

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

PRINTED: 07/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2010
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NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
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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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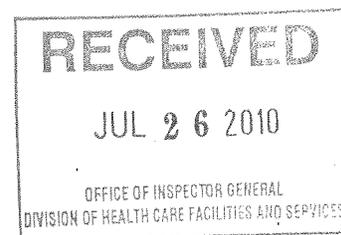
F 274	<p>Continued From page 10 was not self limiting.</p> <p>The findings include:</p> <p>A review of the medical record for Resident #5 revealed diagnoses including; Syncope, Difficulty Ambulation, Chronic Obstructive Pulmonary Disease, and Alzheimer's Dementia. The MDS admission assessment dated 11/24/09 revealed a cognition of zero (0), independent; bed mobility and transfer of a three (3), extensive assistance; ambulation of three (3); eating, zero (0), one (1), independent, supervision. On the Quarterly assessment completed on 02/03/10 the facility assessed the residents cognition the same, zero (0), independent; bed mobility and transfer the same of a three (3), extensive assistance; ambulation, three (3,3) extensive assistance; and eating, three (3), two (2), extensive to limited assistance. On 04/28/10 the facility completed a quarterly MDS assessment although the resident had a significant decline in the following areas; Cognition declined to a two (2), moderately impaired, bed mobility and transfer were assessed at four, three (4,3), total dependence, extensive assistance, and ambulation of eight (8), activity did not occur. The medical record also revealed three (3) admissions to the hospital since admission to the facility.</p> <p>Observation of Resident #5 on 06/29/10 at 10:30am revealed a pleasantly confused resident in no acute distress. There was an oxygen concentrator and mini-neb machine at the bedside. There were fall mats on both sides of the bed. The resident also has a sensor pad to the bed and in the wheelchair. Observation of Resident #5 on 06/29/10 at 2:30pm revealed the resident up in a wheelchair with the spouse</p>	F 274	<p>continued from page 10</p> <p>4. DON to review RUG analysis report as part of Minimum Data Set audit to ensure accurate and timely assessments are completed.</p> <p>5. Completion date: July 23, 2010.</p>	7/23/2010
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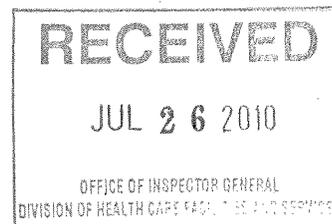
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F 274	<p>Continued From page 11 pushing the resident around.</p> <p>An interview with the MDS coordinator on 07/01/10 at 1:30pm revealed she did not believe Resident #5 was a significant change because the resident changed so much from day to day and week to week. She stated some weeks and days the resident could be doing great and then suddenly change for the worse. The MDS coordinator did state that a significant change should occur if there is a decline in two or more areas that last for more than fourteen days. The MDS coordinator stated she looked for a change since the resident's last assessment in two or more areas.</p> <p>A review of the medical record for Resident #8 revealed admission diagnoses including; Hypertension, Arthritis, and Rheumatoid Arthritis. The resident's admission MDS assessment dated 12/11/09 revealed a cognition of zero (0) independent; Bed mobility and transfer of one (1), one (1) supervision; and ambulation in room and corridor one (1), one (1) supervision. The resident sustained a fall with a fractured hip on 04/07/10. A Quarterly MDS assessment was completed on 03/08/10 with the same assessment as the admission assessment. A Significant change MDS assessment was not completed for Resident #8 when the resident returned to the facility. A Quarterly MDS assessment was completed on 06/07/10. The resident was assessed with a decline in bed mobility, and transfer to a three (3) extensive assistance; ambulation in room and corridor three (3), two (2), extensive assistance and limited assistance. The resident also had a decline in hygiene/bathing from two, two (2,2) to three, two (3,2) extensive assistance.</p>	F 274		



