietary Sanitation (dated 10/01/07) revealed cleaning schedules for all equipment and areas of the Dietary Department were to be posted. In addition, according to policy, staff members assigned to clean the equipment were to document the equipment had been cleaned. The cleaning schedules were to be monitored on a daily basis by the Dietary Manager to verify staff had cleaned the equipment.</p> <p>Observation during the kitchen tour on 10/04/11, at 3:05 PM, revealed vents in the hood over the gas range were covered with a brown buildup of dust. The vent covers were located directly over the burners of the stove.</p> <p>An interview with the Dietary Manager (DM) on 10/04/11, at 3:10 PM, revealed the facility had an agreement with a company to pressure wash the vents every six months. According to the DM, the vents were scheduled to be cleaned in November 2011. The DM acknowledged the stove vent covers needed to be cleaned and that dust from the vents could fall into the residents' food while it was cooking.</p> | F 371  | <p>F-371</p> <p>3. The kitchen staff will provide routine cleaning of the range hood every month in addition to the contracted cleaning once per quarter. (See Exhibit #14, range hood cleaning inspection)</p> <p>4. The Administrator will monitor the monthly cleaning of the range hood every month x 3 months until 100% compliance has been achieved then every other month for 9 months.</p> | 10/10/11             |   |

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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: Unknown</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type III (000) Unprotected</p> <p>SMOKE COMPARTMENTS: Three smoke compartments</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (Wet and DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II Propane Generator</p> <p>A life safety code survey was initiated and concluded on 10/06/11. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for 81 beds and the census was 76 on the day of the survey.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> | K 000  |   |  |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Rosie Eastham* TITLE: *Administrator* (X6) DATE: 10/20/11

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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| K 018<br>SS=F  | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by:<br/>Based on observation and interview, it was determined the facility failed to ensure doors located in corridors were maintained according to National Fire Protection Association (NFPA) standards. Doors must be maintained in order to prevent the spread of smoke and flames. The deficiency had the potential to affect three of three smoke compartments, eighty-one residents, staff, and visitors.</p> <p>The findings include:</p> | K 018  | <p>K-018</p> <ol style="list-style-type: none"> <li>1. The hooks holding the plastic chains were removed completely and replaced with breakaway Velcro.</li> <li>2. An inspection was made of all the doors opening to the hallway. There were no other chains found to be of issue.</li> <li>3. At the suggestion of an inspector, the hooks were replaced by Velcro. All hooks were removed. (See Exhibit 15, work order hook removal)</li> <li>4. Through the monthly safety and routine maintenance it was added that the facility be inspected also for the use of hooks to secure chains at resident doors. If hooks are found they are to be removed and the Administrator is to be notified immediately. (See Exhibit #8 monthly maintenance wear inspection).</li> </ol> | 10/10/11                                     |

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| K 018   | <p>Continued From page 2</p> <p>Observation on 10/06/11, at 11:07 AM, with the Maintenance Supervisor revealed the facility had placed plastic chains on metal hooks on the following resident room door frames: resident rooms 101, 108, 110, 118, 122, 124, 140, and 139, and the beauty shop. Further observation revealed that the plastic chains would need to be removed in order to close the resident room doors, if the resident room doors were fully opened.</p> <p>Interview on 10/06/11, at 11:07 AM, with the Maintenance Supervisor, revealed the facility had placed the plastic chains on the resident room doorframes due to residents wandering into other resident rooms.</p> <p>Reference: NFPA 101 (2000 Edition),</p> <p>19.3.6.3 Corridor Doors.</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments</p> | K 018   |   |   |

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| K 018   | Continued From page 3<br>protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.<br><br>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.<br>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.<br>Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service. | K 018   |  |                      |   |
| K 025<br>SS=F   | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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   | K 025   | K-025<br><br>1. The penetrations were sealed immediately with fire proof caulking at each of the five penetrations. (See exhibit #16, work order sealing fire wall penetrations)<br><br>2. Since the fire wall system influences all other system in the facility, it is deemed by the IDT that all residents residing in the facility had the potential to be affected. |                      |   |

