

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

PRINTED: 05/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/13/2011
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)	(X6) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 5/13/2011 for an abbreviated survey investigating complaint #KY16427 and found the complaint to be substantiated. The facility was found not to meet the minimum requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F". NFPA 101 LIFE SAFETY CODE STANDARD	K 000	Green Meadows Health Care Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance.	
K 038 SS=F	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 and interview, it was determined the facility failed to ensure exit doors were maintained free from obstructions to full instant use in the case of fire or other emergencies according to NFPA standards. The findings include: Observation on 05/13/11 at 10:50 AM revealed the exit door located in the dining room was blocked by another door from the kitchen propped open with boxes, and a chair. Interview on 05/13/11 at 10:50 AM with the Maintenance Director and kitchen staff indicated	K 038	Green Meadows Health Care Center's response to the Statement of Deficiencies and Plan of Correction does not constitute an admission that any deficiency is accurate. Further Green Meadows Health Care Center reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceedings. <u>K038</u> The boxes and chair being used to prop open the door from the kitchen were removed on 05/13/2011 upon being identified, allowing full instant use to	06/02/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *06/02/2011*

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.

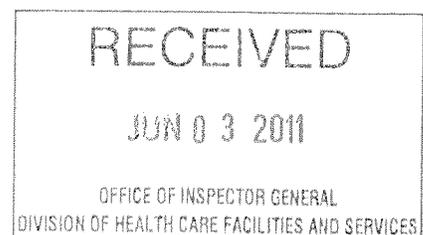
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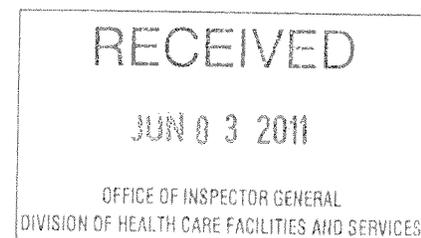
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K 038	Continued From page 1 that this is a common practice when returning trays to the kitchen. Observation on 05/13/11 at 11:15 AM revealed a slide bolt lock installed on doors leading from the dining lounge to the corridor. These doors are located in the temporary path of egress while construction is being completed. Interview on 05/13/11 at 11:15 AM with the Maintenance Director indicated he was unaware that slide bolt locks were prohibited. Observation on 05/13/11 at 11:20 AM revealed a trailer barbecue grill blocking the ramp from the sidewalk to the parking lot. Interview on 05/13/11 at 11:20 AM with the person barbecuing did not realize he had parked the grill on the ramp and moved the grill to another location. Reference: NFPA 101 (2000 edition) 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency Reference: NFPA 101 (2000 edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 038	the exit door in the case of a fire or other emergencies according to NFPA standards. The slide bolt lock was removed on 05/13/2011 from the doors leading from the dining lounge to the corridor ensuring readily accessibility to exits. The vendor who was donating the service of his trailer barbecue grill in celebration of national nursing home week for residents, families, and staff moved the grill away from the ramp on 05/13/2011 upon identification. Interviews of staff working in the dietary department on 05/13/2011 were done to determine who had used the boxes and chair to prop open the door from the kitchen and why they had done so. Education was provided to these staff by the Director of Maintenance as well as being reinforced by the contracted consulting Registered Dietitian on 05/13/2011. The Food Service Supervisor was advised on the need to reinforce and provide ongoing education of dietary employees to not prop open doors in	
K 048	NFPA 101 LIFE SAFETY CODE STANDARD	K 048		



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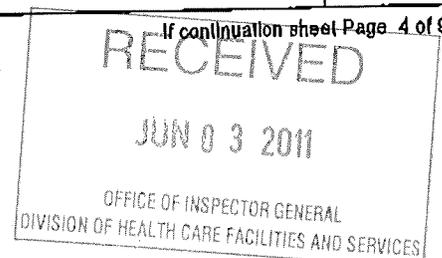
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K 048 SS=F	Continued From page 2 There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have a written plan for the evacuation of residents in the event of an emergency. The deficient practice affected all residents, staff and visitors. The findings include: Observation on 05/13/11 revealed the facility was undergoing renovation in the main entrance back to the main corridor. Arrival at the facility revealed the main entrance to be blocked off for construction personnel only. A second entrance was the temporary main entrance until the facility was complete with the renovation project. Touring the renovation project from the inside with the Maintenance Director revealed that the main corridor had been blocked off with plywood barriers to prevent residents from entering the area under construction. An alternate path through the dining room, around the construction was found to provide ample room to meet egress requirements. The dining room has a marked exit that is not on the evacuation plan, and a new evacuation policy was not in place to offset the removal of the main entrance from the evacuation route. Interview on 05/13/11 with the Maintenance Director revealed that they had not implemented	K 048	the kitchen, dining room, food storage and preparation areas. A walkthrough was made of the entire facility including outside exit areas on 05/13/2011 to ensure exit access was arranged so that exits are readily accessible at all times. All identified concerns were addressed at that time. Education of all facility staff continued on 05/14 through 05/15/2011. Another audit of entire facility was done by Administrator on 05/17/2011 to identify any concerns. A similar audit was completed on 05/26/2011 and 05/31/2011 by the Administrator. A follow up audit was completed 06/03/2011 by the Assistant Director of Maintenance and Floor Tech to ensure all exit doors and means of egress were maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. Employees will be provided education during the general orientation process to address ensuring exit doors are maintained free from obstructions to full instant use in the case of fire or other emergencies. Department Heads	



