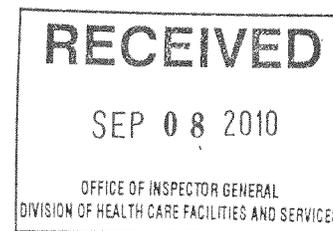


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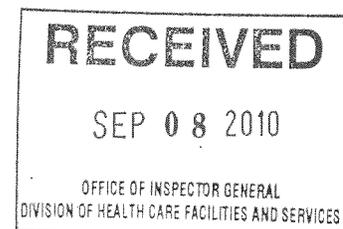
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185205</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/12/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>GREEN VALLEY HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1206 ELEVENTH STREET CARROLLTON, KY 41045</b>	
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F 309	<p>Continued From page 15</p> <p>8:00am, 9:30am, 10:30am, 11:15am and 12:20pm revealed the resident was not wearing TED hose. Continued observation on 08/12/10 at 9:00am revealed the resident was not wearing TED hose.</p> <p>Interview with Certified Nursing Assistant (CNA) #3 on 08/12/10 at 10:50am revealed the CNA knew about the Care Plan and how to follow the Care Plan. When asked to review the Care Plan area on treatments for Resident #2 she stated the resident was to have TED hose applied in the morning and removed in the evening. When asked if they were on the resident at the present time she reported that she had not yet put them on for the day. The CNA reported the normal time for applying TED hose on residents is around 8:00am. The CNA stated that when a resident refuses a treatment it is recorded in the Care Plan on a refusal sheet. She reported there was no refusal sheet present in Resident #2's Care Plan. In addition, she stated that there was a possibility that the resident could develop blood clots when TED hose were not worn as ordered. Interview on 08/12/10 at 11:50am with RN #1 revealed that TED orders show up on the Treatment Administration Record (TAR) on the treatment cart. The RN stated it was the CNA's responsibility to place the TED hose on the resident and the nurse doing the treatments for the day would confirm the presence of the TED hose on the TAR. When asked what a nurse would do if the TED hose were not on the resident when making treatment rounds, she stated the nurse would apply the TED hose to the resident or would call the CNA to apply the TED hose.</p> <p>2. Record review of Resident #12 revealed an</p>	F 309		



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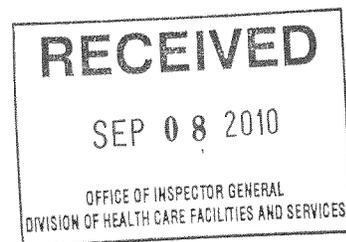
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F 309	<p>Continued From page 16</p> <p>admission date of 07/10/10 with diagnoses including Pneumonia, End Stage Renal Disease (ESRD) requiring dialysis, Peritoneal Dialysis, Mitralaortic stenosis, thrombocytopenia.</p> <p>Review of the Physician orders for Resident #12 revealed an order for weekly H&amp;H written on 07/20/10, and an order for Epogen 10,000 units subcutaneous weekly on Wednesday, hold if Hemoglobin greater than 12. Review of the labs revealed the resident did not receive an H&amp;H until 08/06/10.</p> <p>Interview with RN #2 on 08/12/10 at 10:30am revealed when she receives an order for labs, she fills out the lab requisition for one to two weeks, places orders on the lab boards, then gives the lab order to the Assistant Director of Nursing (ADON) who is in charge of filling out the weekly lab requisitions. The RN stated that it could be detrimental to the resident if the labs are not checked as the physician ordered.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 08/12/10 at 10:00am, regarding the lab order for Resident #12 revealed she had taken the order for Resident # 12 on 07/20/10, but had to be pulled away to assist another resident. The ADON stated that the labs not getting done did not adversely affect the resident. Resident #2's Hemoglobin on 07/15/10 was 11.8g/dl and on 08/06/10 was 8.0g/dl.</p> <p>Observation of Resident #12 on 08/11/10 at 4:30pm revealed the resident sitting up in a wheelchair receiving Peritoneal dialysis. The resident's family was in the room assisting the resident.</p>	F 309		



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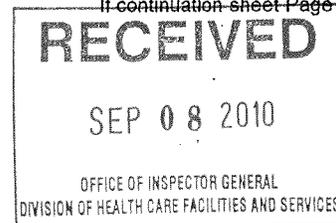
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F 309	Continued From page 17 Observation on 08/12/10 at 8:30am of Resident #12 revealed the resident sitting up in a wheelchair, short of air related to just getting weighed.	F 309		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS  The facility must provide special eating equipment and utensils for residents who need them.  This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to provide one (1) resident (#7) out of twenty three (23) sampled residents, special drinking equipment after assessing the need for specialized utensils and equipment. Resident #7 was identified by the facility staff as needing a sip cup lid with no spout which was not provided for lunch on 08/10/10.  The findings include:  Resident #7 was admitted to the facility with diagnoses to include Osteoarthritis not otherwise specified, Alzheimer's disease, Hearing Loss and Spinal Disorders.  An observation on 08/10/10 at 11:30am revealed Resident #7 was drinking coffee from a sip cup with no lid.  An interview, on 08/10/10 at 11:30am, with the CNA assisting the resident revealed Resident #7	F 369	The facility must provide special eating equipment and utensils for residents who need them.  1. Resident #7 offered cup with lid, but she refused as usual.  2. All residents with specialty help devices have been reviewed and updated as necessary by Dietary Manager and MDS Coordinator on 8/15/10.  3. Nursing staff educated and in-serviced on appropriate uses of assistive devices and appropriate procedures for assessing and removing assistive devices by DON on 8/17/10..  4. Dietary Manager will observe all residents eating with assistive devices weekly for two weeks, then monthly, to ensure appropriateness of device and report any issues to the Director of Nursing. Dietary Manager will report results of audit to QA on 9/25/10 and no less than quarterly thereafter.	9/25/10 24 mz 9/9/10 per facility



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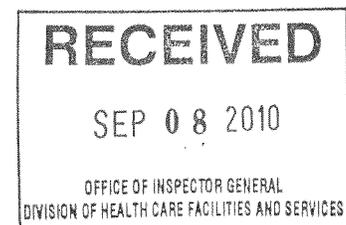
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F 369	Continued From page 18 was supposed to have a lid on the sip cup because the resident had an accident previously and spilled coffee on their self.  An interview with the Dietary Manager on 08/11/10 at 4:25pm revealed Resident #7's name was listed on the Self Help List provided by dietary. The resident was identified as needing a two handled cup with lid and no spout. The dietary manager stated dietary makes up the tray card and then sets the tray out for the CNA's to pour the coffee and put the lid on with no spout on the two handled sip cup. Occupational Therapy identified the need for the specialized cup.  An interview with the Occupational Therapist on 8/11/10 revealed the resident spilled a cup of coffee in the past and a two handled sip cup with a lid and no spout was then ordered to help prevent spills. The Therapist stated, it was the CNAs' and the nurses' responsibility to ensure that the cup and lid was utilized. The Therapist stated there could be a risk that the resident would get burned if there was no lid and the liquid was hot.	F 369		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT  The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.  A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	F 387	The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.  A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	9/25/10 24 MZY 9/9/10 per facility



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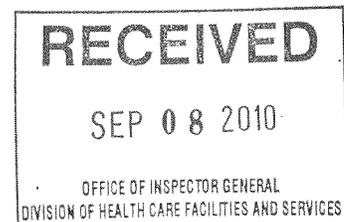
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F 387	<p>Continued From page 19</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure that one (1) resident of the twenty-three (23) sampled residents was seen by a physician at least once every 30 days for the first 90 days after admission. (Resident #5) There was no documentation that Resident #5 was seen by the physician for forty-nine (49) days, 06/23/10-08/11/10.</p> <p>The findings include:</p> <p>A review of the facility policy regarding Physician services revealed the resident was to be seen every thirty days for the first ninety days, then once every sixty days thereafter.</p> <p>A record review revealed Resident #5 was admitted to the facility on 06/03/10 with the following diagnoses; Gastrostomy status, Obstruction Incisional Hernia, Intestinal Obstruction, fasciitis, Disruption of External Wound, Muscle Disorders, Anemia, Senile Dementia, Dysphagia, CVA, Breast CA, Acute Respiratory Failure, Paralysis Agitans.</p> <p>A review of the medical record for Resident #5 revealed there was no evidence the resident's physician conducted a visit or had written a progress note every 30 days for the first 90 days after the resident was admitted to the facility.</p> <p>A review of the physician progress notes revealed an evaluation by the physician on Resident #5 on 06/23/10 but no further exams were noted in the record. This resulted in forty-nine (49) days the resident had not been seen by a physician.</p>	F 387	<ol style="list-style-type: none"> <li>1. Resident #5 was seen on 8/26/10 by nurse practitioner.</li> <li>2. Audit of MD visits completed for all current residents by Medical Records Director on 8/17/10. All were in compliance.</li> <li>3. Medical Records Director will audit all admissions and readmissions monthly to ensure timeliness of scheduled visits.</li> <li>4. Medical Records Director will report results of audits to QA on 9/25/10 and no less than quarterly thereafter.</li> </ol>	



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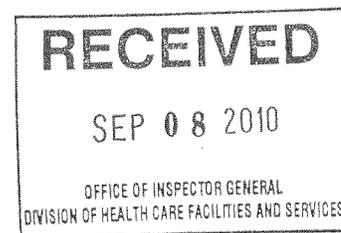
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F 387	Continued From page 20	F 387		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  1. Soiled linen cart immediately removed from clean linen room and properly stored by Housekeeping Director.  2. All soiled linen carts located to ensure none were in areas of potential cross contamination and stored properly by Housekeeping Director on 8/11/10.	9/25/10 24 M28 9/9/10 per facility



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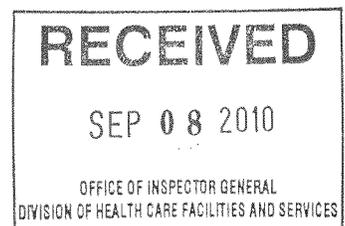
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F 441	Continued From page 21  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: The facility failed to maintain an infection control program to prevent the spread of infection by storing trash and dirty linens in a clean linen room.  The findings include:  Review of the facility policy "Infection Control" dated 2001 (Webb Enterprises) revealed ". . . Environmental sanitation measures break the chain (of infection transmission) by eliminating environmental reservoirs." and ". . . The nursing staff must handle the residents' linen in a way that reduces the possibility of infection. Soiled linen must be placed immediately in a soiled linen	F 441	3. Housekeeping staff educated and in-serviced regarding infection control, cross contamination, and proper linen management by Housekeeping Director on 8/19/10.  4. Housekeeping Director will in-service staff quarterly regarding proper handling of linens. She will also observed soiled linen carts no less than weekly to ensure proper storage and report results of inspection to QA on 9/25/10 and no less than quarterly thereafter.	



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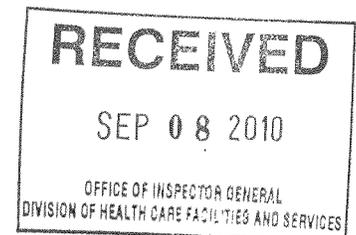
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F 441	<p>Continued From page 22</p> <p>hamper and the lid must be tightly closed." Review of the facility policy "Bloodborne Pathogens" dated 2001 (Webb Enterprises) revealed "Good housekeeping is the next step in good protection. Everyone is responsible for keeping a clean work area and. . .Make sure you discard contaminated materials properly."</p> <p>Observation on 08/10/10 several times throughout the day and on 08/11/10 until 9:15am revealed staff taking dirty trash and dirty linens into a clean linen room on a residential living unit.</p> <p>Interview with CNA #2 on 08/11/10 at 10:00am revealed she was taking dirty linens into the clean linen room because she forgot the trash cart was moved to the shower room; however, she also stated the dirty linen cart and the trash cart were in the clean linen room for the past two (2) days.</p> <p>Interview with the Certified Medication Aide (CMA) on 08/11/10 at 3:10pm revealed she had taken dirty linens and trash into the clean linen room but was unsure if that would be considered cross-contamination if those items touched. The CMA did state that she had been trained by the facility on infection control.</p> <p>Interview with CNA #1 on 08/11/10 at 3:15pm revealed she had taken dirty linens into the clean linen room but she did not think it should be stored there. She also stated she was unsure if she had been in-serviced by the facility on cross-contamination.</p> <p>Interview with the Housekeeping Director on 08/11/10 at 3:30pm revealed her department's personnel were responsible to maintain cleanliness of the clean linen room and she</p>	F 441			



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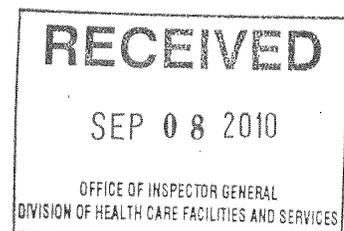
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F 441	Continued From page 23 stated dirty linens and trash should not be stored in the clean linen room.  Interview with the Assistant Director of Nursing on 08/11/10 at 4:10pm revealed clean linens only should be stored in the clean linen room and dirty linens and trash should not be stored in the clean linen room. She also stated it would be cross-contamination to store dirty linens and trash in the clean linen room.  Interview with the Director of Nursing on 08/11/10 at 4:00pm revealed clean linens should be stored in the clean linen room but dirty linens and trash had been stored in that room since a few months after the last standard health survey. She also stated dirty linens and trash stored near clean linens could be a mode of cross-contamination.	F 441		
F 496 SS=E	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING  Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.  Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility	F 496	Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.  Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility	9/25/10 24 mz 9/9/10 per facility



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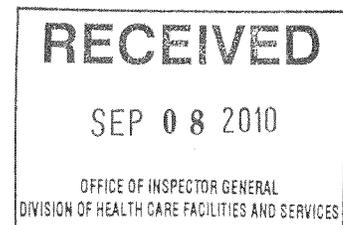
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F 496	<p>Continued From page 24 believes will include information on the individual.</p> <p>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to ensure two (2) of ten (10) employees had nurse aide abuse registry checks in other states completed when that information was made available to them via the criminal record check.</p> <p>The findings include:</p> <p>Review of the Abuse Prohibition policy, not dated, revealed inquiries are made to determine the status of an individual on the Kentucky Abuse Registry. A criminal record check will be performed on all new hires by requesting criminal record information from the Kentucky State Police Department or other approved governmental agencies.</p> <p>Review of ten (10) employee personnel files revealed two (2) nursing assistants, one hired on 05/18/10 and one hired 07/16/10 had lived and worked in California and Arkansas respectively. The files did not contain evidence of nurse aide abuse registry checks in those two states even</p>	F 496	<p>believes will include information on the individual.</p> <p>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.</p> <ol style="list-style-type: none"> <li>Abuse registry check performed by Office Manager on 8/13/10 on two employees cited. Neither were listed on the abuse registries of their respective states.</li> <li>All employee records were audited by Office Manager by 8/20/10 to ensure abuse registry checks performed in all states of residence. All current employees met this compliance standard.</li> <li>Policy amended by Administrator on 8/12/10 to include abuse registry checks in all states of residence for all new staff. Office Manager educated by Administrator regarding new policy and procedure..</li> </ol>	



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

PRINTED: 08/26/2010  
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  08/12/2010
NAME OF PROVIDER OR SUPPLIER  GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
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F 496	Continued From page 25 though the facility was made aware through the criminal record check.  Interview with Human Resources on 08/11/10 at 1:50pm revealed the two states were not checked as she did not think the employees had worked as nursing assistants in those states. However, the checks would be obtained that day.	F 496	4. Office Manager will audit 25% of records of all new hires to ensure new policy and procedure observed, and will report results of audit at QA on 9/25/10 and not less than quarterly thereafter.		



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NAME OF PROVIDER OR SUPPLIER  <b>GREEN VALLEY HEALTH &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1206 ELEVENTH STREET CARROLLTON, KY 41045</b>
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K 000	INITIAL COMMENTS  A Life Safety Code Survey was initiated and concluded on 08/11/2010 for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility was in compliance with NFPA 101 Life Safety Code, 2000 Edition.  No deficiencies were identified during this survey.	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Alan McJade</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9/7/10</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

**RECEIVED**  
SEP 08 2010  
If continuation sheet Page 1 of 1  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES