

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

PRINTED: 04/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/28/2013
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NAME OF PROVIDER OR SUPPLIER GREENWOOD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

A standard health survey was conducted on 03/26/13 through 03/28/13. A Life Safety Code Survey was conducted on 03/28/13. Deficiencies were cited with the highest scope and severity of an "D" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.

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

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.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility's policy, it was determined the facility failed to provide care to promote or enhance dignity for two (2) of twenty-four (24) sampled residents, #2 and #4, and four (4) of seven (7) unsampled residents, B, C, D, and E. Multiple staff were observed at breakfast and lunch on 03/27/13 and at the breakfast meal on 03/28/13 to be standing up while feeding residents in the 300 hall dependent dining room.

The findings include:

Review of the facility's policy regarding Feeding of Residents, revised 11/27/12, revealed when feeding residents, the staff should provide appropriate interaction to enhance the dining experience including sitting down at the table.

F 000

Greenwood Nursing and Rehab Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.

F 241

Greenwood's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenwood Nursing and Rehab Center reserves the right to refute any of the deficiencies on this

Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or any other administrative or legal proceeding.

F 241

Residents #2, #4, B, C and D have been assessed by social services and have not exhibited any negative outcomes from staff standing while feeding them. Resident #E is no longer in the facility. Social Services spoke with all other residents that need feeding assistance to ensure they did not have any negative outcomes from staff standing while feeding.

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

TITLE

(X6) DATE

[Signature]

[Signature]

4/13/13

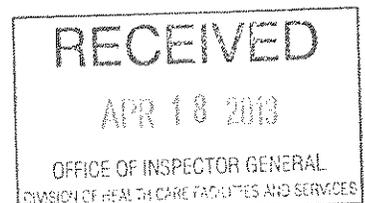
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

APR 18 2013
If continuation sheet Page 1 of 5
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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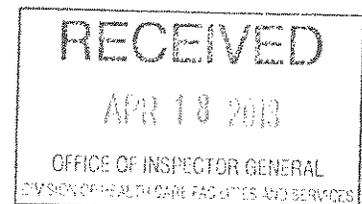
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F 241	<p>Continued From page 1</p> <p>Observation, on 03/27/13 from 7:10 AM to 7:50 AM, revealed the Staff Development Coordinator LPN #2 stood over the resident during the entire meal service while she fed Unsampld Resident B. Certified Nursing Assistant (CNA)'s #2 and #4 were observed standing while feeding Resident #2, and Unsampld Residents C and E.</p> <p>Observation, on 03/27/13 at 11:45 AM until 12:20 PM, revealed CNAs #2, #4, Certified Medication Assistant (CMA) #2 and LPN #2 standing up feeding Residents #2, and #4, and Unsampld Residents B, C, D, and E.</p> <p>Observation, on 03/28/13 at 7:45 AM, revealed CNA's #2, #3, #4, and #5 standing up to feed Residents #2 and #4, and Unsampld Residents B, C, D, and E.</p> <p>Interview, on 03/28/13 at 8:00 AM, with CMA #2 revealed there had not been any specific training provided by the facility on sitting or standing during meal service.</p> <p>Interview, on 03/28/13 at 8:10 AM, with CNA's # 2, #3, #4, and #5 revealed they had not been specifically trained on dignity during meal service related to standing during meal service. They stated they had been trained not to "tower" over the residents and about bite sizes given to the residents. CNA #2 stated it was more comfortable to stand when feeding the residents because of the specialty chairs the residents sit in.</p> <p>Interview, on 03/28/13 at 1:00 PM, with CNA #6, who was also a Restorative Aide, stated she</p>	F 241	<p>Facility staff that physically assist any resident with their meals have been in-service by the staff facilitator on 3/28/13 and on 4/11/13 regarding dignity during meals service related to staff standing during meal service in which they assist the resident.</p> <p>The facility has identified opportunities to implement changes in our current practices to improve the resident's dignity during meal services. These changes include monitoring of every meal in the dining room by the restorative aide or license nurse to ensure staff are seated during assisting residents with their meal. Residents who are assisted with their meals while eating in their rooms have been identified and will be monitored by the Licensed Nurse to ensure that staff are seated while assisting during meals. Monitoring forms will be completed and turned into QI nurse for review. Facility wide in-service regarding feeding a resident was completed on 4/11/13. Residents 2, 4, b, c and d will be included in this audit.</p> <p>The QI nurse will audit to include Resident #2, #4, B, C, and D utilizing a QI summary tool by the Q/I Nurse to ensure staff are seated during assisting residents with their meal. The QI Nurse will take appropriate action as indicated for any potential concern with the providing of dignity concerns while eating.</p>	



