

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/28/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>An abbreviated standard survey was initiated on 05/22/13 and concluded on 05/28/13 investigating KY20208. The Division of Health Care unsubstantiated the complaint, however, related deficiencies were cited.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, the website aquaphorhealing.com, and facility policy, it was determined the facility failed to follow their approach/intervention on the care plan for one (1) of four (4) sampled residents (Resident #3). The facility failed to provide Resident #3 with a treatment ordered by the physician, and Aquaphor Healing Ointment was not applied to the left lower extremity of Resident #3 as ordered.</p> <p>The findings include: Review of the policy Care Planning, 04/08/13, revealed the care plan was a guide to the unique and individual care required for each resident. Interventions on the care plan were listed as what would specifically be done for the resident, including treatments. However, the treatment for</p>	F 282	<ol style="list-style-type: none"> The South Unit nurse assessed resident #3 for dry skin on lower extremities and applied treatment to the affected area on 5/23/13. The North and South Unit Coordinators reviewed all residents with skin treatments and ensured all care plans are followed on 5/23/13. Director of Nursing to re-educate nursing staff on care plan policy and procedures by 6/30/13. North and South Unit Coordinators will review the clinical record of all residents with skin treatments no less than weekly to ensure compliance with care plans. Director of Nursing will audit the clinical records of 25% of residents with skin treatments quarterly and report results to QA on 07/02/13 not less than quarterly thereafter. 	07/05/13

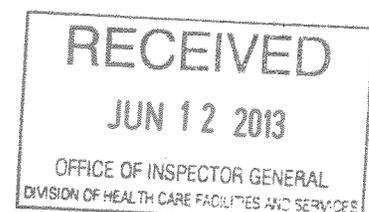
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *6/26/13*

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.

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

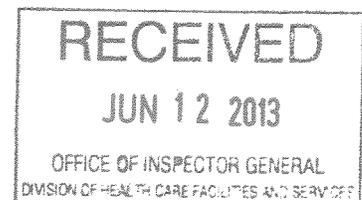
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2013
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 1 Resident #3 was not done.</p> <p>The facility did not have a drug reference book listing Aquaphor Healing Ointment. The web site for the physician ordered ointment, aquaphorhealing.com, revealed the ointment was a skin protectant with glycerine, bisabolol and provitamin B 5. The uses included to protect, soothe and help heal dry, irritated skin. This ointment created a semi-occlusive barrier on the skin.</p> <p>Review of the Treatment Administration Record (TAR) for Resident #3 revealed an order for Aquaphor Healing Ointment to be applied to the left lower extremity of the resident every day. The TAR for 05/01/13 through 05/22/13 revealed there was not a day where the resident received the treatment. All initialed entries by licensed staff on the TAR were circled, indicating the treatment was not done. There was no explanation documented as to why it was not done, found either on the back of the TAR or in the Nurse's Notes.</p> <p>Resident #3 was admitted to the facility on 03/15/11 with diagnoses of Paraplegia, Chronic Airway Obstruction, Joint Pain, Above the Knee Amputation on the Right, Tobacco Use Disorder, Scoliosis, Pyelonephritis and Poljo. The facility assessed the resident as a fifteen (15) on the Brief Interview for Mental Status (BIMS), which was the highest score in measuring cognitive status.</p> <p>Observation, on 05/23/13 at 3:55 PM, of the left lower extremity of Resident #3 revealed a swollen foot, red in color and a marked amount of thick,</p>	F 282			



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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