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K 048	<p>Continued From page 3</p> <p>a new evacuation policy while the main entrance was unusable, and other than verbal, no training or fire drills had been conducted since the remodel began on 03/28/11.</p> <p>Interview on 05/13/11 with two nurses located in the North Wing, and with a member of staff located in the South Wing revealed; All persons interviewed were aware of the obstruction in the current evacuation route and were able to identify all of the other exills in the building by memory and gave an acceptable answer on the route they would take when presented with a possible fire scenario.</p> <p>Actual NFPA Standard: 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every healthcare occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff)</p>	K 048	<p>will notify all vendors who deliver product/supplies/services to the facility to not block means of egress.</p> <p>Audits of all means of egress will be made on a weekly basis by the representatives of the maintenance and/or housekeeping department, having been implemented May 13, 2011. These weekly audits will be done for 12 consecutive weeks (through July 30, 2011). The audits will then be conducted on a monthly basis thereafter. Findings of the audits and a report of actions taken will be presented in writing to the Director of Risks Management on a monthly basis for presentation and review by the Quality Assessment and Assurance (QA&A) Committee. The QA&A Committee will determine action to be taken regarding the frequency of audits. The Director of Maintenance will be responsible for monitoring performance to ensure solutions are sustained.</p>	



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K 048	Continued From page 4 with the signals and emergency action required under varied condllions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2 Procedure In Case of Fire. 19.7.2.1* For health care occupancies, the proper protection of pallents shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy ' s fire safety plan. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmision of alarm to fire department (3) Response to alarms (4) Isolallon of fire (5) Evacuallon of Immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and bulding for evacuation (8) Extlngulshment of fire 19.7.2.3	K 048	<u>K048</u> The Emergency Evacuation Plan was revised on 05/13/2011 to reflect the alternate path around the construction, reflecting the removal of the main entrance from the evacuation route. The revised Emergency Evacuation Plan was posted throughout the facility on 05/13/2011. Employee education was initiated on 05/13/2011 and continued through 05/15/2011 reflecting the revisions to the Emergency Evacuation Plan. All residents, staff and visitors had the potential to be affected by the facility's failure to have a revised Emergency Evacuation Plan during the construction. The written plan for the protection of all residents and for their evacuation in the event of an emergency will be reviewed and revised in the event of renovation, construction, and/or blocking off of access of evacuation route. These revisions will be presented to staff. A fire drill will be	06/21/2011

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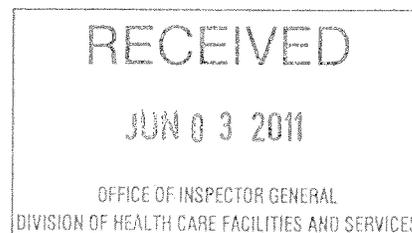
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K 048	Continued From page 6 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined in the fire safety plan.	K 048	conducted on all three shifts to ensure knowledge of revisions made in the evacuation route. Events that will affect the evacuation of residents will be addressed by the QA&A Committee when identified so an action plan can be developed, staff educated and revisions implemented. The Director of Maintenance will be responsible for monitoring performance to ensure solutions are sustained.	
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the installed fire extinguishers to be free of obstructions. The deficient practice affected one of seven smoke compartments, staff and all residents. Findings include: Observation on 05/13/11 at 11:00 AM revealed that the portable fire extinguisher located in the dining room was blocked by chairs stored under the extinguisher.	K 064	<u>K064</u> The chairs stored underneath the portable fire extinguisher in the dining room were removed on 05/13/2011. All portable fire extinguishers were checked throughout the facility by the Administrator on May 13, 2011 to ensure to ensure there were no obstructions to access or visibility. Education was provided to all staff on the importance and requirement of not	06/21/2011