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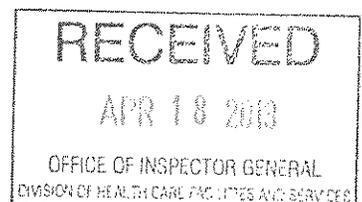
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F 241	<p>Continued From page 2</p> <p>could not say for sure if any training on dignity during meal service had been provided to the staff.</p> <p>Interview, on 03/28/13 at 1:00 PM, with Registered Nurse #3 revealed there was no nurse assigned to the 300 hall dependent dining room during meals to monitor for positioning of residents or supervising staff during meal service.</p> <p>Interview, on 03/28/13 at 1:15 PM, with LPN #2 revealed administrative staff monitored the dining rooms periodically. She stated related to Dignity issues, staff were not to carry on personal conversations when feeding residents and to make sure they were at eye level with the residents. She stated it was a dignity issue to stand when feeding a resident.</p> <p>Interview, on 03/28/13 at 1:55 PM, with the Director of Nursing revealed there was no nurses assigned specifically to the 300 hall dependent dining room, but supervisory staff were in and out of the dining room all the time.</p>	F 241	<p>The results of these audits will be reviewed with the DON & Administrator weekly in the QI Committee meeting that is composed of the QI Nurse, DON, Administrator, Staff Facilitator, Unit Coordinators, MDS Nurse, Safety Nurse, Rehab Director, Social Worker, & Treatment Nurse with further corrective action taken as needed. Results and trends of audits will be reviewed in the monthly Executive QI meeting consisting of the Administrator, DON, QI Nurse, Safety Nurse, Medical Director, Social Services, Unit Coordinators, Activity Director, plus any other person deemed appropriate by the Administrator present.</p> <p>Completion date: 4/12/13</p> <p style="text-align: right;">4/12/13</p>
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences except when the health or safety of the individual or other residents would be endangered.</p>	F 246	<p>F 246</p> <p>Residents F and G had their table height adjusted on 3/28/13 to ensure accommodations of individual needs and ability to reach food items related to proper seating height during meal service. Therapy screens were placed 3/28/13 for both residents to ensure that adjustments to table height would properly accommodate individual needs and promote normal eating positions.</p>



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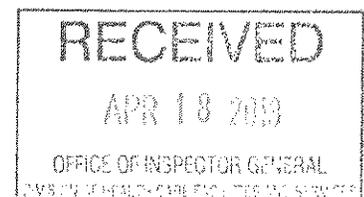
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F 246	<p>Certified From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, it was determined the facility failed to provide a dining table at the appropriate height for the residents to eat in a normal position for twenty-four sampled residents and two (2) of seven (7) unsampled residents, (Unsampled Residents F and G).</p> <p>The finding include:</p> <p>Observation, on 03/27/13 at 7:30 AM, revealed Unsampled Resident F and G were sitting in their wheelchairs at a dining table in the 300 hall dependent dining room. Unsampled Resident F was holding a bowl of oatmeal in his/her hand. The resident asked the surveyor to move the milk closer, because he/she could not reach it. Unsampled Resident G was observed holding the breakfast plate in his/her lap. The table height was at chair level or higher for these two residents.</p> <p>Observation, on 03/27/13 at 12:20 PM, revealed Unsampled Resident F holding a bowl of peaches in his/her lap while attempting to feed self. Unsampled Resident G was holding the lunch plate in his/her lap. Due to the height of the table these residents were observed to not be able to reach the entire meal service from their sitting position. The residents were further noted to have to ask the staff for a item of food off the table in order to eat.</p> <p>Interview, on 03/28/13 at 8:00 AM, with Certified Medication Assistant (CMA) #2 revealed</p>	F 246	<p>All residents have been assessed to ensure that accommodations of individual needs are being met in regards to proper positioning during meals as it relates to the residents ability to independently reach food items from the table. Resident(s) identified by the assessing nurse (Q), staff facilitator MDS, safety coordinator and unit managers) as potentially requiring interventions to assist with proper seating that allows the resident to independently reach food items from table during meals have had a therapy screen placed.</p> <p>The facility has identified opportunities to enhance current monitoring practices and assessments in order to provide residents proper positioning during meals that promote and accommodate residents abilities to independently reach food items that are served. Staff in serviced on 4/11/13 regarding positioning of residents during meal times. A monitoring tool that is completed daily by the restorative aide or license nurse has been implemented to ensure that residents in the dining room continue to have proper positioning that promotes accommodations of individual needs. If issue is determined a license nurse will assess and submit therapy screen.</p>	



