

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

PRINTED: 01/07/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2014
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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345
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F 000 INITIAL COMMENTS

A Recertification Survey was initiated on 12/16/14 and concluded on 12/18/14. Deficient practice was identified with the highest Scope and Severity at an "E" level.

F 252 483.15(h)(1)
SS=D SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, review of the facility's "Environmental Weekly Safety Round" document and the facility's plumber work order documentation, it was determined the facility failed to ensure water temperatures were within standard acceptable parameters.

Observation of water temperatures taken revealed in resident rooms 124, 204 and 208 temperatures were out of the standard range of 100 to 110 degrees Fahrenheit.

The findings include:

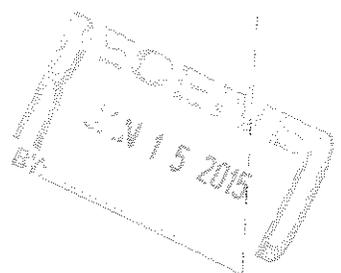
Review of the facility's "Environmental Weekly Safety Round" document revealed water temperatures was an area to be audited during the performance of the rounds.

Observation on 12/16/14 at 9:00 AM during initial tour of the facility revealed the hot water

F 000 RESPONSE PREFACE

Diversicare of Greenville 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.

Diversicare of Greenville's response the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Diversicare of Greenville reserves the right to submit documentation to refute any of the stated deficiencies of this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any administrative or legal proceeding.



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Stacey Bullock, RHA</i>	TITLE Administrator	(X6) DATE 1/8/15
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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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F 252 Continued From page 1
temperatures were: 94 degrees Farenheit for resident room 124; 94 degrees Farenheit for resident room 204; and 90 degrees Farenheit for resident room 208. Further observation on 12/16/14 at 3:00 PM revealed the hot water temperatures were: 94 degrees Farenheit for resident room 124; 92 degrees Farenheit for resident room 204; and 92 degrees Farenheit for resident room 208.

Interview on 12/17/14 at 9:10 AM with Certified Nursing Assistant (CNA) #2 revealed temperatures were taken in the shower rooms before the start of resident showers. CNA #2 stated the water temperatures were reported to the Charge Nurse.

Interview with CNA #3 on 12/17/14 at 12:15 PM, revealed shower aides took hot water temperatures prior to giving resident showers and the range of the temperatures should be between 100 to 110 degrees Farenheit. Per interview, usually five (5) or six (6) showers could be given before the water felt cool and sometimes the hot water temperatures were taken again when that occurred. Further interview with CNA #3 on 12/18/14 at 12:35 PM, revealed during perineal care for Resident #1 the CNA reported the hot water temperature was not warm enough in the resident's room, and the CNA proceeded to the shower room to obtain warmer water for cleansing the resident.

Interview with the Charge Nurse on 12/17/14 at 9:25 AM, revealed hot water temperatures were taken every morning and afternoon before residents' showers were given and reported to him. Per interview, approximately eleven (11) to twelve (12) showers were given on day shift, and

F 252
F 252
Criteria #1: One of the facility hot water heaters was replaced on 12/19/14 by a plumbing contractor. The Maintenance Director followed up with auditing temperatures in all resident rooms including 124, 204, and 208. Temperatures in all resident rooms were noted by the Maintenance Director to be within standard acceptable parameters on 12/24/14. Nursing department immediately began checking all residents water temperatures prior to bed bath or peri care to ensure temperatures were within standard acceptable parameters on 12/18/14.

Criteria #2: The deficient practice had the potential to affect 19 residents (C Hall) in the facility. A licensed plumber assessed the facility hot water tanks on 12/18/14 and determined 1 of the facilities hot water heaters was not functioning appropriately and which halls were affected. All resident rooms were audited by the maintenance director to ensure only these rooms were affected on 12/18/14. Social Services Director interviewed all residents for any concerns voiced in regards to water temperatures and the facility providing a safe, clean, comfortable, and homelike environment, allowing resident to use his or her personal belongings to the extent possible on 12/18/14. Any concerns were immediately brought to the Quality Assurance Committee for review and follow up.