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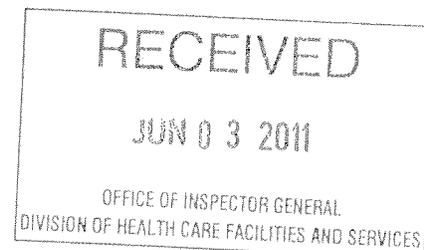
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K 064	Continued From page 6 Interview with the Maintenance Director revealed he was unaware of the obstruction. Reference: NFPA 10 6.2.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected, manually or by electronic monitoring, at more frequent intervals when circumstances require. 6.2.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Operating instructions on nameplate legible and facing outward (4)* Safety seals and tamper indicators not broken or missing (5) Fullness determined by weighing or "hefting" (6) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (7) Pressure gauge reading or indicator in the operable range or position (8) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (9) HMIS label in place NFPA 101 LIFE SAFETY CODE STANDARD	K 064	blocking access to portable fire extinguishers at any time. The education was initiated on May 13, 2011 and continued through May 15, 2011. Education on immediate, unobstructed access and visibility of portable fire extinguishers is included in the general orientation of all employees. A weekly audit of all portable fire extinguishers will continue to be done by the Administrator and/or Director of Maintenance for twelve consecutive weeks beginning May 13, 2011 through August 4, 2011. Thereafter checks on the fire extinguishers will continue at approximately 30-day intervals by the Director of Maintenance. Reports of weekly and 30-day interval checks will be presented by the Director of Maintenance to the QA&A Committee on a monthly basis.	
K 072 SS=F	Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072		



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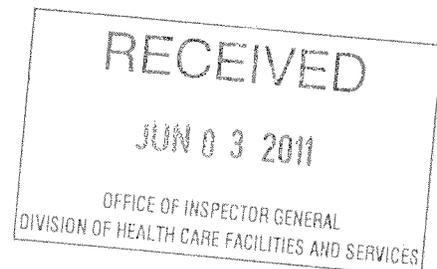
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K 072	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit doors were maintained free from obstructions to full instant use in the case of fire or other emergencies according to NFPA standards. The findings include: Observation on 05/13/11 at 11:00 AM revealed mini blinds located on exit doors throughout the facility. The observations were confirmed with the Maintenance Director, and the Administrator. An interview, on 05/13/11 at 11:00 AM with the Maintenance Director, and the Administrator revealed they were unaware that the mini blinds could not be on the exit doors. Reference: NFPA 101 (2000 edition) 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 072	<u>K072</u> The mini blinds were removed from all exit doors throughout the facility on 05/13/2011. All means of egress were checked on 05/13/2011 by the Director of Maintenance to ensure they were free of any obstructions or impediments. Education to all Department Heads initiated on 05/13/2011 and continued through 05/16/2011 about need for means of egress to be free of all obstructions or impediments. Exit doors will be checked on a monthly basis by the Director of Maintenance and/or Assistant Director of Maintenance to ensure exit doors are maintained free from obstructions or impediments. Report of audits/checks will be made by Director of Maintenance to the QA&A Committee on a monthly basis.	06/21/2011
K 147 SS=E		K 147		



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K 147	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficiency affected one (1) smoke compartment, including residents, staff, and visitors. The findings include: Observations on 05/13/2011 at 11:00 AM, with the Administrator revealed an electrical panel located in the resident corridor was unlocked. Interview on 05/13/2011 at 11:15 AM, with the Maintenance Director, revealed electricians working on the remodel of the front entrance had been working in that electrical panel. On the day of the survey there were no electricians working. This was confirmed with the Maintenance Director. Reference: NFPA 99 (1999 edition)	K 147	<u>K147</u> The electrical panel was locked upon being identified as not being locked on 05/13/2011 by the Director of Maintenance. All electrical panels were checked on 05/13/2011 to ensure they were locked. The Administrator checked all electrical panels again on 05/14/2011 to ensure they were locked. Administrator met with the assigned Interim building superintendent on 05/16/2011 to advise him electrical panels need to remain locked when not in use by the electricians. Administrator also conveyed this message to project manager and electrician on 05/16/2011. The electrical panels throughout the facility have been checked once a week since 05/13/2011 by the Administrator. Weekly checks of all electrical panels will be done for 12 consecutive weeks beginning 05/13/2011. Thereafter checks of all electrical panels will be	06/21/2011



K147

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done on a monthly basis by the Director or Assistant Director of Maintenance. Findings of these checks of all electrical panels will be presented to the QA&A Committee by the Director of Assistant Director of Maintenance.

Green Meadows Health Care Center

Provider #: 185464

Date Survey Completed: 05/13/2011

Event ID: UNHM21

Facility ID: 100637A

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