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

PRINTED: 10/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185464		10/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MEADOWS HEALTH CARE CENTER 1	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
F 000	INITIAL COMMENTS A standard health survey was initiated on 10/08/13 and concluded on 10/10/13 with deficiencies cited at the highest scope and severity of a "D". A Life Safety Code Survey was initiated and concluded on 10/10/13 with deficiencies cited at the highest scope and severity of an "F" with the facility having the opportunity to correct deficiencies before remedies would be recommended for imposition.	F 000	The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truths of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State laws.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure staff followed the care plan for continuous tube feeding for one (1) of twenty-one (21) sampled residents, Resident #6. The facility failed to follow the care plan developed related to Nutrition with an intervention to provide the tube feeding as ordered for Resident #6 to be continuos. The findings include: Review of the facility's policy regarding Comprehensive Care Plans, revised 11/2008, revealed the facility would develop a care plan to meet the residents medical and nursing needs, as identified in the comprehensive assessment.	F 282	RESIDENTS AFFECTED The care plan for Resident #6 was updated on 10/10/2013 to reflect the change of the tube feeding order for bolus feedings, Glucerna 1.2 at 1 can bolus 6 times a day. RESIDENTS POTENTIALLY AFFECTED All residents with continuous tube feeding ordered could possibly be affected should the staff not follow the care plan for continuous tube feeding. SYSTEMIC MEASURES A policy and procedure for administering enteral nutrition was created and all licensed nursing staff provided education on the new policy and procedure. This mandatory in-service has been completed for all licensed nurses by 11/06/2013. The Director of Nursing and Staff Development Coordinator have provided the training for all licensed nurses. The nurses providing care to Resident #6 during the survey received education presented by the Director of Nursing which addressed following the plan of care for continuous tube feedings. One of the nurses received training on 10/17/2013 the other nurse received training on 10/21/2013.	11/20/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X [signature] TITLE: X Administrator (X6) DATE: X 11/14/2013

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

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F 282	Continued From page 1 The policy stated the care plan would be kept in a binder and be accessible to all personnel for implementation and monitoring of the resident's care. Review of the medical record for Resident #6 revealed the facility admitted the resident on 09/13/13 with diagnoses of Intracerebral Hemorrhage and Pneumonia. Review of the physicians orders revealed on admission the resident's diet was nothing by mouth with tube feeding at fifty-five (55) cubic centimeters (cc) per hour continuously. An order was written on 09/24/13 for the tube feeding to run at 60 cc an hour continuously. Review of the Comprehensive Care Plan for Resident #6 revealed the facility developed a care plan potential for altered nutrition related to nutrition and hydration needs to be met via tube feeding regimen. An intervention listed was provide tube feeding per order. Observation, on 10/08/13 at 12:10 PM, revealed Resident #6 sitting up in the wheelchair in the room. The resident was receiving a breathing treatment. The tube feeding was not infusing. The resident stated he/she did not eat by mouth. Observation at 1:30 PM found the resident out of the room. The feeding pump remained in the room. At 2:50 PM, the resident was in the room with a Speech Therapist. The tube feeding was not infusing at that time. Observation, at 3:40 PM, 4:00 PM and 5:00 PM, found the resident lying in the bed with the tube feeding disconnected and not infusing. Observation, on 10/09/13 at 3:15 PM, found Resident #6 out of the room. The feeding pump	F 282	Continued from page 1 MONITORING MEASURES The Staff Development Coordinator will monitor the residents receiving tube feedings on a weekly basis. Findings will be documented, staff education provided as needed and a written summary of findings will be presented to the Quality Assessment and Assurance Committee on a monthly basis reflecting audits for twelve (12) months commencing in November 2013. The Quality Assessment and Assurance Committee will evaluate the effectiveness of the program to monitor the process and provide direction for further actions to be taken as necessary.	

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F 282	Continued From page 2 and tube feed remained in the room. Observation, on 10/10/13 at 1:40 PM, found Resident #6 in the Therapy Department with the tube feeding not present with the resident. Interview with LPN #3, on 10/10/13 at 1:50 PM, who had been providing care for Resident #6 on that day, revealed she had placed the tube feeding on hold for Resident #6 to go to the Therapy Department. She stated the nursing staff had been doing this. She further stated she was not sure of the protocol for a patient on continuous tube feeding and when it could be turned off. She stated a potential complication for the resident not receiving tube feeding as ordered and care planned was malnutrition. Interview, on 10/10/13 at 1:00 PM, with Licensed Practical Nurse (LPN) #2 revealed a resident's tube feeding should run continually if that is the way the physician ordered it. She stated it should not be turned off unless there was an order to hold the tube feeding for therapy or other care needs and there was no order to hold the tube feeding. Interview with the Occupational Therapist, on 10/10/13 at 1:45 PM, revealed the therapist would ask for the tube feeding to be put on hold when the resident came to the Therapy Department. She stated the nursing staff never indicated the tube feeding could not be on hold for Resident #6 during therapy. Interview with Registered Nurse #1, on 10/10/13 at 4:05 PM, revealed if the resident did not receive tube feedings as ordered the care plan was not followed. He stated there was not an	F 282		

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F 282	Continued From page 3 order to hold the tube feeding for therapy. Interview with the Director of Nursing (DON), on 10/10/13 at 4:10 PM, revealed the facility failed to follow the care plan when they failed to follow the Physician orders.	F 282		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure a tube feeding was administered continuously as ordered for one (1) of twenty-one (21) sampled residents, Resident #6. The findings include: Interview with the Director of Nursing, on 10/10/13 at 4:10 PM, revealed the facility did not have a policy on continuous tube feeding or following Physician orders. Review of the medical record for Resident #6	F 328	RESIDENTS AFFECTED The tube feeding order for Resident #6 was changed to bolus feedings, Glucerna 1.2 at 1 can bolus 6 times a day. The care plan for Resident #6 was updated on 10/10/2013 to reflect the change of the tube feeding order. RESIDENTS POTENTIALLY AFFECTED All residents with continuous tube feeding ordered could possibly be affected should the staff not administer the feeding as ordered. SYSTEMIC MEASURES A policy and procedure for administering enteral nutrition was created and all licensed nursing staff have been provided education on the new policy and procedure, including the provision of tube feedings according to physician's orders. This mandatory in-service was completed by 11/06/2013 for all licensed nurses. The Director of Nursing and Staff Development Coordinator have provided the training to all licensed nurses. The nurses providing care to Resident #6 during the survey received education presented by the Director of Nursing addressing following the physician's orders and plan of care for continuous tube feeding orders. MONITORING MEASURES The Staff Development Coordinator will monitor	11/20/2013

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F 328	Continued From page 4 revealed the facility admitted the resident on 09/13/13 with diagnoses of Intracerebral Hemorrhage and Pneumonia. Review of the physicians orders revealed on admission the resident's diet was nothing by mouth with tube feeding to infuse at fifty-five (55) cubic centimeter (cc) per hour continuously. An order was written on 09/24/13 for the tube feeding to infuse at sixty (60) cc an hour continuously. Review of the Nutrition assessment, dated 09/18/13, revealed the Dietician made a recommendation to increase the tube feeding to 60 cc/hr continuously to meet the resident's caloric needs to maintain the current body weight. A note, dated 10/02/13, revealed the resident had gained 6.5 pounds since 09/20/13. Observation, on 10/08/13 at 12:10 PM, revealed Resident #6 was sitting up in the wheelchair in the room. The resident was receiving a breathing treatment at the time. The tube feeding was not infusing. The resident stated he/she did not eat by mouth. Observation at 1:30 PM found the resident out of the room and the feeding pump remained in the room. At 2:50 PM, the resident was in the room with a Speech Therapist. The tube feeding was not infusing at that time. Observation at 3:40 PM, 4:00 PM and 5:00 PM found the resident lying in the bed with the tube feeding disconnected and not infusing. Observation, on 10/09/13 at 3:15 PM, found Resident #6 out of the room while the feeding pump and tube feed remained in the room. Observation, on 10/10/13 at 1:40 PM, found Resident #6 in the Therapy Department with the tube feeding not present with the resident.	F 328	Continued from page 4 the residents receiving tube feeding on a weekly basis. Findings will be documented reflecting observation of infusion of tube feedings at random times throughout the day. Education will be provided to staff as needed. A summary of findings will be presented in writing to the Quality Assessment and Assurance Committee on a monthly basis for twelve (12) months commencing in November 2013. The Quality Assessment and Assurance Committee will evaluate the effectiveness of the program to monitor the process and provide direction for further actions to be taken as necessary.	

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F 328	Continued From page 5 Interview with Licensed Practical Nurse (LPN) #2, on 10/10/13 at 1:00 PM, revealed if a resident had an order for a continuous tube feeding it should run continually. She stated it should not be turned off unless there was an order to hold the tube feeding for therapy or other care needs. She stated there was not an order to hold the tube feeding for Resident #6. Interview with the Director of Nursing, on 10/10/13 at 1:25 PM, revealed if there was an order for a continuous tube feeding for a resident it should be continuous and taken with the resident to therapy. Interview with the Occupational Therapist, on 10/10/13 at 1:45 PM, revealed the therapist would ask the nursing staff to hold the tube feeding when the resident came to the Therapy Department. She stated nursing never indicated the tube feeding could not be on hold for Resident #6. Interview with LPN #3, on 10/10/13 at 1:50 PM, who had been providing care for Resident #6 on that day, revealed she had placed the tube feeding on hold for Resident #6 to go to the Therapy Department. She stated nursing had been doing this. She stated she was not sure of the protocol for a patient on continuous tube feeding and when it could be turned off. She stated the potential complication if the resident was not receiving tube feeding as ordered was malnutrition. Interview with the Registered Dietician (RD) via telephone, on 10/10/13 at 2:30 PM, revealed the RD who was assigned to this facility was on vacation. She stated they were a contracted	F 328		