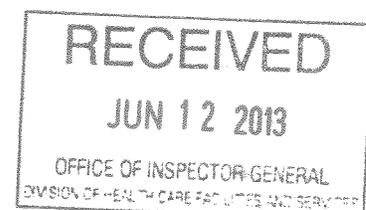
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2013
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 2</p> <p>scaly dry skin on the calf. Resident #3 was without any noted distress or pain.</p> <p>Interview, on 05/23/13 at 8:00 AM, with Resident #3 revealed he/she received a treatment to his/her coccyx everyday by nursing. However, continued interview with Resident #3 revealed he/she was not aware there was an order for a treatment to his/her lower left leg. Resident #3 stated if he/she had known about an order for a treatment, he/she would have had it done. Resident #3 denied ever having refused a treatment to his/her left lower leg.</p> <p>Interview, on 05/23/13 at 3:50 PM, with the Wound Care Registered Nurse (RN) revealed Resident #3 was ordered Aquaphor Ointment for the dry skin on top of his/her foot. She stated the resident had refused the treatment, which Resident #3 denied. She revealed she had not viewed the left lower extremity of the resident for the two weeks prior to this observation on 05/23/13.</p> <p>Continued interview revealed her part of the care plan for Resident #3 was based on her weekly assessment of the resident and she would add her own part to the care plan. However, there was not an approach added by the Wound Care RN. In addition, the Wound Care RN was not listed as responsible for the Problem/Need of the risk for pressure, nursing in general was noted.</p> <p>Interview, on 05/23/13 at 3:40 PM, with Licensed Practical Nurse (LPN) Minimum Data Set (MDS) #2 revealed if a treatment was on the care plan, the resident should receive that treatment. She stated the care plan was updated quarterly and</p>	F 282			



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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

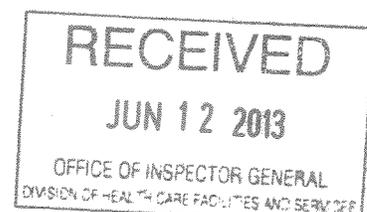
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2013
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page 3 as needed. She revealed to know if the care plan was being monitored for treatments being given, one would have to go to the treatment record and verify that the treatment was being done. She revealed she did not know of anyone reviewing the TAR to verify the care plan was being followed. Interview, on 05/23/13 at 4:35 PM, with the Director of Nursing (DON) revealed the Interdisciplinary Team (IDT) writes the care plans and the care plan was updated by nurses on a day to day basis with changes or new concerns. She revealed the "treatments as ordered" noted on the care plan under Approach should be monitored by the nurse on the floor or the unit coordinator. She revealed no one monitored to ensure the treatment for Resident #3 was followed. She revealed there was a breakdown when the refusal of the treatment by Resident #3 was not documented or when the treatment was not given for a period of time and the physician not notified. The DON revealed there was not a system in place at present to monitor the Medication Administration Records (MAR) and the TAR. She stated she was new to the position and had started to address the issues that have been identified needing attention.	F 282			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			



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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

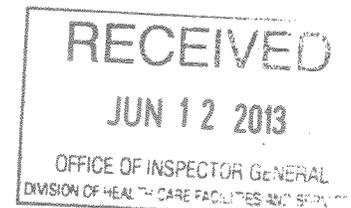
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2013
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview, record review, the facility policies Medication Administration-General Guidelines, Effective 02/01/10, Notification of Physicians, Revised 08/06/2000 and Notification of Change, Effective 07/01/08, it was determined the facility failed to provide the necessary care and services to one (1) of four (4) sampled residents, Resident #3. The Aquaphor Healing Ointment ordered applied to the left lower extremity of the Resident #3, was noted on the treatment record as not done, for the Month of May 2013, from 05/01/13 through 05/22/13. The physician was not notified, nor was there any documentation giving the reason the treatment was not done. The findings include: Review of the policy Notification of Physicians, Revised 08/06/2000, revealed the refusal of treatments was considered a non-immediate notification item, however, the policy stated the notification of refusals required a follow-up within three (3) to five (5) days. The physician for Resident #3 was not notified of the resident not receiving his/her Aquaphor Healing Ointment ordered treatment until after more than three (3) weeks. The physician was notified after the concern was identified by the surveyor. Review of the policy Medication	F 309	1. South Unit nurse contacted physician of res #3 to notify of refusals of treatment on 5/23/13, and new treatment in place. 2. The North and South Unit Coordinators reviewed all residents with MD orders for skin treatments on 5/23/13. Physicians notified on all residents with three or more consecutive refusals. 3. Documentation guidelines amended to state physician notification will not exceed three consecutive refusals of treatment. Director of Nursing will educate all nursing staff no later than 6/30/13. 4. Unit Coordinators will audit all treatment records weekly for 90 days, then monthly to ensure physicians are notified of refusals, when appropriate. Unit Coordinators will report results of audit at QA on 07/02/13 and not less than quarterly thereafter.	07/05/13	



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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

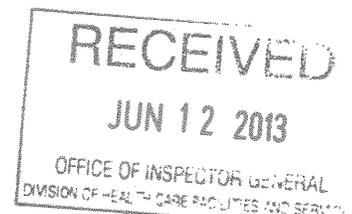
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2013
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 5</p> <p>Administration-General Guidelines, Effective 02/01/10, revealed if a dose of regularly scheduled medication was withheld or refused, the space provided on the front of the Medication Administration Record (MAR), in this case the Treatment Administration Record (TAR), as the treatment was a medication, for that dosage administration was initialed and circled. However, the policy did not address what the process was if a regularly scheduled medication was withheld or refused for over three (3) weeks in a row.</p> <p>Review of the policy Notification of Changes, Effective 07/01/08, revealed the refusal to follow treatment regimen was a condition that should be communicated to the physician.</p> <p>Review of the medical record for Resident #3 revealed no Nurses Notes in May 2013 addressing the lower left extremity of the resident. There was no assessment of the limb. There was no entry to indicate a treatment had been refused or withheld. The record did not contain any physician notification for a treatment ordered and not performed for over three (3) weeks.</p> <p>Review of the TAR for Resident #3 revealed an order for Aquaphor Healing Ointment to be applied to the left lower extremity of the resident every day. For the month of May, 2013, from 05/01/13 through 05/22/13, all TAR nursing documentation for the Aquaphor Healing Ointment consisted of nurse initials with a circle around it, indicating the treatment was not given. There was no explanation why the treatment was not done on the back of the TAR.</p> <p>Resident #3 was admitted to the facility on</p>	F 309			



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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2013
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 6</p> <p>03/15/11 with diagnoses of Paraplegia, Chronic Airway Obstruction, Joint Pain, Above the Knee Amputation on the Right, Tobacco Use Disorder, Scoliosis, Pyelonephritis and Polio. The facility assessed the resident with a score of fifteen (15) on the Brief Interview for Mental Status (BIMS), which was the highest score in measuring cognitive status.</p> <p>Observation, on 05/23/13 at 3:55 PM, of the left lower extremity of Resident #3 revealed a swollen foot, red in color and a marked amount of thick, scaly dry skin on the calf. Resident #3 was without any noted distress or pain.</p> <p>Interview, on 05/23/13 at 8:00 AM, with Resident #3 revealed he/she received a treatment to his/her coccyx everyday by nursing. However, continued interview with Resident #3 revealed he/she was not aware there was an order for a treatment to his/her lower left leg. Resident #3 stated if he/she had known about an order for a treatment, he/she would have had it done. Resident #3 denied ever having refused a treatment to his/her left lower leg.</p> <p>Interview, on 05/23/13 at 9:15 AM, with Registered Nurse (RN) #2 revealed treatments, when not done, should be reported to the physician probably by day two (2). She revealed, on the TAR, when initials were circled by a date blocked off, that indicated that the treatment was not done. She stated the nurse should then chart the reason why it was not done on the back of the TAR or in the Nurse's Notes. She stated the reason for the documentation was because the nurse was to carry out the physician order, and if that did not happen, there was the documented</p>	F 309			



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

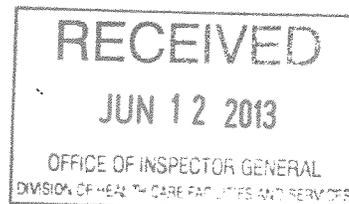
PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/28/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

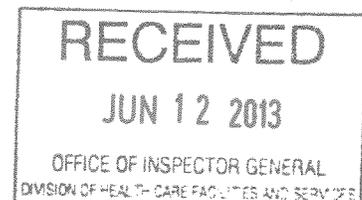
F 309	<p>Continued From page 7 explanation.</p> <p>Interview, on 05/23/13 at 9:30 AM, with the In-Service Coordinator revealed all licensed nursing staff had been in-serviced on physician notification. She revealed the practice was to notify the physician in two (2) or three (3) days if a simple treatment was not being done. However, the licensed staff did not notify the physician of Resident #3 not receiving an ordered treatment for more than twenty-one (21) days.</p> <p>Interview, on 05/23/13 at 3:50 PM, with the Wound Care Registered Nurse (RN) revealed Resident #3 was ordered Aquaphor Ointment for the dry skin on top of his/her foot. She stated the resident had refused the treatment, which Resident #3 denied. Based on Resident #3 not receiving the treatment for weeks, the Wound Care RN had called the physician's office earlier this date to have the treatment discontinued. Following the call to the physician, with this surveyor present, she observed the left lower extremity of Resident #3 and indicated she would not request the treatment discontinued. She revealed she had not viewed the left lower extremity of the resident for the two weeks prior to this observation on 05/23/13.</p> <p>Interview, on 05/23/13 at 4:25 PM, with the Director of Nursing (DON) revealed if an initialed entry on the TAR was circled, there would need to be documentation on the back of the TAR or in the Nurse's Notes to explain why the treatment was not done. She stated the physician was to be notified when treatments were not done so he/she was aware of the treatments the resident was or was not receiving. For Resident #3, she</p>	F 309		
-------	---	-------	--	--



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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

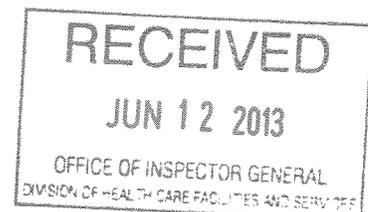
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2013
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 8 stated to not follow the orders could result in dry skin or a physical development. The DON revealed she did not have a system in place yet to monitor orders and ensure they were being carried out. The DON stated she was new to her position.	F 309			
F 514 SS=D	483.75(l)(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: Based on interview, record review and facility Medical Records Policy Statement, undated, it was determined the facility failed to maintain accurate documentation for one (1) of four (4) sampled residents, Resident #1. The Treatment Administration Record (TAR) was not filled in with the initials of the nursing staff who checked Resident #1 for having a DuoDerm present on his/her coccyx as ordered by the physician. The findings include:	F 514	1. South Unit Coordinator reviewed the treatment record of res #1 for appropriate documentation on 5/23/13. 2. The North and South Unit Coordinators reviewed all treatment records for appropriate documentation on 05/24/13. 3. Director of Nursing will re-educate nursing staff on appropriate documentation by 6/30/13. North and South Unit Coordinators will review treatment records no less than weekly to ensure accurate documentation. 4. Director of Nursing will audit 25% of treatment records quarterly and report results to QA on 07/02/13 and not less than quarterly.	07/05/13	



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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2013
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 9</p> <p>Review of the facility Medical Records Policy Statement, undated, revealed the medical record would be kept current and up to date by physicians, nurses and all persons authorized to give care and treatments to residents.</p> <p>Review of the Medical Record for Resident #1 revealed a Physician's Order dated 05/20/13 for DuoDerm applied to the coccyx and to check its placement every shift.</p> <p>Review of the TAR for May 2013 revealed the new order listed: DuoDerm spot, apply to coccyx, every three (3) day change and PRN (as needed), ensure DuoDerm in place every shift. The TAR had the date blocked off beginning 05/20/13 for the every third day to change. Between 05/21/13 and 05/27/13 the facility was responsible to ensure the placement of the DuoDerm on the coccyx fourteen (14) times by nursing personnel. The documentation on the TAR revealed documented checks seven (7) times.</p> <p>Interview, on 05/28/13 at 2:15 PM, with the Wound Care Registered Nurse (RN) revealed the nursing staff should be documenting on the TAR that the DuoDerm was in place. She stated she had followed up with the staff to ensure they were checking the DuoDerm, and told they had been. However, she stated the nurses had not been signing off on the TAR that they did check the DuoDerm.</p> <p>Interview, on 05/28/13 at 2:30 PM, with Licensed Practical Nurse (LPN) #1 revealed if the TAR was not signed off, there may be staff that did not understand that when they checked the DuoDerm</p>	F 514			



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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2013
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	Continued From page 10 for placement, it was to be signed off on the TAR. Interview, on 05/28/13 at 2:30 PM, with RN #2 revealed to check the DuoDerm every shift meant it was a treatment to be initialed off on the TAR to indicate it was checked for placement. She stated she believed that staff forgot to mark the TAR. She revealed Resident #1 gets much attention to his/her care by the staff. Interview, on 05/23/13 at 4:25 PM, with the Director of Nursing (DON) revealed she did not have a system in place yet to monitor documentation of orders on the TAR and ensure they were completed. The DON stated she was new to her position.	F 514			