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F 252	Continued From page 2 approximately six (6) to eight (8) were given in the evenings. The Charge Nurse stated additionally sponge baths were given for residents who requested that. Additional interview revealed should a low hot water temperature reading occur it was reported to maintenance to address. Interview with the Maintenance Director on 12/16/14 at 10:00 AM and 12/18/14 at 5:35 PM, revealed he did not take hot water temperatures every day and randomly selected rooms on both sides of the halls when he took the temperatures. The Maintenance Director stated although he had identified an issue with variances of hot water temperatures on the 100 and 200 halls since 12/16/14, he had not done anything about it. Per interview, staff could give three (3) or four (4) showers with hot water temperature remaining at 110 degrees Farenheit. He revealed the hot water temperatures should be between the standard range of 100 and 110 degrees Farenheit at all times; however, it was possible the hot water heater could have calcium in it causing lower temperatures. The Maintenance Director stated the facility's contracted plumber had been contacted and was supposed to check the hot water heater. Review of the plumber's work order documentation dated 12/18/14, revealed one (1) of the facility's fifty (50) gallon water tanks was "not getting hot". Continued review revealed the plumber documented "need to replace both tanks" and check the circulating pump while the system was down. Interview with the Administrator on 12/18/14 at 12:47 PM, revealed hot water temperatures should be between the range of 100 to 110	F 252	Criteria #3: Maintenance Director and staff development coordinator were in-serviced on F 252 Safe/Clean/Comfortable/Homelike Environment and immediate interventions put in place to ensure F 252 is followed on 12/16/14 by the administrator. The staff development coordinator will in-service all remaining staff on F 252. All staff in-service education will be completed by target date. Any staff member that has not received in-service by target date will receive in-service prior to their next days' work. Criteria #4: The maintenance Director will monitor all rooms on C hall and 10% random rooms on other halls to ensure water temperature is within standard acceptable parameters daily times 7 days, then 10% random room audits on all halls weekly times 4 weeks, then monthly ongoing. The maintenance Director will report findings to the Quality Assurance Performance Improvement committee weekly X 4 weeks, then monthly. The Quality Assurance Performance Improvement committee may increase or decrease monitoring according to findings. The Quality Assurance Performance Improvement committee is comprised of the Administrator, Director of Nursing Services, Medical Director, Assistant Director of Nursing, Activities Director, Staff Development Coordinator, Dietary Manager, Social Services Director, Business office manager, payroll manager, medical records director, and Admissions MDS Coordinator, and Housekeeping Supervisor. Criteria #5: Target date	1/31/2015	

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F 252	Continued From page 3 degrees Farenheit. Per interview, the comfort level of the lower hot water temperatures was subjective and the contractor was to come that day. The Administrator stated depending on the contractor's findings, the facility might need to purchase one (1) new hot water heater.	F 252		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's "Housekeeping In-Service" documentation, it was determined the facility failed to ensure housekeeping and maintenance services were provided to maintain a sanitary, orderly and comfortable interior. Observation of the facility's community shower rooms revealed cracked, broken or missing tiles. Continued observation of all the shower rooms revealed a brownish to black substance on the floors and walls. Additionally, observation of the shower chairs revealed one (1) of the safety belts on one (1) chair to have a brownish to black substance on the belt. The findings include: Review of the facility's "Housekeeping In-Service" documentation revealed it the subject was titled, "7-Step Daily Washroom Cleaning" dated 05/11/00. Review of the "7-Step Daily Washroom Cleaning" documentation revealed staff were to	F 253	F 253 Criteria #1: All shower rooms with broken tile, missing grout, cracked peeling toilet lid covers, and discolored grout were repaired by the Maintenance Director. Repair work was completed by 12/22/14. Housekeeping Department deep cleaned all shower rooms including all grout in all shower rooms on 12/18/14 prior to Maintenance Director repairs to ensure all grout was in need of repair instead of just deep clean. All shower chair belts were removed and laundered. New belts were ordered to replace any stained belts by the maintenance director on 12/19/14. Contractors were in the facility 1/9/14 to estimate cost and timeline for shower room renovations to be completed over the next few months. Criteria #2: The deficient practice had the potential to affect all residents that used shower rooms in the facility and staff that used shower rooms. All shower rooms were assessed for any needed repair work of grout, tile, shower chair belts, and toilets seats by the Maintenance Director on 12/18/14 to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	

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F 253 Continued From page 4

spray sanitizer on the shower stall walls and fixtures, and wipe it down using a brush if needed. Per the documentation this killed germs, mildew and mold. Continued review revealed when cleaning the shower chairs and gurney staff were to spray with a germicide and wipe them down using a brush as needed to get into grout easier.