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F 246	<p>Continued From page 4</p> <p>Unsampled Resident G had always put the meal plate in his/her lap. She stated if Unsampled Resident F was not able to reach his/her food that could be a problem with adequate nutrition. She stated the residents could also be more independent if they were positioned where they could reach their food without assistance.</p> <p>Interview, on 03/28/13 at 2:10 AM, with Certified Nursing Assistants #3, #4, and #5 revealed the residents should be able to reach their food and if they cannot, the table should be adjusted or the residents should be placed in a higher chair.</p> <p>Interview, on 03/28/13 at 1:15 PM, with Licensed Practical Nurse #2 revealed there was a problem with accommodation of needs for Unsampled Residents F and G, related to table height, during meal service. She stated Therapy monitored and evaluated for positioning at times.</p> <p>Interview, on 03/28/13 at 1:55 PM, with the Director of Nursing revealed they did not have an assigned nurse to monitor for proper positioning in the dining room. She stated supervisory staff and Therapy were in and out of the dining room all the time.</p>	F 246	<p>The QI nurse will audit to include Resident F and G utilizing a QI summary tool. Will review and verify that residents had proper positioning during meals to promote and accommodate resident's abilities to independently reach food items that are served. The QI Nurse will take appropriate action as indicated for any concerns discovered over accommodations of individual needs in regards to proper positioning during meals as it relates to the residents ability to Independently reach food items from the table.</p> <p>The results of these audits will be reviewed with the DON & Administrator weekly in the QI Committee meeting that is composed of the QI Nurse, DON, Administrator, Staff Facilitator, Unit Coordinators, MDS Nurse, Safety Nurse, Rehab Director, Social Worker, & Treatment Nurse with further corrective action taken as needed. Results and trends of audits will be reviewed in the monthly Executive QI meeting consisting of the Administrator, DON, QI Nurse, Safety Nurse, Medical Director, Social Services, Unit Coordinators, Activity Director, plus any other person deemed appropriate by the Administrator present.</p> <p>Completion date: 4/12/13</p> <p style="text-align: right;">4/12/13</p>



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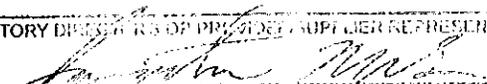
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K 000	INITIAL COMMENTS: PLAN APPROVAL: 1977 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/RF TYPE OF STRUCTURE: One (1) story Type V (111) SMOKE COMPARTMENTS: Eleven (11) smoke compartments FIRE ALARM: Complete fire alarm system with heat and smoke detectors SPRINKLER SYSTEM: Complete automatic wet sprinkler system. GENERATOR: Type _____ generator, installed in October 2010. Fuel source is diesel. A standard Life Safety Code survey was conducted on 03/28/13. Greenwood Nursing and Rehab Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred twenty eight (128) beds with a census of one hundred twenty seven (123) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) Deficiencies were cited with the highest deficiency identified at a "D" level.	K 000	Greenwood Nursing and Rehab Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Greenwood's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenwood Nursing and Rehab Center reserves the right to refute any of the deficiencies on this facility. Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or any other administrative or legal proceeding.	
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REGULATORY DIVISION'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 4/17/13
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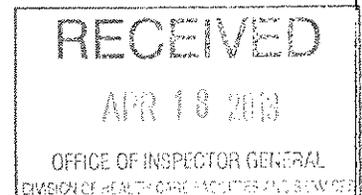
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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE REGULATION SERVICES

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K 062 SS=D	<p>NFPA 13 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 16.12, NFPA 13 NFPA 25, 9.7.5</p> <p>The STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure sprinkler requirements were maintained according to NFPA standards. This deficient practice affected one (1) of an (01) smoke compartments, staff and approximately ten (10) residents. The facility has the capacity for 128 beds with a census of 123 the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour, on 03/28/13 at 10:30 AM, with the Director of Maintenance (DOM) revealed inadequate sprinkler coverage was observed in the 200 corridor shower room. The walls in the shower room would prevent the sprinkler from reaching all areas in this room.</p> <p>Interview with the DOM on 03/28/13 at 10:30 AM, revealed he was not aware of the improper sprinkler coverage.</p> <p>The findings were provided to the Director of Nursing during exit.</p> <p>Reference: NFPA 13 2009 edition</p>	K 062	<p>K-062</p> <p>There were no specific residents identified.</p> <p>Eagle Fire Protection have been contracted to install sprinkler heads in the 200 corridor shower room. This has been completed as of 4/11/13.</p> <p>All other shower rooms were inspected by the Director of Maintenance and any deficiencies found regarding inadequate sprinkler coverage have been corrected by Eagle Fire Protection as of 4/11/13.</p> <p>The Director of Maintenance has been re-in serviced by the Administrator on 3/28/13 on the requirement of K062.</p> <p>The Director of Maintenance will complete monthly audits to ensure that adequate sprinkler coverage is maintained in the shower rooms.</p> <p>Audit findings will be reviewed monthly with the Administrator, DON and the Medical Director during the Executive Quality Improvement meetings.</p> <p>Completion date 4/12/13</p>	4/12/13



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K 062 Continued From page 2
5-5.3.1 Performance Objective.
Sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-5.5.2 and 5-5.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard.

K 062

K066

K 066 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
Smoking regulations adopted and include no less than the following provisions:

K 066

There are no specific residents identified in the deficiency.

The facility has purchased and implemented the use of a metal self closing container to empty cigarette ashtrays in as required.

Housekeeping and Laundry staff has been in serviced as of 4/11/13 on the use of the self closing metal container when emptying cigarette ashtrays.

The Director of Maintenance and Director of Housekeeping / LDY was in-service on the requirements of K066 by the administrator on 3/28/13.

The Director of Housekeeping / LDY will complete weekly audits to ensure compliance of housekeeping staff utilizing the self closing metal container when they empty cigarette ashtrays.

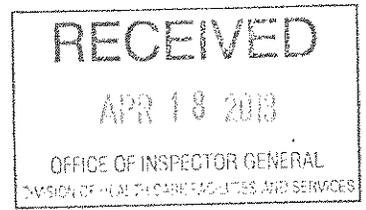
Audit findings will be reviewed monthly with the Administrator the DON and the Medical Director during the Executive Quality Improvement meetings.

Date of completion is 4/12/13.

4/12/13

- (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.
- (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.
- (3) Ashtrays of non-combustible material and safe design are provided in all areas where smoking is permitted.
- (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4

This STANDARD was met as evidenced by: Patient observation and interview it was determined the facility failed to maintain the



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NAME OF PROVIDER OR SUPPLIER GREENWOOD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 066	<p>Continued From page 3</p> <p>smoking area according to NFPA standards. This deficient practice affected one (1) of eleven (11) smoke compartments, staff and residents.</p> <p>The findings include:</p> <p>During the Life Safety Code tour, on 03/28/13 at 10:40 AM, with the Director of Maintenance (DOM) revealed a smoking area in the courtyard of the facility was observed without a metal self-closing container for empty cigarette ashtrays in as required.</p> <p>Interview with the DOM, on 03/28/13 at 10:40 AM, revealed he was not aware of this requirement.</p> <p>This deficient practice was provided to the Director of Nursing during exit.</p>	K 066		
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