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F 328	Continued From page 6 service and visited the facilities once a week. She stated if the Resident had an order for continuous tube feed they assumed it was running continuously unless documented otherwise. She stated usually they would write a recommendation for the tube feeding to run twenty-two (22) hours to allow for bathing and other care needs of the resident. She stated the recommendation was based on an estimated calculation to maintain the resident's current weight. She stated if the resident's tube feeding was not running as recommended there was a potential for weight loss.	F 328		

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1990 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III Unprotected, Mixed Construction. SMOKE COMPARTMENTS: Seven (7) smoke compartments. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic dry sprinkler system. GENERATOR: Type II, 100KW generator. Fuel source is Natural Gas. A standard Life Safety Code survey was conducted on 10/10/13. Green Meadows Health Care Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. 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	K 000	The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truths of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State laws.	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

X [signature] — X Administrator — X 11/14/2013

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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K 000	Continued From page 1 deficiency identified at F level.	K 000		
K 045 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect five (5) of seven (7) smoke compartments, all residents, staff and visitors. The facility has one-hundred and twenty-two (122) certified beds and the census was one-hundred and three (103) on the day of the survey. The facility failed to provide the required level of illumination outside an exit for discharge. The findings include: Observations, on 10/10/13 between 8:42 AM and 10:20 AM, with the Maintenance Director revealed the exits from the Activities Room at the South Wing, small Dining Room at the South Wing, the Therapy Gym, the Main Dining Room and the T.V. Room at the North Wing, did not have exterior egress lighting to provide the required level of illumination at each exit discharge location. The exits were equipped with a light fixture with only one bulb.	K 045	RESIDENTS AFFECTED All residents of the facility had the potential to be affected, however no specific residents identified as having been affected. The Director of Maintenance has contacted a vendor to order the fixtures on 11/14/2013. RESIDENTS POTENTIALLY AFFECTED All residents have the potential to be affected should the facility fail to provide the required level of illumination outside and exit for discharge. SYSTEMIC MEASURES The Director of Maintenance checked all lighting fixtures at all exterior egress to identify any other lighting fixtures that would need to be replaced with appropriate light fixtures. No others were identified. The lighting fixtures will be replaced and provide the required level of illumination outside all exits for discharge by 11/24/2013. MONITORING MEASURES The Director of Maintenance will check all light fixtures at exits for discharge on a monthly basis to ensure proper illumination. Findings will be put in writing and presented to the Quality Assessment and Assurance Committee on a monthly basis. The Quality Assessment and Assurance Committee will determine the effectiveness of the monitoring and provide directions to the Director of Maintenance for any necessary changes to the monitoring system.	11/24/2013

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K 045	Continued From page 2 Interviews, on 10/10/13 between 8:42 AM and 10:20 PM, with the Maintenance Director revealed he was not aware of the requirement for exterior light fixtures required for egress to have two (2) bulbs. Reference NFPA 101 (2000 edition) 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. 7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation,	K 045		

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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

(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 045	Continued From page 3 the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050	RESIDENTS AFFECTED All residents of the facility had the potential to be affected however no specific residents were identified as having been affected. RESIDENTS POTENTIALLY AFFECTED All residents of the facility have the potential to be affected by the facility's failure to conduct fire drills quarterly on each shift at random times. SYSTEMIC MEASURES The Administrator provided education to the Director of Maintenance on the standard for conducting, documenting and maintaining records of fire drills per established standards.	11/20/2013

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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 10/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185464		10/10/2013

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K 050	Continued From page 4	K 050	Continued from page 4	

This STANDARD is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect each of the seven (7) smoke compartments, all residents, staff, and visitors. The facility has one-hundred and twenty-two (122) certified beds and the census was one-hundred and three (103) on the day of the survey.

The findings include:

Record review, on 10/10/13 at 1:02 PM, with the Maintenance Director revealed the facility had no documentation of fire drills being conducted during the second shift in the second quarter of 2013 and during the third shift in the first quarter of 2013.

Interview, on 10/10/13 at 1:02 PM, with the Maintenance Director revealed he was not aware of fire drills not being conducted at a minimum of one per shift per quarter at random times.

Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.

This education was provided on to the Director of Maintenance on October 22, 2013. The Director of Maintenance will conduct fire drills quarterly on each shift at random times. A copy of each fire drill that has been conducted during the prior month will be presented to the Quality Assessment and Assurance Committee. The Quality Assessment and Assurance Committee will review the reports and make the determination of any necessary changes to the action plan to ensure compliance.

MONITORING MEASURES
The Director of Maintenance will present copies of all fire drills to the Quality Assessment and Assurance Committee on a monthly basis commencing in October 2013. The Quality Assessment and Assurance Committee will review the written report on fire drills presented by the Director of Maintenance. Any changes necessary will be directed by the Quality Assessment and Assurance Committee.

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