Review of the facility's, "Cleaning Procedures" documentation dated 05/01/05, revealed a procedure titled, "Scrub Ceramic Tile" which noted staff were to use a wire or grout brush to scrub while applying the cleaning solution to the tiles. Further review of the "Cleaning Procedures" revealed a procedure titled "Bathroom Cleaning" which noted staff were to spot clean the walls.

Review of the facility's "Quality Control Inspection Housekeeping" documents dated 12/10/14 and 12/15/14 revealed deep cleaning of the bathroom walls and floor on those dates was completed with no issues noted.

Review of the facility's "Deep Clean" schedules for the shower rooms revealed 11/12/14 and 11/26/14 "all shower rooms" were to be deep cleaned. Review of the December "Deep Clean" schedule revealed all shower rooms were to be deep cleaned every Wednesday.

Observation on 12/16/14 at 9:08 AM during the initial tour of the facility revealed the shower room on the 200 hall had tile missing on corner of the shower stall with a brownish black substance in the grout lines. Continued observation on 12/16/14 at 9:20 AM, in shower room 230 revealed a brownish black substance in the grout lines between the tiles, and a shower chair with a

F 253 Criteria #3: Maintenance Director and Housekeeping Supervisor were in-serviced on F 253 Housekeeping & Maintenance Service and immediate interventions put in place to ensure F 253 is followed on 12/18/14 by the administrator. The Housekeeping supervisor will in-service all remaining housekeeping staff on F 253 and interventions in place to ensure F 253 is followed. All staff in-service education will be completed by target date. Any staff member that has not received in-service by target date will receive in-service prior to their next days' work.

Criteria #4: The Housekeeping Supervisor will monitor all shower rooms for any stained grout, cracked or missing tile, toilet seat repairs, shower chair belts, and any other housekeeping or maintenance service needs daily times 7 days, then weekly times 4 weeks, then monthly ongoing. The Housekeeping Supervisor will report findings to the Quality Assurance Performance Improvement committee weekly X 4 weeks, then monthly. The Quality Assurance Performance Improvement committee may increase or decrease monitoring according to findings. The Quality Assurance Performance Improvement committee is comprised of the Administrator, Director of Nursing Services, Medical Director, Assistant Director of Nursing, Activities Director, Staff Development Coordinator, Dietary Manager, Social Services Director, Business office manager, payroll manager, medical records director, and Admissions Director, MDS Coordinator, and Housekeeping Supervisor.

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F 253 Continued From page 5
safety belt attached which had a brownish black discoloration on the belt. Further observation during the initial tour of the facility revealed the shower room on the 300 hall had missing grout and a cracked peeling toilet lid cover.

F 253 Criteria #5: Target date 1/31/2015

Interview with Certified Nursing Assistant (CNA) #2 on 12/17/14 at 9:10 AM, and with CNA #3 at 12:15 PM, revealed the CNAs were unsure of what the brownish/black substance in the grout lines between the tiles was. Both CNAs stated they thought it could be mold. CNA #3 stated the brownish/black substance should not be there. CNA #2 revealed CNAs used to spray showers down after use; however, starting in October the housekeeping department cleaned the shower rooms. Per interview, CNA #3 stated there should not be cracked/missing tiles in the shower rooms, it was not homelike. CNA #3 stated the safety belt on the shower chair which had the brownish/black substance could be mold and/or feces. CNA #3 reported the shower rooms were not homelike and she would not want to personally take a shower in the shower rooms.

Interview with Housekeeper #1 on 12/17/14 at 3:40 PM, revealed his job duties were to clean the shower room during routine cleaning and every Wednesday the floor tech's scrubbed the floors in the shower rooms. Housekeeper #1 revealed he had observed possible mold in the caulking and grout areas between the tiles. Per interview, the tile in the shower rooms should not be broken or missing.

Interview with the Housekeeping Supervisor on 12/18/14 at 3:00 PM, revealed shower rooms were cleaned daily using the "7-Step cleaning process" which included disinfecting walls, using

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F 253 Continued From page 6
a machine to clean the floor tiles and a brush for the grout lines between tiles. The Housekeeping Supervisor revealed shower rooms with the brownish/black substance between the tiles and the broken or missing tiles were not a homelike environment. Per interview, the shower rooms needed to be remodeled. According to the Housekeeping Supervisor, the safety belts on shower chairs were wiped down with bleach wipes every day and every week the belts were to be replaced and the ones removed laundered. Further interview revealed her expectations were for her staff to do every day cleaning and properly follow the facility's "7-Step" procedures. She stated she did rounds all day long every day to ensure her staff were doing their jobs as assigned.

