

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

PRINTED: 10/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/22/2015
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
(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 Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/22/15 as alleged.	{F 000}			

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

TITLE

(X6) DATE

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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185205	(Y2) Multiple Construction A. Building _____ B. Wing _____	(Y3) Date of Revisit 10/22/2015
Name of Facility GREEN VALLEY HEALTH & REHABILITATION CENTER	Street Address, City, State, Zip Code 1206 ELEVENTH STREET CARROLLTON, KY 41045	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0156 Reg. # 483.10(b)(5) - (10), 483.10(t) LSC _____	Correction Completed 09/26/2015	ID Prefix F0170 Reg. # 483.10(i)(1) LSC _____	Correction Completed 09/26/2015	ID Prefix F0441 Reg. # 483.65 LSC _____	Correction Completed 10/22/2015
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <i>spm</i>	Reviewed By <i>kt</i>	Date: <i>10/26/15</i>	Signature of Surveyor: <i>Susan J. Alder-Mason</i>	Date: <i>10-26-15</i>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 9/24/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right; margin-left: 20px;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

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F 000	INITIAL COMMENTS	F 000	This Plan of Correction is prepared and executed because it is required by the provisions of State and Federal law and not because Green Valley Health and Rehabilitation agrees with the citations noted on the pages of this Statement of Deficiencies.	
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the	F 156	<ol style="list-style-type: none"> 1. Required postings regarding Medicare and Medicaid were visibly posted in the facility 9/25/2015. 2. Administrator completed a tour of the facility 9/25/2015 to ensure information required in F-156 was visibly posted in the facility. 3. Administrator will conduct monthly tours of the facility for three months then quarterly through 10/2016 to ensure information is visibly posted in the facility per regulation. 4. Administrator will report findings of facility tours to the Quality Assurance Committee quarterly through 10/2016. 	9/26/2015

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

Christopher Thomas

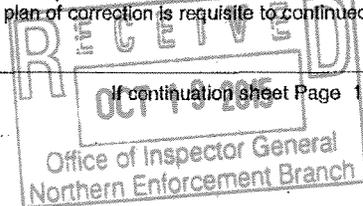
TITLE

Administrator

(X6) DATE

10/15/15

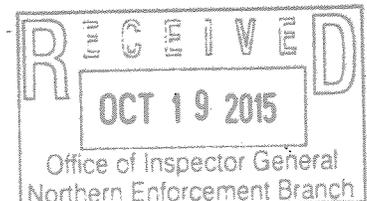
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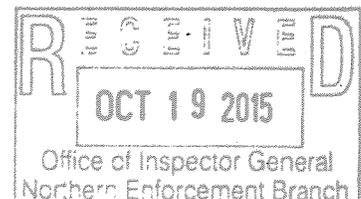
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F 156	<p>Continued From page 1</p> <p>facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p>	F 156			



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F 156	<p>Continued From page 2</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to prominently post, in the facility, how to apply for and use Medicare and Medicaid.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing, on 09/25/15 at 1:10 PM, revealed the facility had no policy regarding the posting of how to apply for and use Medicare and Medicaid.</p> <p>Observation of the facility, on 09/24/15 at 2:20 PM, revealed no evidence of the required posted information on how to apply for and use Medicare and Medicaid.</p> <p>Interview with Registered Nurse (RN) #1, on 09/23/15 at 2:50 PM, revealed she had no knowledge regarding the posting of information explaining how to apply for and use Medicare and Medicaid.</p> <p>Interview with the Bookkeeper, on 09/24/15 at 2:50 PM, revealed she had no knowledge of the requirement for the posting of information</p>	F 156		