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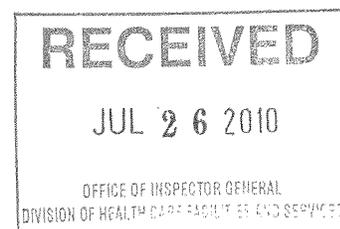
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F 274	Continued From page 12 Observation of Resident #8 on 06/29/10 at 10:40am revealed a well groomed alert, oriented and pleasant resident, sitting up in a recliner. The resident had a wheelchair in the room that was used when he/she wanted to go to the bathroom. The resident now complained of pain to the right knee since the most recent hip surgery. The resident stated the physician was aware of the pain. Observation of Resident #8 on 06/30/10 at 9:00am revealed the resident sitting up in the wheelchair in the room. An interview with the MDS coordinator on 07/01/10 at 1:30pm revealed she did not believe Resident #8 was a significant change because she believed the resident would return to his/her baseline. The MDS coordinator did state that a significant change should occur if there were a decline in two or more areas that lasted for more than fourteen days. The MDS coordinator stated she looked for changes since the resident's last assessment in two or more areas to determine a significant change. She further stated the purpose of the MDS assessment was to ensure the residents receive the proper care, and care planning.	F 274		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 Food procure, store/prepare/serve-sanitary 1. No specific residents were identified as having been effected.	7/23/2010



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F 371	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure foods were stored, prepared, distributed, and served under sanitary conditions as evidenced by open food items not labeled or dated, and employees' hair not completely covered by a hairnet. The findings include: Review of the facility policy for Sanitation and Infection Control, Issued March 2009, revealed the employees were to wear a hair net or head covering that ensured all hair was covered in food preparation areas. Observation on 06/29/10 at 11:45am revealed three (3) Dietary Aides (DA) wore hairnets without their hair completely covered. The three (3) dietary aides had loose hair hanging out from under their head covering in the nape of their necks and in front of their ears. DA #3's hair was observed to touch her clothing in the neck area. Observation, on 06/30/10 at 11:55am, revealed DA #3 remained with strands of loose hair exposed from head covering. Interview with DA #2, on 06/29/10 at 9:10am, revealed she had been trained on the use of the head covers while in the kitchen, and the head covers are suppose to cover the entire head. She reported all food items kept in the refrigerator are	F 371	continued from page 13 2. All residents have the potential to be effected should the facility fail to ensure foods are stored, prepared, distributed, and served under sanitary conditions such as not labeling or dating open food items and employees not completely covering their hair with hairnets. 3. Dietary manager in-serviced all dietary staff on-ensuring foods are stored, prepared, distributed, and served under sanitary conditions as evident by labeling and dating all opened foods as well as proper use of hairnets. 4. Weekly audits completed by consultant registered dietician that include-checking foods to ensure correctly labeled and dated and employees properly wearing hair nets. Audit findings will be reviewed/addressed by Dietary manager who will provide education as needed, based on audit findings. The Dietary	7/23/2010



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F 371	<p>Continued From page 14</p> <p>to be dated, labeled and initialed when placed in the refrigerator.</p> <p>Interview with DA #3, on 06/30/10 at 10:49am, revealed the head covers were to cover all of your hair and head.</p> <p>Review of the facility policy for Handling of Leftovers, issued March 2009, revealed leftovers will be placed in shallow containers, dated, labeled, chilled rapidly, used within three days, and reheated to proper temperatures to prevent contamination, and food borne illness. The facility policy revealed leftover food items are refrigerated immediately, and labeled with the following: prepared date, use by date, contents, and initials.</p> <p>Observation of the refrigerator, on 06/30/10 at 9:20am, revealed eleven (11) drinking cup containers, and a gallon pitcher of brown liquid substance without initials or date opened.</p> <p>Interview with DA #1, on 06/30/10 at 9:20am, revealed all containers in the refrigerator was suppose to be labeled, and covered to identify the food or drink with the date and the initials of who prepared the food item. She identified the gallon pitcher with the brown liquid substance as tea, and reported they had not made their tea for the day yet. She identified two (2) containers as Carnation Instant Breakfast, two (2) containers of apple juice, three (3) containers of tomato juice, one (1) container of cranberry juice, and three (3) containers of orange juice without dates and initials, not covered and stored in the refrigerator.</p> <p>Interview with the Dietary Manager, on 06/30/10 at 10:15am, revealed the staff have been</p>	F 371	<p>continued from page 14</p> <p>manager will present, in writing, the findings of these weekly audits and the actions taken to address any concerns to the Quality Assurance Committee on a monthly and quarterly basis. The Quality Assurance Committee will determine the plan of action after the third Quality Assurance Committee meeting.</p> <p>5. Completion date: July 23, 2010</p>	7/23/2010
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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FINANCIAL SERVICES

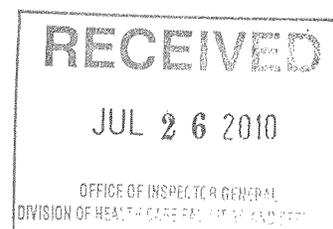
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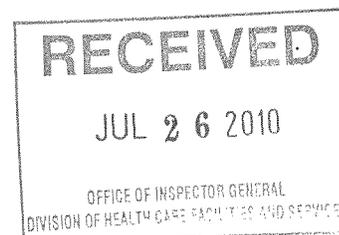
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F 371	Continued From page 15 instructed to date, label, and identify all food items that were opened and refrigerated. She reported the facility does have a policy to address the handling of leftovers, and a policy on sanitation and infection control, which included the use of head and hair coverings. She reported these policies have been reviewed with the staff.	F 371	F 441 Infection control, prevent spread, linens	7/23/2010
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p>	F 441	<p>1. On 6/29/10 CNA #1 was educated on appropriate preparation of drinks for meals including proper ice usage. No residents were identified as having been affected by cited deficient practice. No residents were identified through nursing observation and assessment to be affected by the cited deficient practice</p> <p>2. All residents have the potential to be affected by ice scoops stored in plastic containers without lids, proper drainage and consumption of potentially contaminated ice.</p> <p>3. CNA #1 was immediately provided education by unit manager who witnessed potentially contaminated ice administered to resident. All staff working 6/29/10 in-serviced on proper provision of ice to residents. Staff in-serviced on the 8th, 9th, and 22 of July to address- obtaining ice for</p>	



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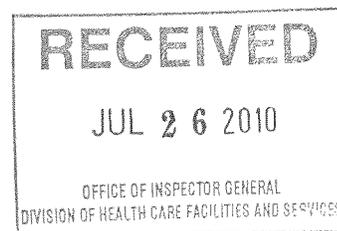
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F 441	Continued From page 16 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to establish and maintain an infection control program designed to provide safe and sanitary environment to prevent transmission of disease and infection as evidenced by ice scoops stored in plastic holders in one inch water without drain holes, and one cart had no lid covering a scoop, employee used contaminated ice for residents. The findings include: Observation, on 06/29/10 at 12:40pm, and 06/30/10 12:15pm, of the ice scoop holder attached to the side of the ice chest on North Hall revealed it did not have a lid to cover the scoop for protection from environmental elements. Observation, on 06/29/10 at 12:25pm, and 06/30/10 12:09pm, of the ice scoop holder attached to the side of the ice chest on South Hall revealed water in the bottom of the container. There was one inch of water observed in the base of the container on both days at the time of the observations. Observation of Certified Nurse Assistant #1, on 06/29/10 at 11:40am, revealed the Nurse Assistant served the lunch meal tray to two (2)	F 441	continued from page 16 consumption, proper ice scoop storage including lids and drainage holes. Ice scoop holders were replaced with new ones which included lids and drainage holes. Potable ice is available for resident consumption on both units at all times including meals. Meal service training to be included in general orientation. 4. Weekly meal service audits will be completed on the unit by assigned staff. Audits will include- checking to ensure ice scoops are properly stored in containers with lids and drainage holes, to ensure no standing water and observation of staff as well as interviews with staff to ensure potable ice is provided for resident consumption. Findings of these audits will be reviewed by Dietary manager, Unit managers, Staff Development Coordinator, as well as other members of management during morning meeting. The report of these audits will be provided to the Quality Assurance Committee for the next three Quarterly Assurance	7/23/2010

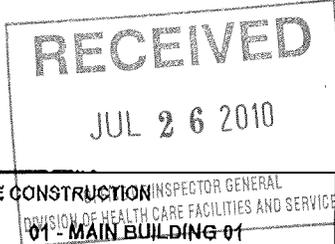


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F 441	<p>Continued From page 17</p> <p>residents on the South Hall, known as the Transltions. The ice provided in the glass for both residents to drink from was taken from the uncovered bulk container holding milk cartons, and food/drink items, which required chilled temperatures. CNA #1 poured tea over the ice and served it to the residents.</p> <p>Observation of Certified Nurse Assistant #14 on 06/29/10 at 11:45 revealed service of ice in a glass from a container holding the ice scoop that was standing in one inch of water. She removed the ice scoop from the standing water, scooped the ice into the glass, poured water over ice, and served to residents.</p> <p>Interview with CNA #1, on 06/29/10 at 2:00pm, revealed she had been employed for eight (8) weeks and had not been in-serviced on how to serve meals, other than to make sure the diet cards matched the food being served, and to the correct residents. She reported she had ten (10) days of orientation with another staff member that had been there about six (6) months.</p> <p>Interview with CNA #14, on 06/29/10 at 12:20pm, revealed she had not had any special training on meal service and the service of the ice. She reported she does use the ice from the ice cooler that is provided from the kitchen for the residents' glasses and drinks. She reports there has not been any direction provided on the water standing in the bottom of the scoop holder.</p>	F 441	<p>Continued from page 17</p> <p>Committee meetings.</p> <p>5. Completion date: July 23, 2010</p>	7/23/2010	





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K 000	INITIAL COMMENTS A life safety code survey was inflated and concluded on July 8, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "E" level.	K 000	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.	
K 026 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain fire/smoke dampers that penetrated the fire/smoke barrier walls in the attic area. This deficient practice affected four (4) of seven (7) smoke compartments, staff and approximately forty (40) residents. The facility has the capacity for 122 beds with a census of 69 the day of the survey. The findings include: During the Life Safety Code survey on July 8,	K 025	K 025 Life safety code standard 1. No specific residents were identified as being affected by deficient practice. 2. All residents have the potential to be affected should a fire/smoke damper fail to close to prevent fire and hot gasses from penetrating the fire/smoke barrier wall. 3. Maintenance Director made aware of K025 by life safety surveyor on July 8, 2010. Maintenance Director given copy of requirements to meet K025 on	7/23/2010

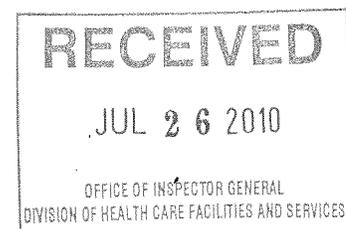
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator DATE: 07/26/2010

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

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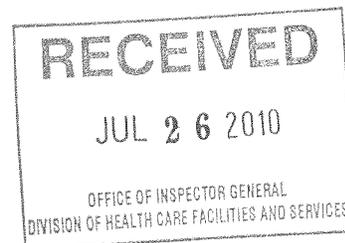
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K 025	Continued From page 1 2010, at 9:40am, with the Director of Maintenance, in the attic next to room 2 a fire/smoke barrier wall was observed to have ductwork that contained a fire/smoke damper. A fire/smoke damper closes to prevent fire and hot gases from penetrating the fire/smoke barrier wall and is required to be inspected and maintained every four (4) years. The Director of Maintenance was unaware of the requirements pertaining to fire/smoke dampers. During the survey two (2) other fire/smoke dampers that have not been maintained were observed in the attic area. Reference: NFPA 90a 1999 edition 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 025	continued from page 1. July 15, 2010. On July 23, 2010 fire/smoke damper were inspected to ensure fusible links (where applicable) were removed; all dampers were operated to verify that they fully close; the latch, if provided, was checked; and moving parts were lubricated as necessary. 4. Maintenance Director to keep log of fire/smoke damper maintenance inspections that includes- at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. 5. Completion date: July 23, 2010.	7/23/2010
K 056 SS=E	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	K 056	K 056 Life code standard 1. No specific residents were identified as have been affected by the cited deficient practice. 2. All residents have the potential to be affected by cited deficient practice. 3. The identified outside canopy and four exterior exit overhangs will have a sprinkler system installed. A proposal has been	8/27/2010



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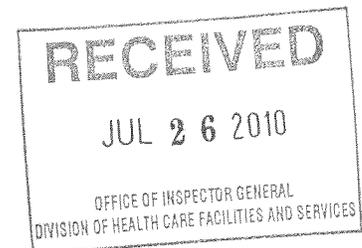
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/08/2010
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(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 056	Continued From page 2 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 the facility failed to ensure the outside canopy and overhangs at the facility were sprinkler protected as required. This deficient practice affected five (5) of seven (7) smoke compartments, staff and approximately forty (40) residents. The facility has the capacity for 122 beds with a census of 69 the day of the survey. The findings include: During the Life Safety Code survey on July 8, 2010, at 10:15 a.m., with the Director of Maintenance, a combustible canopy approximately 20' X 30' and an exterior exit overhang approximately 6' X 4' located at the front of the facility were noted not to be sprinkler protected. Combustible canopies and overhangs exceeding four foot in width must be sprinkler protected. The Director of Maintenance stated he thought the canopy and overhangs would not be required to be sprinkler protected because the canopy and overhangs were not sprinkler protected when the building was built. During the survey three (3) other exterior exit overhangs were observed not to be sprinkler protected. Reference: NFPA 13 1999 edition	K 056	continued from page 2. accepted as presented by the contracted provider that services/ maintains the facility's sprinkler system. The vendor will begin the instillation of the sprinkler system no later than Monday, August 2, 2010. The project will be completed as quickly as possible dependant on the length of time it takes the sprinkler pendants to arrive, which is a two to three week time frame. The vendor will expedite the process to ensure the identified areas are sprinkler protected as required. 4. The vendor installing the sprinkler system in the canopy and four exterior exterior exit overhangs will monitor the system on a quarterly basis and document these inspections. Any identified areas of concern will be addressed as quickly as possible after identification. 5. Completion date: Project initiated August 2, 2010 or sooner. Anticipated time frame of completion is August 27, 2010 if not sooner. The Division of Health Care Regional Program Manager will be notified in writing of the completion of the project to sprinkler protect the facility as required.	8/27/2010



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/08/2010
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
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K 056	Continued From page 3 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 the safety of residents, staff and other occupants of the building by allowing unapproved portable space heating units in office areas. This deficient practice affected one (1) of seven (7) smoke compartments. The facility has the capacity for 122 beds with a census of 69 the day of the survey. The findings include: During the Life Safety Code tour on July 8, 2010, at 10:40 a.m., with the Director of Maintenance, an unapproved portable space heater was noted to be located in the staffing office room. Portable space heating units must be tested and approved for use in these areas. An interview at this time revealed the Director of Maintenance was unaware of the requirements for the use of portable space heaters. During the survey	K 070	K 070 Life Safety Code Standard 1. No specific residents were identified as being affected by deficient practice cited. 2. All residents have the potential to be affected by cited deficient practice. 3. The two identified portable space heaters were removed from building on July 8, 2010. Building was inspected by Director of Maintenance to ensure no portable space heaters were in facility. Management staff were in-serviced on- Portable space heating devices are prohibited an all health care occupancies, except in non-sleeping staff and employee areas where the heating element of such devices do not exceed 212 degrees F (100 degrees C). 4. Audit to be completed by assigned member of management to ensure facility is free of any unapproved heaters. These audits will be completed weekly and reviewed by the Quality Assurance Committee.	7/23/2010



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NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047		
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K 070	Continued From page 4 another unapproved space heater was observed in an office in the kitchen area. 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).	K 070	continued from page 4 5. Completion date: July 23, 2010	7/23/2010	