F 253

Interview with the Maintenance Director on 12/16/14 at 10:00 AM and 12/18/14 at 5:35 AM revealed he and the Administrator had been talking about "re-doing" all the facility's shower rooms; however, this had not been presented to "Corporate" yet, and they were just getting estimates at that time. Per interview, he currently felt like all the shower rooms were homelike, although he would not want showers in his home to be in the condition the facility shower rooms were. Additional interview revealed he was unsure how long the tiles had been broken and depended on staff to make him aware of such issues.

Interview with the Administrator on 12/18/14 at 12:47 PM, revealed the brownish/black substance should not be between the tiles in the shower rooms. Per interview, the tiles should not be broken, cracked or missing either as this was not aesthetically pleasing and one could tell they had

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F 253: Continued From page 7
used different colors of grout in there. The Administrator revealed the shower chair safety belt with the brownish/black discoloration should not be on the chair. She stated staff were to spray the belts with bleach after each use and her expectation was for the belts to be taken off and laundered weekly. According to the Administrator, housekeeping was responsible for removing and replacing the safety belts on the shower chairs; however, she was unsure what day this was done on. The Administrator stated she would not want the conditions of the facility's shower rooms in her home, and that was why she was going to request renovations of the rooms.

F 253

F 323 SS=E 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

F 323

Criteria #1: All shower room cabinet locks, which included 200 and 300 hall shower room cabinets, were check to ensure they were locked and the keys stored at the nurses station by the administrator on 12/18/14. A new process for shower room cabinet key storage was implemented by the administrator on 12/18/14. All resident rooms and shower rooms were checked for toilet bolt covers by the Maintenance Director on 12/18/14. All missing toilet bolt covers were installed by maintenance director by 12/24/14.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure the environment was as free from accident hazards as possible as evidenced by observation of the storage cabinets in two (2) of three (3) of the facility's shower rooms which were locked; however, had the key hung on the cabinet handle within reach of residents. Additionally, toilet bolts were observed to be exposed and uncovered for seventeen (17) of

Criteria #2: The deficient practice of shower room cabinet key storage had the potential to affect 11 residents with a diagnosis of dementia that could freely move about the facility.

The deficient practice of missing toilet bolt covers had the potential to affect all residents, families, and staff.

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F 323 Continued From page 8
seventeen (17) resident bathrooms.

The findings include:

Review of the facility's policy titled, "Chemical Storage" dated 08/01/12, revealed the facility was to store chemicals in a safe manner and doors would have locks for security purposes. Interview on 12/18/14 at 4:20 PM, with the Administrator revealed this was the only chemical storage policy the facility had.

Review of the facility's Census and Condition revealed of the thirty (30) residents with Dementia, eleven (11) of them could move independently about the facility. These residents included Residents #4 and #6, and Unsampled Residents A, B, C, D, E, F, G, H, I.

Observation on 12/16/14 at 9:05 AM, 9:08 AM and 9:20 AM, during initial tour of the facility, revealed the 200 and 300 half shower room cabinets were locked; however, the key was hanging on the cabinet handle within reach of residents. Continued observation revealed the 200 shower room cabinet contained one (1) container of Sani-Cloth Wipes with Bleach, one (1) bottle of Spit Shine Speed Clean and one (1) Bio-hazard Sharps disposable container half way full. Observation of the 300 shower room cabinet revealed it contained one (1) container of Comet Bleach Cleanser, one (1) container of Dispatch Disinfectant towels with Bleach, one (1) container of Sani-Cloths with Bleach, one (1) container of Bar Keepers Friend polish and cleaner, twenty-one (21) razors, a Bio-hazard sharps disposable container half way full, and one (1) bottle of Shout Triple Action spray.

F 323

Criteria #3: The Director of Nursing services Maintenance Director, and the Staff Development coordinator were in-serviced on F 323 that the facility must ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents on 12/18/14 by the administrator. In-service also included new procedure for shower room cabinet key storage and that all toilet bolts must have covers on them. The Staff development coordinator will continue to in-service all staff on F 323, that all toilet bolts must have covers, to report and maintenance issues immediately, and new shower room key storage procedures. All staff in-service education will be completed by target date. Any staff member that has not received in-service by target date will receive in-service prior to their next days' work.

Criteria #4: The maintenance Director will audit all patient rooms and shower rooms to ensure toilet bolt covers are in place. Random audits will be conducted on 10% of resident bathrooms and shower room toilets to ensure toilet bolt caps are in place weekly times 4 weeks, then monthly ongoing.

The Staff Development coordinator will audit all shower room cabinets for being locked and proper key storage daily times 7 days, then weekly times 4 weeks, then monthly ongoing.

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F 323	Continued From page 9 Review of the Material Safety Data Sheet (MSDS) for the Sani-Cloth with Bleach wipers revealed: to keep out of reach of children; avoid contact with eyes and skin; and the product might cause irritation to the gastrointestinal tract if swallowed. Further review of the MSDS revealed to contact poison control if ingested. Review of the MSDS for the Spit Shine Kleen and Burnish product revealed: it might be harmful if swallowed, could cause gastric distress and a blockage; might cause skin and eye irritation; and to keep out of reach of children. Review of the MSDS for the Bar Keepers Friend product revealed it contained a hazardous ingredient, oxalic acid (a poisonous crystalline acid with a sour taste used for bleaching and cleansing) which could cause eye and skin irritation and was harmful if swallowed. Review of the MSDS for the Dispatch Disinfectant with Bleach towels product revealed it caused gastrointestinal irritation if swallowed and eye irritation if it came in contact with the eyes. Review of the MSDS for the Shout Stain Remover product revealed it was harmful if swallowed and caused eye and skin irritation. Further review revealed to get medical attention immediately. Review of the MSDS for the Comet Bleach Cleanser product revealed ingestion could cause gastrointestinal irritation and if ingested to seek medical attention. Further review revealed the product was considered a hazardous chemical. Interview with Certified Nursing Assistant (CNA)	F 323	(F323 Criteria #4 continued) The maintenance Director and Staff Development coordinator will report findings to the Quality Assurance Performance Improvement committee weekly X 4 weeks, then monthly. The Quality Assurance Performance Improvement committee may increase or decrease monitoring according to findings. The Quality Assurance Performance Improvement committee is comprised of the Administrator, Director of Nursing Services, Medical Director, Assistant Director of Nursing, Activities Director, Staff Development Coordinator, Dietary Manager, Social Services Director, Business office manager, payroll manager, medical records director, and Admissions Director, MDS Coordinator, and Housekeeping Supervisor. Criteria #5: Target date	1/31/2015	

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F 323 Continued From page 10

#3 on 12/17/14 at 12:15 PM, revealed residents could reach the key to the shower room cabinet and possibly open the cabinet and access the items stored in it. Per interview, the key should not be hanging on the cabinet handle, as it was supposed to be hung on the hook in the back of the cabinet which was up high. CNA #3 stated the items stored in the shower room cabinets would be hazardous to residents.

Interview with the Director of Nursing (DON) on 12/18/14 at 4:45 PM, revealed it was her expectation for staff to hang the key to the shower room cabinets up high and out of reach of residents. The DON stated staff should not hang the keys on cabinet handles accessible to residents after completing showers.

Interview with the Administrator on 12/18/14 at 12:47 PM, revealed her expectation was for staff to ensure the shower room cabinets with chemicals were locked and the key hung out of residents' reach so they couldn't access the chemicals. Further interview revealed the facility had never had any incidents of residents accessing the chemicals; however, now that a concern had been identified the facility had improved their practice/process to further protect the residents.

2. Observation on 12/16/14 beginning at 9:00 AM, revealed seventeen (17) of seventeen (17) resident bathrooms had uncovered and exposed toilet bolts.

Interview with the Maintenance Director on 12/18/14 at 5:35 PM, revealed safety would be an issue with the toilet bolts uncovered and exposed, as it could cause a possible injury to residents

F 323

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F 323	Continued From page 11 with the bolt covers missing. Additional interview with the Administrator on 12/18/14 at 12:47 PM, revealed there was a potential for a resident to be injured with the toilet bolts uncovered and exposed depending on the situation. The Administrator stated that was why they made the bolt covers. Per interview, it was her expectation for the toilet bolts to have covers over them.	F 323			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's freezer and refrigerator temperature logs and facility policy, it was determined the facility failed to ensure food for resident consumption was stored, prepared, distributed and served under sanitary conditions to prevent the outbreak of foodborne illness. Observation during the initial kitchen tour revealed scoops stored in food storage bins. Additionally, review of the freezer and refrigerator temperature logs for December 2014 revealed the logs were incomplete.	F 371	Criteria #1: The scoops stored in the food storage bins were immediately removed from the food storage bins by the Dietary Manager on 12/16/14. The food in storage bins was discarded, storage bins cleaned, and new food items added to the clean storage bins on 12/16/14 by the dietary manager. New procedure put in place for scoops to be washed after every use and to be stored with clean dishes, not in food storage bins. Procedure implemented on 12/16/14 by dietary manager. Freezer and refrigerator temperatures verified to be to be within safe range for food storage by the dietary manager on 12/16/14. Freezer and refrigerator food items inspected for any indication of temperatures outside of satisfactory range with none identified by the Dietary Manager on 12/16/14.		

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F 371	<p>Continued From page 12</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the facility's policy titled, "Employee Sanitary Practices" effective 08/01/12, revealed staff should use clean spoons when testing food and should not return them to the food. <p>Observation of the kitchen during initial tour on 12/16/14 at 8:52 AM, revealed a scoop stored in the flour storage bin, a scoop stored in the sugar bin and a scoop stored in the corn meal bin.</p> <p>Interview with the Dietary Manager (DM) on 12/16/14 at 8:52 AM, revealed the facility did store the scoops in the bins with the handles up. Per interview, should the scoop handle slip or fall into the food, it would be an infection control issue and potential cross contamination of the food items.</p> <p>Interview with the Administrator, on 12/18/14 at 12:47 PM, revealed the scoops should not be stored in the food bins for sanitary reasons. Review of the facility's policy titled, "Refrigerated Storage" effective 06/01/13, revealed it was essential that refrigerator temperatures be low enough to safely keep the most perishable foods, and temperatures which were consistently 38 degrees Fahrenheit or below would provide the needed safety margin. Further review of the Policy revealed temperature checks should be documented daily. <p>Review of the facility's, "Refrigeration Log" form for December 2014, revealed no documented evidence of temperatures for the dates of 12/05/14, 12/10/14, 12/12/14, 12/13/14 and</p> </p>	F 371	<p>Criteria #2: The deficient practice had the potential to affect all residents, staff, and visitors.</p> <p>Criteria #3: The Dietary Manager was in-service on F 371 Food Procure, Store/Prepare/Serve – Sanitary including recording the freezer and refrigerator temperature per facility procedures and scoop storage per facility procedures by the Administrator on 12/16/14. The Dietary Manager will continue to in-service all dietary staff on F 371, recording of freezer and refrigerator temperatures, and scoop storage procedures. All dietary staff in-service education will be completed by target date. Any staff member that has not received in-service by target date will receive in-service prior to their next days' work.</p> <p>Criteria #4: The Dietary Manager will audit proper recording of freezer and refrigerator temperature logs and scoop storage for procedures being followed daily times 7 days, weekly times 4 weeks, then monthly ongoing.</p> <p>The Dietary Manager will report findings to the Quality Assurance Performance Improvement committee weekly X 4 weeks, then monthly. The Quality Assurance Performance Improvement committee may increase or decrease monitoring according to findings. The Quality Assurance Performance Improvement committee is comprised of the Administrator, Director of</p>

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F 371 Continued From page 13
12/14/14. Additional review of the Log revealed incomplete documentation of temperatures for five (5) additional days of temperatures recorded.

Continued interview with the Dietary Manager (DM) on 12/16/14 at 8:52 AM, revealed the freezer and refrigerator logs should be completed twice each day to ensure proper food storage temperatures were maintained.

Continued interview with the Administrator on 12/18/14 at 12:47 PM, revealed the refrigerator temperatures should be documented per the facility policy to ensure proper food temperature storage, and to track and trend temperatures of the equipment.

F 514 SS=D 483.75(1)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

F 371 (F371 continued)

Nursing Services, Medical Director, Assistant Director of Nursing, Activities Director, Staff Development Coordinator, Dietary Manager, Social Services Director, Business office manager, payroll manager, medical records director, and Admissions Director, MDS Coordinator, and Housekeeping Supervisor.

Criteria #5: Target date 1/31/2015

F 514
Criteria #1: Resident #13's discharge summary was signed by the physician on 12/18/14.

Criteria #2: The deficient practice had the potential to affect all residents.

Criteria #3: 100% audit of all closed charts within the last year for complete documentation will be completed by target date by the Medical Records Coordinator. The Medical Records Coordinator will audit all current discharge resident charts weekly to ensure timely discharge summary completion and F 514 records-complete/accurate/accessible has been followed. The Medical Records Coordinator was in-serviced on F 514 Records – complete/accurate/accessible which included obtaining complete physician discharge summary within 30 days of discharge. In-service conducted by the Administrator on

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F 514 Continued From page 14

Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure the medical record was complete and accurate for one (1) of thirteen (13) sampled residents (Resident #13). Review of Resident #13's closed medical record revealed no documented evidence it contained a Discharge Summary signed by the Physician within thirty (30) days.

The findings include:

Review of the facility's policy titled, "Clinical Records Manual", dated 07/01/07, revealed the purpose of the policy was to ensure residents' clinical records were maintained in accordance with professional practice standards. Review revealed residents' clinical records were to be complete and accurately documented.

Interview with the Administrator on 12/18/14 at 12:47 PM, revealed the facility did not have a policy for completion of the Discharge Summary.

Record review revealed the facility admitted Resident #13 on 09/17/14, with diagnoses which included Pneumonia, Depression, Coronary Artery Disease, Alzheimer's Disease, Anorexia and Failure to Thrive. Continued record review revealed Resident #13 expired on 11/10/14 at 10:15 PM. Further record review revealed the Discharge Summary was not signed by the Physician.

Interview with the Medical Records Coordinator on 12/18/14 at 12:55 PM, revealed Resident #13's Physician was the facility's Medical Director. She stated when she realized the closed record of Resident #13 was being

F 514 (F514 continued)

Criteria #4: Findings of audits will be reported to the Quality Assurance Performance Committee weekly times 4 weeks, then monthly ongoing. The Quality Assurance Performance Improvement committee may increase or decrease monitoring according to findings. The Quality Assurance Performance Improvement committee is comprised of the Administrator, Director of Nursing Services, Medical Director, Assistant Director of Nursing, Activities Director, Staff Development Coordinator, Dietary Manager, Social Services Director, Business office manager, payroll manager, medical records director, and Admissions Director, MDS Coordinator, and Housekeeping Supervisor.

Criteria #5: Target date 1/31/2015

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F 514	<p>Continued From page 15</p> <p>reviewed by the State Surveyors, she had observed the Discharge Summary had not been signed by the Physician/Medical Director. Per interview, she went to the Physician's office on 12/18/14 and requested the original Discharge Summary be signed by the Physician.</p> <p>Interview with the Director of Nursing (DON) on 12/18/14 at 4:45 PM, revealed she had completed the Discharge Summary on 11/10/14, as she was present in the facility when Resident #13 expired. Per interview, either she or the Charge Nurse would do the narrative on Discharge Summaries and the Physician/Medical Director would read and sign the Summaries. Additional interview revealed Resident #13's closed medical record was not complete due to the Discharge Summary not being signed by the Physician/Medical Director.</p> <p>Continued interview with the Administrator on 12/18/14 at 12:47 PM, revealed her expectation was for Discharge Summaries to be signed within the thirty (30) day time frame to ensure discharged residents' medical records were complete.</p>	F 514		

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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

BUILDING: 01.

PLAN APPROVAL: 1965.

SURVEY UNDER: 2000 Existing.

FACILITY TYPE: SNF/NF.

TYPE OF STRUCTURE: One (1) story, Type III (211).

SMOKE COMPARTMENTS: Four (4) smoke compartments.

FIRE ALARM: Complete fire alarm system installed in 1965, with 35 smoke detectors and 1 heat detector.

SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1965 and upgraded in 2003.

GENERATOR: Type II generator installed in 2008. Fuel source is Diesel.

A Standard Life Safety Code Survey was conducted on 12/18/14. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty-two (62) beds with a census of fifty (50) on the day of the survey.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from

K 000 RESPONSE PREFACE

Diversicare of Greenville 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.

Diversicare of Greenville's response the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Diversicare of Greenville reserves the right to submit documentation to refute any of the stated deficiencies of this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any administrative or legal proceeding.

RECEIVED
JAN 15 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Stacey Bullock LOMA</i>	TITLE Administrator	(X6) DATE 1/8/2015
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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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K 000 Continued From page 1
Fire).

K 000

Deficiencies were cited with the highest deficiency identified at "D" level.

K 072 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

K 072 K 072

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

Criteria #1: The office Wing Corridor was cleared of (2) chairs, one (1) table, one (1) copy machine, and two (2) cardboard boxes by the Maintenance Director on 12/18/2014.

Criteria #2: The deficient practice had the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors.

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficient practice had the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty-two (62) beds and at the time of the survey, the census was fifty (50).

Criteria #3: Maintenance Director and staff development coordinator were in-serviced on K 072 NFPA 101 Life Safety Code Standard which included that means of egress are continuously maintained free of all obstruction 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 on 12/18/14 by the Administrator. The staff development coordinator will in-service all remaining staff on K 072. All staff in-service education be completed by target date. Any staff member that has not received in-service by target date will prior to their next days' work.

The findings include:

Observation on 12/18/14 at 1:12 PM, with the Maintenance Director revealed the storage of two (2) chairs, one (1) table, one (1) copy machine, and two (2) cardboard boxes in the Office Wing Corridor.

Interview, on 12/18/14 at 1:13 PM, with the Maintenance Director revealed the items were routinely stored in this location.

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K 072 Continued From page 2
The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 12/18/14.

Actual NFPA Standard:

Reference: NFPA 101 (2000 Edition) 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 (200 Edition) 7.3.2*
Measurement of Means of Egress.
The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration.
Exception: Projections not more than 31/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below.

Reference: S&C-12-21-LSC

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 was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to

K 072 Criteria #4: The maintenance Director will monitor all facility means of egress to ensure they are continuously maintained free of all obstruction or impediments to full instant use in the case of fire or other emergency. The maintenance Director will report findings to the Quality Assurance Performance Improvement committee weekly X 4 weeks, then monthly. The Quality Assurance Performance Improvement committee may increase or decrease monitoring according to findings. The Quality Assurance Performance Improvement committee is comprised of the Administrator, Director of Nursing Services, Medical Director, Assistant Director of Nursing, Activities Director, Staff Development Coordinator, Dietary Manager, Social Services Director, Business office manager, payroll manager, medical records director, and Admissions Director, MDS Coordinator, and Housekeeping Supervisor.

K 147 Criteria #5: Target date 1/31/2015

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K 147 Continued From page 3
affect one (1) of three (3) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty-two (62) beds and at the time of the survey, the census was fifty (50).

The findings include:

Observation, on 12/18/14 at 1:03 PM with the Maintenance Director, revealed an unlocked electrical panel located in the corridor by the Conference Room which was accessible to residents.

Interview, on 12/18/14 at 1:04 PM, with the Maintenance Director revealed he was not aware the electrical panel was not locked.

The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 12/18/14.

Actual NFPA Standard:

Reference: NFPA 70 (1999 edition) 110-26. Spaces 10.26 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.
(A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or

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Criteria #1: The electrical panel located in the corridor by the Conference Room was locked by the Maintenance Director on 12/18/2014.

Criteria #2: The deficient practice had the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors.

Criteria #3: Maintenance Director and staff development coordinator were in-serviced on K 147 NFPA 101 Life Safety Code Standard Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 on 12/18/14 by the administrator. The staff development coordinator will in-service all remaining staff on K 072. All staff in-service education will be completed by target date. Any staff member that has not received in-service by target date will receive in-service prior to their next days' work.

Criteria #4: The maintenance Director will monitor all facility electrical panels to ensure they are locked and facility is compliant with K 147 NFPA 101 Life Safety Code Standard. The maintenance Director will report findings to the Quality Assurance Performance Improvement committee weekly X 4 weeks, then monthly. The Quality Assurance Performance Improvement committee may increase or

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185317	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2014
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF GREENVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 521 GREENE DR. GREENVILLE, KY 42345	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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permitted elsewhere in this Code.
(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.
Table 110.26(A)(1) Working Spaces

Nominal Voltage to Ground	Condition 1	Condition 2	Condition 3	Minimum Clear Distance
0-150	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	
151-600		900 mm (3 ft)	1 m (3½ ft)	
				1.2 m (4 ft)

Note: Where the conditions are as follows:
Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts.
Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded.
Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.

(a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is

K 147: decrease monitoring according to findings. The Quality Assurance Performance Improvement committee is comprised of the Administrator, Director of Nursing Services, Medical Director, Assistant Director of Nursing, Activities Director, Staff Development Coordinator, Dietary Manager, Social Services Director, Business office manager, payroll manager, medical records director, and Admissions Director, MDS Coordinator, and Housekeeping Supervisor.

Criteria #5: Target date

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required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided.
(b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc.
(c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation.
(2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels.
(3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment.
(B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be

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K 147	<p>Continued From page 6</p> <p>suitably guarded.</p> <p>(C) Entrance to Working Space.</p> <p>(1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment.</p> <p>(2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met.</p> <p>(a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted.</p> <p>(b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition.</p> <p>(D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment</p>	K 147		

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K 147	Continued From page 7 rooms, the illumination shall not be controlled by automatic means only. 370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147	