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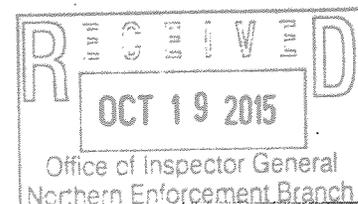
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F 156	Continued From page 3 regarding how to apply for and use Medicare and Medicaid.	F 156		
F 170 SS=D	<p>483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL</p> <p>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and review of the facility's policy, it was determined the facility failed to ensure one (1) of sixteen (16) sampled residents and one (1) unsampled resident (Unsampled Resident A) received mail unread by the facility. The facility opened and read the mail for Unsampled Resident A. The resident signed for assistance with opening mail; however, the facility had no permission to read the resident's mail prior to delivery.</p> <p>The findings include: Review of the Resident Admission Agreement, not dated, revealed residents were given the opportunity to decide how their mail was handled by the facility. Residents could authorize and request the facility to assist them with opening their mail or they could decide to receive all mail</p>	F 170	<ol style="list-style-type: none"> 1. Education provided to Bookkeeper by Administrator on proper handling of resident mail on 9/25/2015. 2. Resident files reviewed by Bookkeeper to see who requested assist with mail opening. Social Services checked with each resident that requested assist to inquire if there were any additional issues with mail. Informed residents that moving forward, mail will only be opened upon request. 3. Mail addressed to cognitively intact residents will be delivered to the resident unopened. Mail will be opened only if the resident requests assistance in opening envelopes. Assistance in reading mail will be provided only upon the request of the resident. Any such request will be documented in the Medical Record. Mail addressed to cognitively impaired residents will be forwarded to the resident's POA or next of kin. This process was initiated 9/25/2015. Social Services, Activities Staff and Bookkeeper were educated by Administrator on this process 9/25/2015. Resident Council will be made aware of process changes by the Activities Director during the October 2015 meeting. 	9/26/2015

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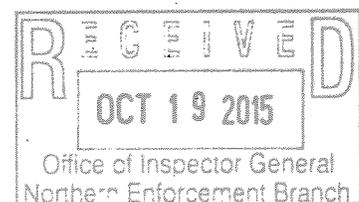
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F 170	<p>Continued From page 4 unopened.</p> <p>Review of the Resident Admission Agreement for Unsampld Resident A, revealed the resident requested assistance with opening mail.</p> <p>Interview with Unsampld Resident A, on 09/23/15 at 10:15 AM, revealed the resident's mail had been opened and removed from the envelope prior to the resident's mail being delivered. The resident stated the mail was opened and read more than a few times by facility staff and this was not right.</p> <p>Interview with the Bookkeeper, on 09/24/15 at 9:30 AM, revealed she opened mail for residents who had requested the assistance. She stated she opened and read the mail of Unsampld Resident A in order to see what was in the envelope and if there was a bill or something that needed to be addressed. She stated mail was sometimes delivered addressed to Green Valley and the resident. She stated she felt she could open mail if the facility's name was on the envelope. She stated after she went through all the mail, it was passed on to the Activity Director for delivery to residents. She stated she should not have read the resident's mail.</p> <p>Interview with the Activity Director, on 09/24/15 at 2:28 PM, revealed mail envelopes were opened for those residents that requested assistance. He stated the mail was not to be removed from the envelope or read unless the resident specifically requested him to perform that service. He stated Unsampld Resident A had never made that request. He stated it violated resident rights to read the resident's mail without permission or a request from the resident.</p>	F 170	4. Social Services Director will interview a sample of 10 residents with BIMS of 13-15 monthly regarding delivery of personal mail for three months then quarterly through October 2016. Activities Director will ask residents during Resident Council monthly for three months about issues with mail delivery. Results of interviews will be reported to the Quality Assurance Committee quarterly through October 2016.		



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F 170	Continued From page 5	F 170			
F 441 SS=E	<p>Interview with the Administrator, on 09/24/15 at 9:38 AM, revealed some residents made requests for assistance opening their mail. He stated that did not mean the resident's mail could be read. He stated this situation would be corrected and he was not aware the Bookkeeper was reading residents' mail.</p> <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</p>	F 441	<ol style="list-style-type: none"> C.N.A #5 was re-educated by the Director of Staff Development on the proper use of PPE on 9/23/15 with return demonstration competency. Housekeeper #1 was re-educated by the Housekeeping Director on the proper use of PPE/gloves on 9/22/15 with return demonstration competency. Houskeeper #2 and Laundry Aide #1 were re-educated by the Housekeeping Director on not breaking the isolation barrier with equipment/carts on 9/22/15 with return demonstration competency. DON and/or Nurse Managers reviewed MD orders and Nursing Report Sheets from 9/1/2015 through 10/2/2015 to determine if there were any adverse events related to staff not following established Infection Control practices. 	10/22/2015	



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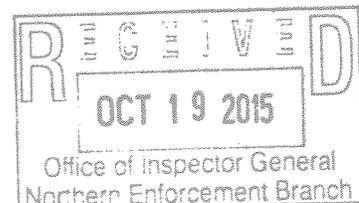
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F 441	<p>Continued From page 6 hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to have an effective system in place to ensure staff was compliant with transmission-based precautions including the use and disposal of gloves for two (2) of four (4) residents in contact precautions (Residents #1 and #6) of the sixteen (16) sampled residents.</p> <p>Housekeeping staff were observed in Resident #6's room cleaning without the use of disposable gloves and taking a rolling trash can halfway into the room while the resident was on contact precautions. The resident had Escherichia Coli Extended-Spectrum B-Lactamases in the urine and was incontinent. In addition, nursing staff was observed in Resident #1's room removing the disposable gown by untying the strings around the neck and waist with contaminated gloves. The resident had Clostridium difficile infection and was in contact precautions.</p> <p>The findings include: Review of the facility's policy for Personal</p>	F 441	<p>3. Director of Staff Development to provide additional training on Isolation procedures and PPE use by 10/21/2015 to Nursing Staff and Housekeeping Staff. Newly hired employees will receive education on Isolation procedures and PPE upon hire and at least annually thereafter. Infection Control in-services will be completed by the Director of Staff Development quarterly through 9/30/2016.</p> <p>4. DON and Unit Managers will observe five (5) staff members daily for proper use of PPE and adherence to infection control policies for two (2) weeks. Re-education will be provided immediately as needed. Thereafter, DON and Unit Managers will conduct observations of fifteen (15) staff for proper use of PPE and adherence to infection control policies for weekly for four (4) weeks. Then DON and Unit Managers will conduct observations for fifteen (15) staff monthly through 10/2016. Audits and one-on-one education opportunities will be presented to the QA Committee by the Director of Nursing quarterly through 10/2016.</p>	

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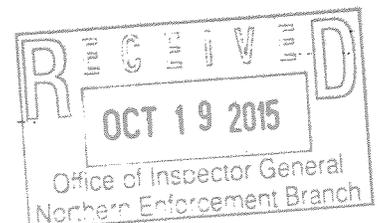
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F 441	<p>Continued From page 7</p> <p>Protective Equipment (PPE), dated 08/01/12, revealed employees were required to perform tasks that may involve exposure to blood/body fluids would be provided appropriate protective clothing and equipment.</p> <p>Review of the facility's policy for Transmission-Based Precautions, dated 08/01/12, revealed Standard Precautions and Contact Precautions would be implemented for residents with known or suspected infection or colonization with microorganisms that could be transmitted by direct contact with the resident or by indirect contact with environmental surfaces or resident-care items in the resident's environment. Examples of infections requiring Contact Precautions included Clostridium difficile with diarrhea and infections or colonization with multi-drug resistant organisms. Staff was to wear a gown as outlined under Standard Precautions. The staff was to remove the gown and perform hand hygiene before leaving the resident's environment.</p> <p>1. Review of the clinical record for Resident #1, revealed the facility admitted the resident with diagnoses of Hypertension, Hypothyroidism, and Dementia, on 07/23/07, and was readmitted from the hospital, on 09/22/15, with a diagnosis of Clostridium difficile Colitis.</p> <p>Review of the clinical record for Resident #1, revealed the facility completed a significant change Minimum Data Set (MDS) assessment on 08/17/15 which revealed facility assessed the resident with a moderate cognitive impairment and required limited to extensive assistance with all activities of daily living. In addition, the resident was incontinent of bowel and bladder.</p>	F 441		



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NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 8</p> <p>The facility placed the resident in Contact Precautions for Clostridium difficile Colitis.</p> <p>Observation of Resident #1, on 09/23/15 at 11:57 AM, revealed the resident was sitting up in bed with a tray table over him/her, but not eating. Certified Nurse Assistant (CNA) #5 put on PPE and entered the room. The CNA took the utensils from the resident and cut the resident's food. The CNA's personal protective gown touched the resident's linen and bed rails. When finished, the CNA reached behind his head and untied the strings on the gown's neck and waist and removed the disposable gown. He then removed the disposable gloves and performed hand washing.</p> <p>Interview with CNA #5, on 09/23/15 at 1:30 PM, revealed he had received training on the use of Personal Protective Equipment a few months ago. He stated he did not realize he untied the gown strings and made contact with his personal clothing while still wearing gloves. He stated he should have taken the disposable gloves off first then removed the disposable gown. He stated residents could become sick if infection control practices were not followed.</p> <p>Interview with CNA #6, on 09/23/15 at 2:59 PM, revealed when leaving a contact precautions room, they take off the gloves first then untie the gown and remove it carefully. She stated untying the gown while wearing contaminated gloves could contaminate your personal clothing could cause residents and others to become sick from germs. She stated she received training some months ago.</p> <p>2. Review of the clinical records for Resident #6,</p>	F 441			



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

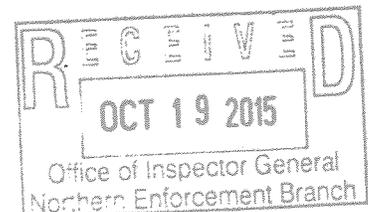
PRINTED: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/24/2015
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F 441	<p>Continued From page 9</p> <p>revealed the facility admitted the resident on 03/18/15 with diagnoses of Hypertension, Bipolar Disorder, Lung Cancer, and Dementia with Behavioral Disorder.</p> <p>Review of the clinical record for Resident #6, revealed the facility completed a quarterly MDS assessment on 06/25/15, and assessed the resident with a Brief Interview for Mental Status and a score of three (3) of fifteen (15) and was not interviewable. The resident was incontinent of bowel and bladder.</p> <p>Review of Resident #6's care plan, dated 09/20/15, revealed the resident had a urinary tract infection with Escherichia Coli Extended-Spectrum B-Lactamases, was incontinent, and was placed in contact precautions.</p> <p>Observation of Resident #6, on 09/22/15 at 9:52 AM, revealed Housekeeper #2 inside the resident's room. There was a sign posted on the door requesting everyone to see a nurse before entering the room and an isolation equipment table was located right outside the door. The Housekeeper wore a disposable gown over her clothing and had reusable yellow rubber gloves on her hands that came to mid forearm and resembled dishwashing gloves. The housekeeper exited the room and removed the yellow rubber gloves and placed them on top on the housekeeping cart. She then used a sanitizer on her hands and replaced the yellow rubber gloves. She removed a dust mop from the cart and went back into the room to continue cleaning.</p> <p>Interview with Housekeeper #1, on 09/22/15 at 3:06 PM, revealed she had received training on</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
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F 441	<p>Continued From page 10</p> <p>isolation. She stated she did wear rubber gloves in the room; however, she was not aware the gloves were to be disposable. She stated no one told her and people had seen her use the rubber gloves and nothing was ever said. She indicated the gloves might have germs on them and could be spread to others.</p> <p>Observation of Resident #6, on 09/22/15 at 2:42 PM, revealed Housekeeper #2 and Laundry Staff #1 rolled a large yellow trash can on wheels into the room to collect trash then rolled the cart back out into the hallway. The cart was half way over the threshold of the room.</p> <p>Interview with Laundry Staff #1, on 09/22/15 at 3:25 PM, revealed she had received training for handling of items from the isolation rooms. She stated she thought she rolled the cart just an inch or so into the isolation room. She stated the trash cart should have remained in the hallway to prevent spreading germs.</p> <p>Interview with the Director of Environmental Services, on 09/24/15 at 4:05 PM, revealed rubber gloves were not used when cleaning isolation or other rooms. She stated disposable gloves were to be worn and disposed of to prevent the spread of infection. She stated trash carts and housekeeping carts were to be left at the door to an isolation room to prevent the spread of germs to others.</p>	F 441			



**FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)**

PROVIDER NUMBER K1 185205	FACILITY NAME GREEN VALLEY HEALTH & REHABILITATION CENTER	SURVEY DATE *K4 09/23/2015
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K6 DATE OF PLAN APPROVAL 01/01/1976	K3 : MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS <u> 1 </u> NUMBER OF THIS BUILDING <u> 01 </u>	<input checked="" type="checkbox"/> A A BUILDING <input type="checkbox"/> B WING <input type="checkbox"/> C FLOOR <input type="checkbox"/> D APARTMENT UNIT
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<p>LSC FORM INDICATOR</p> <table border="1" style="width:100%; border-collapse: collapse; margin-bottom: 5px;"> <tr><th align="center" colspan="3">Health Care Form</th></tr> <tr><td style="width:5%;">12</td><td style="width:20%;">2786 R</td><td style="width:75%;">2000 EXISTING</td></tr> <tr><td>13</td><td>2786 R</td><td>2000 NEW</td></tr> </table> <table border="1" style="width:100%; border-collapse: collapse; margin-bottom: 5px;"> <tr><th align="center" colspan="3">ASC Form</th></tr> <tr><td style="width:5%;">14</td><td style="width:20%;">2786 U</td><td style="width:75%;">2000 EXISTING</td></tr> <tr><td>15</td><td>2786 U</td><td>2000 NEW</td></tr> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><th align="center" colspan="3">ICF/MR Form</th></tr> <tr><td style="width:5%;">16</td><td style="width:20%;">2786 V, W, X</td><td style="width:75%;">2000 EXISTING</td></tr> <tr><td>17</td><td>2786 V, W, X</td><td>2000 NEW</td></tr> </table> <p>*K7 <input type="checkbox"/> 12 SELECT NUMBER OF FORM USED FROM ABOVE</p> <p><i>(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)</i></p> <p>K29: <input type="checkbox"/> 3 K56: <input type="checkbox"/> 3</p>	Health Care Form			12	2786 R	2000 EXISTING	13	2786 R	2000 NEW	ASC Form			14	2786 U	2000 EXISTING	15	2786 U	2000 NEW	ICF/MR Form			16	2786 V, W, X	2000 EXISTING	17	2786 V, W, X	2000 NEW	<p>COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21</p> <p>SMALL (16 BEDS OR LESS)</p> <p>K8: <input type="checkbox"/> 1 PROMPT 2 SLOW 3 IMPRACTICAL</p> <hr/> <p>LARGE</p> <p>K8: <input type="checkbox"/> 4 PROMPT 5 SLOW 6 IMPRACTICAL</p> <hr/> <p>APARTMENT HOUSE</p> <p>K8: <input type="checkbox"/> 7 PROMPT 8 SLOW 9 IMPRACTICAL</p> <hr/> <p>ENTER E-SCORE HERE</p> <p>K5: <input type="checkbox"/> e.g 2.5</p>
Health Care Form																												
12	2786 R	2000 EXISTING																										
13	2786 R	2000 NEW																										
ASC Form																												
14	2786 U	2000 EXISTING																										
15	2786 U	2000 NEW																										
ICF/MR Form																												
16	2786 V, W, X	2000 EXISTING																										
17	2786 V, W, X	2000 NEW																										

***K9 : FACILITY MEETS LSC BASED ON:** *(Check all that apply)*

A1 <input type="checkbox"/>	A2 <input checked="" type="checkbox"/>	A3 <input type="checkbox"/>	A4 <input type="checkbox"/>	A5 <input type="checkbox"/>
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC: B. <input type="checkbox"/>	K180: A. <input checked="" type="checkbox"/> B. <input type="checkbox"/> C. <input type="checkbox"/> FULLY SPRINKLERED PARTIALLY SPRINKLERED NONE (All required areas are sprinklered) (Not all required areas are sprinklered) (No sprinkler system)
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***MANDATORY**

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

PRINTED: 10/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 10/15/2015
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
(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 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/02/15 as alleged.	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207, and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185205	(Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing	(Y3) Date of Revisit 10/15/2015
Name of Facility GREEN VALLEY HEALTH & REHABILITATION CENTER		Street Address, City, State, Zip Code 1206 ELEVENTH STREET CARROLLTON, KY 41045

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0029	Correction Completed 09/29/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0038	Correction Completed 10/02/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0147	Correction Completed 09/29/2015
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <i>SF</i>	Reviewed By <i>LT</i>	Date: <i>10/26/15</i>	Signature of Surveyor: <i>Sean Fulder-Mc</i>	Date: <i>10-26-15</i>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 9/23/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

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

PRINTED: 09/28/2015
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NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045
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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: 1977, 1989, 2007</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V Unprotected.</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator installed in 2005. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 09/23/15. The facility was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p> <p>Deficiencies were cited with the highest deficiency identified at "D" level.</p>	K 000	<p>This Plan of Correction is prepared and executed because it is required by the provisions of State and Federal law and not because Green Valley Health and Rehabilitation agrees with the citations noted on the pages of this Statement of Deficiencies.</p> <ol style="list-style-type: none"> 1. Door to the staff lounge was equipped with a self-closing device 9/25/2015. 2. Administrator completed a tour of the facility 9/28/2015 to ensure doors requiring self-closing devices were appropriately equipped. 3. Director of Maintenance will conduct monthly tours of the facility for three months then quarterly through 10/2016 to ensure doors requiring self-closing devices are appropriately equipped. 4. Director of Maintenance will report findings of facility tours to the Quality Assurance Committee quarterly through 10/2016. 	9/29/2015
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Christopher Thome</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10/15/15</i>
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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.

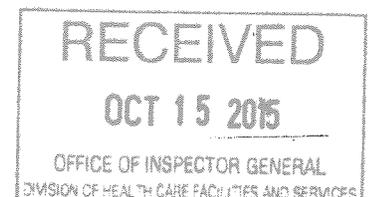
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If continuation sheet Page 1 of 10
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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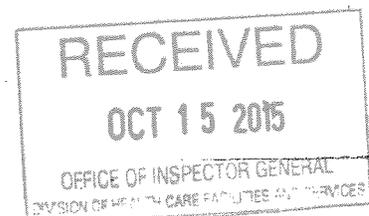
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K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, approximately twenty-five (25) residents, staff and visitors. The facility has seventy-eight (78) certified beds and the census was seventy-two (72) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 09/23/15 at 11:18 AM, with the Maintenance Director and the Regional Maintenance Director revealed the door to the Staff lounge, which had thirty-five (35) personal lockers located within the room, was not equipped with a self-closing device.</p>	K 029		



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K 029	<p>Continued From page 2</p> <p>Interview, on 09/23/15 at 11:20 AM, with the Maintenance Director and the Regional Maintenance Director revealed they were unaware of the code requirement of any room containing staff personal lockers, concealing unknown items, was classified as a hazardous storage room, requiring the door to be equipped with a self-closing device.</p> <p>The census of seventy-two (72) was verified by the Administrator, on 09/23/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director and the Regional Maintenance Director at the exit interview on 09/23/15.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms</p>	K 029			



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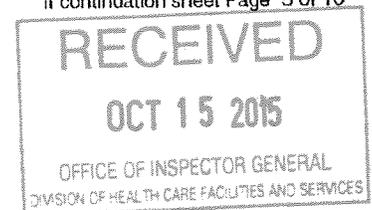
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K 029	Continued From page 3 (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029		
K 038 SS=D	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure exit doors equipped with fifteen (15) second delayed egress hardware were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility has seventy-eight (78) certified beds and the census was seventy-two	K 038	1. Exit door in the laundry room corridor was repaired by RF Technologies on 9/25/2015. 2. Director of Maintenance completed weekly TELS module of the facility 10/1/2015 to ensure fifteen (15) second egress doors functioned properly. 3. Director of Maintenance will conduct TELS module weekly to ensure fifteen (15) second egress doors function properly. 4. Director of Maintenance will report findings of weekly TELS checks of the fifteen (15) second egress doors to the Quality Assurance Committee quarterly through 10/2016.	10/2/2015

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES
OFFICE OF INSPECTOR GENERAL
FEDERAL BUREAU OF INVESTIGATION AND SERVICES

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

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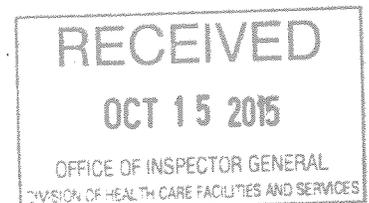
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/23/2015
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 038	<p>Continued From page 4 (72) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 09/23/15 at 1:19 PM, with the Maintenance Director and the Regional Maintenance Director revealed the exit door located in the laundry room corridor, was equipped with fifteen (15) second delayed egress hardware, but did not open within fifteen (15) seconds when tested. The exit door would open upon activation of the fire alarm system.</p> <p>Interview, on 09/23/15 at 1:21 PM, with the Maintenance Director and the Regional Maintenance Director revealed they were not aware the laundry room corridor exit door, equipped with fifteen (15) second delayed egress hardware was malfunctioning. They stated all exit doors were tested on the previous day, 09/22/15, and all of the exit doors functioned properly. Review of the facility's exit door test records, on 09/23/15 at 2:43 PM, confirmed all exit doors were tested on the previous day, 09/22/15, and functioned properly.</p> <p>The census of fifty-nine (72) was verified by the Administrator 09/23/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director and the Regional Maintenance Director at the exit interview on 09/23/15.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress</p>	K 038			



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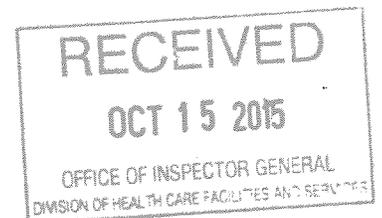
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K 038	Continued From page 5 locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once	K 038		



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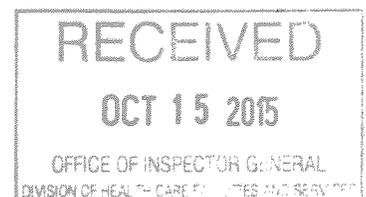
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K 038	Continued From page 6 the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any	K 038		



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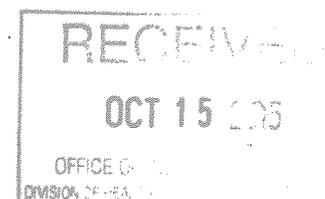
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K 038	Continued From page 7 exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.	K 038		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring and devices were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff, and visitors. The facility has seventy-eight (78) certified beds and the census was seventy-two (72) on the day of the survey.	K 147		



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K 147	Continued From page 8 The findings include: Observation, on 09/23/15 at 10:31 AM, with the Maintenance Director and the Regional Maintenance Director revealed an electrical panel located in the sitting room, near the main entrance, was thought to be locked, but the lock malfunctioned when tested. Electrical panels are required to be locked, when located in areas where residents have access, to prevent unauthorized entry. Interview, on 09/23/15 at 10:33 AM, with the Maintenance Director and the Regional Maintenance Director revealed they were aware of the requirement that electrical panels be locked when they are accessible to residents and visitors, but unaware of the lock not functioning properly. The census of seventy-two (72) was verified by the Administrator on 09/23/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director and the Regional Maintenance Director at the exit interview on 09/23/15. Reference: NFPA 70 (1999 edition) 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147	1. New lock was placed on the electrical panel in the sitting room near the main entrance on 9/25/2015. 2. Administrator completed a tour of the facility 9/28/2015 to ensure electrical panel locks functioned appropriately. 3. Director of Maintenance will conduct monthly tours of the facility for three months then quarterly through 10/2016 to ensure electrical panel locks function appropriately. 4. Director of Maintenance will report findings of facility tours to the Quality Assurance Committee quarterly through 10/2016.	9/29/2015



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