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| K 025  | Continued From page 4<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. Smoke barriers must be maintained to ensure they limit the transfer of smoke and fire into corridors and resident rooms. The deficiency had the potential to affect two of three smoke compartments, forty-one residents, staff, and visitors. The facility is licensed for 81 beds and the census was 76 on the day of the survey.<br><br>The findings include:<br><br>Observation on 10/06/11, at 10:30 AM, with the Maintenance Supervisor revealed the Dining Area smoke barrier had five non-filled penetrations around piping into the smoke barrier.<br><br>Interview on 10/06/11, at 10:30 AM, with the Maintenance Supervisor revealed he was unaware of the penetration in the smoke barrier.<br><br>Reference: NFPA 101 (2000 Edition).<br><br>8.2.4.4 Penetrations and Miscellaneous Openings in Smoke Partitions.<br><br>8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows: | K 025  | K-025 Continued<br><br>3. All open penetrations were sealed by fire rated caulking as recommended by inspector.<br><br>4. The fire walls are inspected quarterly for any issues that may arise. The inspection is reported to the Quality Assurance Committee, any discrepancies are documented and reported to the Administrator immediately. (See Exhibit # 17, smoke barrier monitor log). | 10/10/11                                     |

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| K 025  | Continued From page 5<br>(1) The space between the penetrating item and the smoke partition shall meet one of the following conditions:<br>a. It shall be filled with a material that is capable of limiting the transfer of smoke.<br>b. It shall be protected by an approved device that is designed for the specific purpose.<br>(2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions:<br>a. It shall be filled with a material that is capable of limiting the transfer of smoke.<br>b. It shall be protected by an approved device that is designed for the specific purpose.<br>(3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions:<br>a. It shall be made on either side of the smoke partitions. | K 025  |   |  |
| K 027<br>SS=F  | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¼-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<br><br>This STANDARD is not met as evidenced by:  | K 027  | K-027<br><br>1. The door was assessed for a door closure ,which was installed immediately.<br><br>2. Since the smoke barrier system influences all other systems in the facility, it is deemed by the IDT that all residents residing in the facility had the potential to be affected. |  |

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

PRINTED: 10/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |   |  |                      |   |
|---|--|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                            |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185267</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>10/06/2011</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDARS OF LEBANON NURSING CENTER</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>337 SOUTH HARRISON STREET<br/>LEBANON, KY 40033</b>  |                      |   |
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| K 027   | Continued From page 6<br>Based on observation and interview, the facility failed to maintain a smoke door that would close and resist the passage of smoke. The deficient practice affected two of three smoke compartments, staff, and forty-one residents. The facility has the capacity for 81 beds with a census of 76 on the day of the survey.<br><br>The findings include:<br><br>Observation on 10/06/11, at 10:30 AM, revealed that the door in the smoke barrier did not have a self-closure installed on the door as required by NFPA 101 Life Safety Code. Doors in smoke barriers are required to be self-closing to resist the passage of smoke.<br><br>Interview with the facility Maintenance Supervisor on 10/06/11, at 10:30 AM, revealed that the facility was not aware the door was required to have a closure installed on the door.<br><br>NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke. | K 027   | K-027 Continued.<br><br>3. A door closure was attached to the smoke barrier (See Exhibit #16, door closure)<br><br>4. The smoke barriers are inspected quarterly for any issues that may arise. This inspection is reported to the quality assurance committee any discrepancies are documented and reported to the Administrator immediately. (See Exhibit #17, smoke barrier monitor log). | 10/10/11             |   |
| K 147<br>SS=D   | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to use extension cords according to NFPA standards. Extension   | K 147   | K-147<br><br>1. The small washer was taken out of service immediately. A licensed electrician was contracted to remedy the issue.<br><br>2. The IDT inspected the area and determined that due to the potential for arching that all residents could have been affected.   |                      |   |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDARS OF LEBANON NURSING CENTER</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>337 SOUTH HARRISON STREET<br/>LEBANON, KY 40033</b>  |                      |   |
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| K 147   | <p>Continued From page 7</p> <p>cords must be used according to NFPA standards to limit the possibility of fire. The deficiency affected one smoke compartment and staff.</p> <p>The findings include:</p> <p>Observation on 10/06/11, at 10:45 AM, revealed a surge protector being used to supply power to a washing machine and chemical dispenser. Surge protectors cannot be used as permanent wiring.</p> <p>Interview on 10/06/11, at 10:45 AM, with the Maintenance Supervisor revealed he was unaware that the surge protector could not be used in this manner.</p> <p>Reference: NFPA 70 (1999 Edition).</p> <p>400-8. Uses Not Permitted<br/>Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> <li>1. As a substitute for the fixed wiring of a structure</li> <li>2. Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</li> <li>3. Where run through doorways, windows, or similar openings</li> <li>4. Where attached to building surfaces<br/>Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8.</li> <li>5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</li> <li>6. Where installed in raceways, except as</li> </ol> | K 147   | <p>K-147 Continued</p> <p>3. A licensed electrician was contracted to establish an electrical ground fault outlet x 2 for the area which carried the small washer.<br/>(See Exhibit #18, invoice for ground fault outlets).</p> <p>4. Wiring and outlets in various departments are monitored on a monthly basis and reported to Quality Assurance Committee<br/>(See Exhibit # 8, General maintenance monitor).</p> | 10/12/11             |   |

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|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDARS OF LEBANON NURSING CENTER</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>337 SOUTH HARRISON STREET<br/>LEBANON, KY 40033</b>                 |                      |   |
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| K 147   | Continued From page 8 otherwise permitted in this Code.  | K 147   |   |                      |   |

# EXHIBIT # 8

## Cedars of Lebanon Nursing Center Monthly Paint, Wiring, General Wear Inspection Month

|              |        |           |   |        |           |
|--------------|--------|-----------|---|--------|-----------|
| A101-1 Paint | Wiring | Gen. Wear | 138-1 Paint   | Wiring | Gen. Wear |
| Comment:     |        |           |   |        |           |
| A102-1 Paint | Wiring | Gen. Wear |   |        |           |
| A103-1 Paint | Wiring | Gen. Wear | 139-1 Paint   | Wiring | Gen. Wear |
| A104-1 Paint | Wiring | Gen. Wear |   |        |           |
| A105-1 Paint | Wiring | Gen. Wear | 140-1 Paint   | Wiring | Gen. Wear |
| A106-1 Paint | Wiring | Gen. Wear |   |        |           |
| A107-1 Paint | Wiring | Gen. Wear | 142-1 Paint   | Wiring | Gen. Wear |
| A108-1 Paint | Wiring | Gen. Wear |   |        |           |
| A110-1 Paint | Wiring | Gen. Wear | 143-1 Paint   | Wiring | Gen. Wear |
| A112-1 Paint | Wiring | Gen. Wear | 144-1 Paint   | Wiring | Gen. Wear |
| A114-1 Paint | Wiring | Gen. Wear | 145-1 Paint   | Wiring | Gen. Wear |
| A116-1 Paint | Wiring | Gen. Wear | 146-1 Paint   | Wiring | Gen. Wear |
| A118-1 Paint | Wiring | Gen. Wear | 147-1 Paint   | Wiring | Gen. Wear |
| A119-1 Paint | Wiring | Gen. Wear | 148-1 Paint   | Wiring | Gen. Wear |
| A120-1 Paint | Wiring | Gen. Wear | 149-1 Paint   | Wiring | Gen. Wear |
| A121-1 Paint | Wiring | Gen. Wear | 150-1 Paint   | Wiring | Gen. Wear |
| A122-1 Paint | Wiring | Gen. Wear | Cleanliness of facility:<br>No metal hooks used to secure chains: |        |           |
| A123-1 Paint | Wiring | Gen. Wear | Dinning Room<br>Paint Wiring Gen. Wear                            |        |           |
| A124-1 Paint | Wiring | Gen. Wear | Chapel/Activity<br>Paint Wiring Gen. Wear                         |        |           |
|              |        |           | A/C Condensate tubing: Intact or leaking                          |        |           |
|              |        |           | DON/ADON  |        |           |
| A125-1 Paint | Wiring | Gen. Wear | Paint Wiring Gen. Wear  |        |           |
|              |        |           | Medical Records<br>Paint Wiring Gen. Wear                         |        |           |
| 134-1 Paint  | Wiring | Gen. Wear | Upstairs<br>Paint Wiring Gen. Wear                                |        |           |
| 134-1 Paint  | Wiring | Gen. Wear |   |        |           |
| 136-1 Paint  | Wiring | Gen. Wear | Raley Hall Paint Wiring Gen. Wear                                 |        |           |
|              |        |           | Davis Hall Paint Wiring Gen. Wear                                 |        |           |
| 137-1 Paint  | Wiring | Gen. Wear |   |        |           |
|              |        |           | Date  |        |           |
|              |        |           | Signature or Initials   |        |           |
|              |        |           |   |        |           |

# EXHIBIT # 15

## INTRAFACILITY REQUEST FOR REPAIRS OR ALTERATIONS

Fac. # \_\_\_\_\_

INSTRUCTIONS: This form is to be filled out in duplicate by the Supervisor of the department making the request. Both requisitions should then be sent to the Director of Maintenance.

Date 10/26/11 Location \_\_\_\_\_ Requested by Alain

NATURE OF REQUEST (explain fully) Replace door chain hook with velcro  
Rooms 101, 108, 110, 118, 119, 122, 125, 139, 140  
and Beauty shop -

Approved Tony Mattingly Labor \_\_\_\_\_ Hrs. \_\_\_\_\_ Min. \_\_\_\_\_ \$ \_\_\_\_\_  
Director of Maintenance

Date completed 10-10-11 Completed by Tony Mattingly Material: \_\_\_\_\_

Routine  Critical Total \$ \_\_\_\_\_

### For Use By Facility Maintenance Department

Itemized list of material used for repairs. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# EXHIBIT # 16

## INTRAFACILITY REQUEST FOR REPAIRS OR ALTERATIONS

Fac. # \_\_\_\_\_

INSTRUCTIONS: This form is to be filled out **in duplicate** by the Supervisor of the department making the request. Both requisitions should then be sent to the Director of Maintenance.

Date 10/6/11 Location Smoke barrier Requested by Admin O/G  
NATURE OF REQUEST (explain fully) Penetrations in smoke barrier fire rated  
Door closure for top of stairs door

Approved T.M. Labor \_\_\_\_\_ Hrs. \_\_\_\_\_ Min. \_\_\_\_\_ \$ \_\_\_\_\_  
Director of Maintenance

Date completed 10/10/11 Completed by Tony Mattingly Material: \_\_\_\_\_

Routine  Critical Total \$ \_\_\_\_\_

### For Use By Facility Maintenance Department

Itemized list of material used for repairs. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 2010 FIRE AND SMOKE BARRIERS

| VILLAGE OF LEBANON / COL   | JANUARY | APRIL | JULY | OCTOBER |
|--|---------|-------|------|---------|
| DATE:  |         |       |      |         |
| INITIALS:  |         |       |      |         |
| Facility floor plans maintained / posted   |         |       |      |         |
| Outside contractors / vendors informed of barrier locations prior to work  |         |       |      |         |
| Outside contractors / vendors informed of responsibility for protectin barriers / re-sealing any penetration with approved |         |       |      |         |
| Penetrations make by in-house personnel - resealed with approved sealant   |         |       |      |         |
| Doors in smoke / fire barriers tight with no gap larger than 1/8 inch  |         |       |      |         |
| Doors are self-closing or automatic closing  |         |       |      |         |
| Doors in smoke / fire barriers held open with approved devices only (no wedges)  |         |       |      |         |
| Duct penetrations of smoke / fire barriers protected by approved damper  |         |       |      |         |
| Required dampers close upon activation of fire alarm or duct detector  |         |       |      |         |
| Duct penetrations of smoke / fire barriers protected by approved damper  |         |       |      |         |
|  |         |       |      |         |
|  |         |       |      |         |
|  |         |       |      |         |
|  |         |       |      |         |
| LIST EQUIPMENT REPAIRED:   | NOTES:  |       |      |         |

# EXHIBIT # 18

748514

|                         |       |                |
|-------------------------|-------|----------------|
| CUSTOMER'S ORDER NO.    | DEPT. | DATE: 10-12-11 |
| NAME: Cedars of Lebanon |       |                |
| ADDRESS:                |       |                |
| CITY, STATE, ZIP        |       |                |

|          |      |        |        |          |           |          |
|----------|------|--------|--------|----------|-----------|----------|
| SOLD BY: | CASH | C.O.D. | CHARGE | ON ACCT. | MDSE RTD. | PAID OUT |
|----------|------|--------|--------|----------|-----------|----------|

| QUANTITY | DESCRIPTION         | PRICE | AMOUNT |
|----------|---------------------|-------|--------|
| 1        | Service Call        |       |        |
| 2        | Water Heater        | \$75  |        |
| 3        |                     |       |        |
| 4        |                     |       |        |
| 5        |                     |       |        |
| 6        |                     |       |        |
| 7        | Install new plug    |       |        |
| 8        | for washing machine |       |        |
| 9        | Change plug in mech | \$180 |        |
| 10       | Rm for washer       |       |        |
| 11       | Repair water line   |       |        |
| 12       |                     |       |        |
| 13       | Mike Gribbin's      |       |        |
| 14       | 402-7673 Total      | \$255 |        |
| 15       |                     |       |        |

RECEIVED BY: