

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

PRINTED: 10/31/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/18/2012
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NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
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(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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F 000	INITIAL COMMENTS A standard health survey was initiated on 10/16/12 and concluded on 10/18/12 and a Life Safety Code survey was initiated on 10/16/12 and concluded on 10/17/12 with deficiencies cited at the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State laws.	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged; and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.	F 156	RESIDENTS AFFECTED: The appropriate signage for Medicare and Medicaid benefits and the Ombudsman posting were posted in an area that is accessible to all of the residents. RESIDENTS POTENTIALLY AFFECTED: All residents of the facility had the potential to be affected because the inappropriate Medicare and Medicaid benefits signage and because of the location of the Medicare and Medicaid benefits signage and Ombudsman posting. SYSTEMIC MEASURES: The appropriate signage for Medicare and Medicaid benefits and the Ombudsman posting was posted in an area that is accessible to all of the residents and the residents attending the Resident Council Meeting on 11/09/2012 were told about the new location of the appropriate signage for Medicare and Medicaid benefits and the Ombudsman posting. MONITORING MEASURES: The Receptionist will check on a monthly basis to verify the appropriate signage for Medicare and Medicaid benefits and Ombudsman postings are located in an area that is accessible to all of the residents. Findings of this monthly check will be provided to the Director of Social	11/27/2012

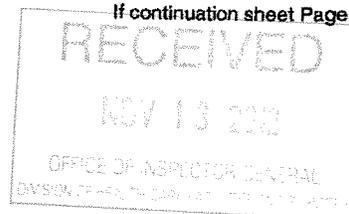
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X [Signature]</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>X 11/12/2012</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may 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.

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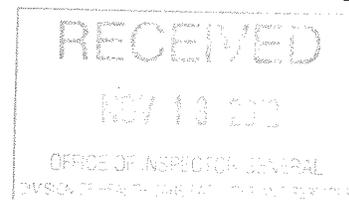
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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	Social Services who will present findings to the Quality Assessment and Assurance Committee on a quarterly basis.	



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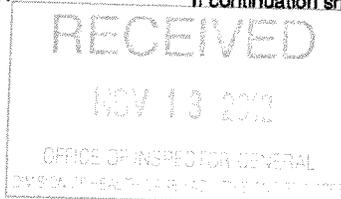
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F 156	<p>Continued From page 2</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to post the appropriate signage for Medicare and Medicaid benefits. In addition, the facility failed to post Medicare and Medicaid signage and the Ombudsman posting in an area that was accessible to all of the residents.</p> <p>The findings include:</p>	F 156		



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F 156	Continued From page 3 Observation, on 10/18/12 at 8:00 AM, revealed an alcove at the main entrance to the facility. The alcove was between two (2) doors with the interior door having a key pad and locked at the time of the observation. Signage stating to contact social services for information regarding Medicare and Medicaid was seen on the wall next to the interior door of the alcove and it faced away from the facility. The Ombudsman posting was seen in the alcove area behind the locked door. No other postings were noted in the facility during the environment tour. Interview with the Administrator, on 10/18/12 at 10:45 AM, revealed no other Medicare and Medicaid signage was posted in the facility. The Administrator revealed there were two (2) ombudsman postings in the facility, one in the alcove area and the other by the therapy room. The Administrator revealed the therapy room was located in a separate area behind a locked door. The Administrator confirmed the front entrance was locked in the evening which restricted access to the sign. The Administrator confirmed that the Ombudsman posting was difficult to see through the alcove glass and the Medicare and Medicaid signage was incorrect and not visible at all from inside the facility. The Administrator revealed incorrect signage and improper placement of the postings prevented the residents from exercising their rights.	F 156		
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.	F 253	RESIDENTS AFFECTED: A C.N.A., on October 22, 2012 removed all items not identified and placed residents' personal items in labeled storage bags in all identified areas. The unlabeled personal items found in the communal showers were discarded. The Housekeeping/Laundry	11/27/2012



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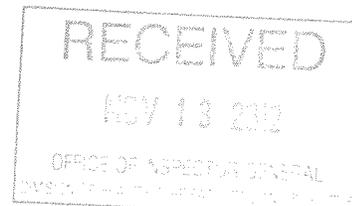
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F 253	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's July 2012 Mandatory In-Service Record, it was determined the facility failed to keep the personal care equipment of the residents properly stored. Seven (7) Resident Rooms 25, 27, 28, 29, 31, 32 and 34 had personal items in unlabeled bins or laying out without being identified as to who they belonged to in shared bathrooms. In addition, multiple personal items were unlabeled in three (3) of the four (4) communal showers. Additionally, soiled privacy curtains were found during the Environment tour in four (4) of the sixty (60) resident rooms.</p> <p>The findings include:</p> <p>The facility did not have a policy for the storage of personal care equipment.</p> <p>1. Review of the facility's July 2012 Mandatory In-Service Record revealed for Nurses and Certified Nursing Assistants (CNA), under the bullet point State Preparedness, all current facility employees were in-serviced on the storage of the personal care items of residents. Personal care items were to be placed in baggies with the name of the resident on the bag, then put in the resident's drawer.</p> <p>Observation, on 10/16/12 beginning at 10:00 AM, during the tour of the facility, revealed the following: Room 25 had two (2) toothbrushes together on the sink with no label and two (2) hair brushes in the bathroom without names on them;</p>	F 253	<p>Supervisor, on 10/19/2012 laundered the four privacy curtains found soiled.</p> <p>RESIDENTS POTENTIALLY AFFECTED: All residents of the facility had the potential to be affected if their personal care equipment is not stored properly.</p> <p>SYSTEMIC MEASURES: All resident rooms and communal showers were inspected by 10/24/2012 by an assigned C.N.A. to ensure all residents' personal care equipment was labeled and/or placed in baggies labeled with residents' names. All privacy curtains within the facility were checked by the Director of Housekeeping/ Laundry on 10/19/2012. Soiled privacy curtains found at that time were laundered. A policy was developed on labeling and storing of residents' personal care equipment. All staff are required to attend a mandatory in-service initiated 11/08/2012 and presented again at two times on 11/09/2012, and again on 11/16/2012. All staff not attending will be removed from the schedule until they attend the in-service. Forms were created to be used to audit the storage of residents' personal care equipment in resident rooms and communal showers and to audit privacy curtains. Individuals assigned to complete audits and their assigned areas to audit include:</p> <ol style="list-style-type: none"> 1. Director of Nursing: Communal Showers 2. Marketing Director: Rooms 1-5 3. Staff Development Coordinator: Rooms 6-10 4. Risk Care Manager: Rooms 11-15 5. Wound Care/Restorative Nurse: Rooms 16-20 6. Social Services: Rooms 21-25 7. Dietary Manager: Rooms 26-30 	
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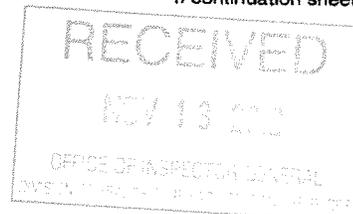
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F 253	<p>Continued From page 5</p> <p>Room 27 had a toothbrush by the sink with no name on it; Room 28 had two (2) toothbrushes in the same cup with no names on them and three (3) combs and two (2) hair brushes stored together in a plastic bin without a name on it; Room 29 had a denture cup, unlabeled, by the sink; and Room 31 had a toothbrush next to the sink without a name on it.</p> <p>Observation, on 10/18/12 beginning at 10:00 AM, revealed Room 25 had five (5) toothbrushes at the sink behind the faucet, all with no identifying label. Also present in Room 25 were two (2) combs and one (1) brush at the side of the sink, without a label, and a hair brush behind the commode without a name on it. Room 27 had a toothbrush behind the faucet and a denture cup at the sink, both without a name on them. Room 29 had a denture cup without a name on it by the sink, as did Room 32, with three (3) denture cups having no identification on them. Rooms 31 and 32 both were found with two (2) toothbrushes behind the faucet without any name present, and Room 34 had one toothbrush behind the faucet without a label.</p> <p>Interview, on 10/18/12 at 10:20 AM, with the Housekeeping Manager revealed Housekeeping was not responsible for the personal care items of the residents. She revealed the Certified Nursing Assistants (CNA) were responsible for the toothbrushes that belonged to the residents.</p> <p>Interview, on 10/18/12 at 10:30 AM, with CNA #6 revealed the CNAs were responsible for the personal care items of the residents. She stated she had not been in-serviced on the personal care items but had been given plastic bags for</p>	F 253	<p>8. Maintenance: Rooms 31-36 9. MDS Coordinator: Rooms 37-41 10. Bookkeeper: Rooms 42-46 11. Housekeeping: Rooms 47-51 12. Medical Records: 52-56 13. Activities: 57-61</p> <p>Completed audits will be presented to the Administrator for review.</p> <p>MONITORING MEASURES: A summary of the audits of resident rooms and communal showers to ensure proper storage of residents' personal care equipment and the cleanliness of privacy curtains will be presented to the Quality Assessment and Assurance Committee on a quarterly basis by the Administrator.</p>	
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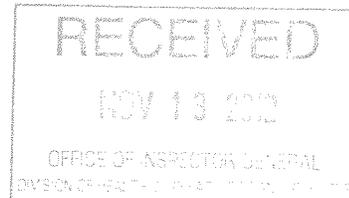
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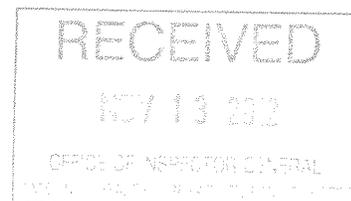
F 253	<p>Continued From page 6</p> <p>their storage. She revealed it was important to appropriately store personal care items for infection control. She stated infections could be passed on to others if not properly stored.</p> <p>Interview, on 10/18/12 at 10:33 AM, with CNA #7 revealed the CNA was responsible to store the personal care items of the resident's in a baggie, with the name of the resident on it, in a drawer. She revealed she was taught this upon hire and the nurses monitor that items were stored properly. She revealed improper storage was unsanitary and one could get sick.</p> <p>Interview, on 10/18/12 at 10:45 AM, with CNA #3 revealed all staff was responsible for the storage of the personal care items of the residents. She revealed after daily cares were done, the items were to be put back in the baggie that had the resident's name on it and stored in the resident's drawer. She did not know who was to monitor the personal care equipment.</p> <p>Interview, on 10/18/12 at 10:50 AM, with CNA #8 revealed the CNAs were responsible for the personal care equipment of the residents. She stated she had been in-serviced during her orientation and knew that personal care items were placed in baggies. It was revealed that the nurses monitor the personal care equipment. She revealed if a resident used another resident's toothbrush, they could become ill.</p> <p>Interview, on 10/18/12 at 11:00 AM, with CNA #9 revealed everyone was responsible for the storage of the resident's personal care equipment. She stated items were to be stored, sealed in a baggie, in the bedside table of the</p>	F 253		
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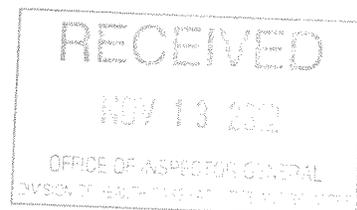
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F 253	<p>Continued From page 7</p> <p>resident. She did not know how the personal care item storage was monitored. She did reveal that failure to appropriately store these items may cause cross contamination and a resident may get ill.</p> <p>Interview, on 10/18/12 at 11:10 AM, with the Orchard Unit Manager (LPN) revealed she would like the CNA to take responsibility for the personal care items of the residents. She revealed it was the responsibility of the medication cart nurse to monitor the personal care items. In addition, she revealed failure to properly store personal care items could result in reinfection or contamination of the resident.</p> <p>Interview, on 10/18/12 at 11:15 AM, with LPN #5 revealed all staff members were responsible for the personal care items of the resident. He revealed he had been in-serviced but it had been some time ago. He was not aware the medication cart nurse was the person responsible to monitor those items. He revealed all the nurses were responsible to monitor. If items were not stored appropriately, he revealed bacteria and germs would spread and soon the whole resident hall would have an illness.</p> <p>Interview, on 10/18/12 at 11:25 AM, with the Nurse House Supervisor revealed the CNAs perform the AM and PM care so ultimately the responsibility for storage of the personal care items falls on the CNA, but everyone was responsible. She revealed staff had been in-serviced and failure to store personal care items appropriately could cause infection control issues. She revealed personal care items were to be monitored by the nurses on the hall and the</p>	F 253			



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F 253	Continued From page 8 House Supervisor. Interview, on 10/18/12 at 11:25 AM, with the Director of Nursing revealed the CNAs were responsible for the personal care equipment of the residents' because they were the staff that completed the primary care for the residents. He revealed all staff was in-serviced in July 2012 at a mandatory in-service. He also revealed the nurses on the floor, department heads and he were the ones responsible to monitor the personal care items of the resident's. He revealed if the personal care equipment was not stored appropriately, cross contamination could occur and spread illness. 2. Observation of the Oak Lane shower room, on 10/18/12 at 8:52 AM, revealed a green colored basket on the top shelf of the closet containing Dry Idea Roll On Deodorant with no cap, Right Guard Deodorant with no cap, Ban Deoderant with no cap, and Tena 3 (three) in 1 (one) wash cream with no label or name to signify ownership. A brown colored basket contained a hair brush with no name or label and different colored strands of hair in the bristles. Another hair brush was found on the floor with hair entwined in the bristles. Two (2) razors were noted lying on the shelf uncapped and with black hair like particles in the blade. Interview with Certified Nursing Assistant (CNA) #1, on 10/18/12 at 9:05 AM, revealed the hair brushes and deodorants did appear to be used and not new. The CNA revealed staff were not supposed to keep personal hygiene items in the shower rooms, or use single items on different residents due to the potential for cross	F 253			



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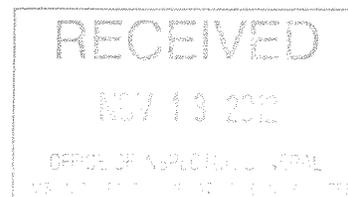
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F 253	<p>Continued From page 9</p> <p>contamination. The CNA revealed she did not know how the items got in the shower room and revealed the facility had provided training on the use of communal items.</p> <p>Observation of Orchard Unit shower room 1 (one), on 10/18/12 at 9:30 AM, revealed Right Guard Deodorant, Old Spice High Endurance Deodorant, and Degree Deodorant in the cabinet. None of the items were labeled to show ownership. Observation of Orchard Unit shower room 2 (two), on 10/18/12 at 9:35 AM, revealed Pantene 2:1 shampoo in the shower stall sitting on the handrail. The top shelf of the closet contained Degree Ultra Clear Deodorant, Hask hair and scalp treatment with the spout open, Lady Speed Stick Deodorant and Head and Shoulders shampoo with no name or label of ownership. A plastic bin with drawers contained Carmex tube lip treatment, Max Block chapstick, and Avon chapstick which were all unlabeled to indicate ownership.</p> <p>Interview with CNA #2, on 10/18/12 at 9:30 AM, revealed communal items were not supposed to be used in the shower room due to concerns with infection control. The CNA revealed she had attended training on the use of communal items and did not know why the items were in the shower room.</p> <p>Interview with CNA #3, on 10/18/12 at 9:40 AM, revealed the shampoo had been in the shower room stall for a couple of days and she did not know who it belonged to or how it got in the shower room. The CNA revealed the chapstick, razors and the deodorant all appeared to be used. The CNA revealed the items were not</p>	F 253		
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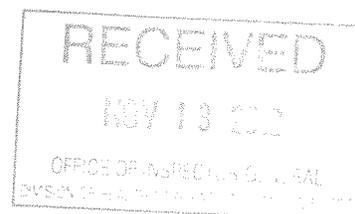
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/18/2012
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F 253	<p>Continued From page 10</p> <p>supposed to be in the shower rooms because they could be used on different residents and it would be considered misuse of someone else's property. The CNA revealed toiletry items should stay in the residents room and transported back and forth with the resident.</p> <p>Interview with the Orchard Unit Manager (UM), on 10/8/12 at 11:08 AM, revealed no one was assigned to monitor communal hygiene items in the shower rooms. The UM revealed CNA's had chores which included cleaning the shower room and personal items should be taken care of at that time. The UM revealed she had noticed miscellaneous items before in the shower rooms.</p> <p>Interview with the Transition Unit Manager (UM), on 10/18/12 at 2:10 PM, revealed communal hygiene items are not to be used. The UM revealed both CNA's and nurses are responsible to monitor for items in the shower room. The UM revealed a potential safety hazard with uncapped razors and deodorants.</p> <p>Interview with the Director of Nursing (DON), on 10/18/12 at 10:57 AM, revealed a potential for cross contamination. The DON revealed there was not an audit for monitoring of the shower rooms for hygiene items. The DON revealed there was a person assigned to clean the shower rooms but that did not include monitoring of the hygiene items. The DON revealed staff had been provided training on communal items in the shower room.</p> <p>Review of the mandatory in-service for all staff, dated July 2012, did not include communal hygiene items in the shower room.</p>	F 253		
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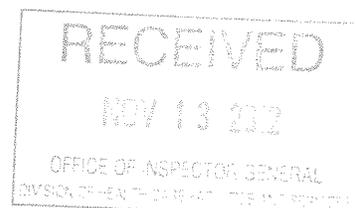
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F 253	Continued From page 11 3. Review of the facility's policy Housekeeping, not dated, revealed monitoring or laundering of privacy curtains was not included in the procedures. Observations during the environment tour, on 10/17/12 at 10:10 AM, revealed soiled privacy curtains with a brown colored substance in rooms 25, 28 bed A and B, 29, and 33. The Administrator, the Director of Maintenance, and the Director of Housekeeping were in attendance during the environment tour. Interview with the Director of Housekeeping, on 10/18/12 at 10:45 AM, revealed housekeepers were to watch for the cleanliness of the privacy curtains during room cleaning. The Director of Housekeeping revealed the housekeepers had a form they use when cleaning the resident rooms which included monitoring of the curtains. The Director of Housekeeping revealed she did random room rounds monthly to ensure cleanliness. Further interview with the Director of Housekeeping, on 10/18/12 at 12:07 PM, revealed the housekeeping check list for daily cleaning did include the curtains, however, the forms had not been used in months.	F 253		
F 441 SS=E	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	F 441	RESIDENTS AFFECTED: The staff members identified providing care to the identified residents were provided education on proper hand hygiene and procedure while providing care. LPN #7 received education by the Director of Nursing on the procedure for proper skin assessment and the need to go from clean to dirty. LPN #6 received education by the Director of Nursing on washing hands before and after removing	11/27/2012



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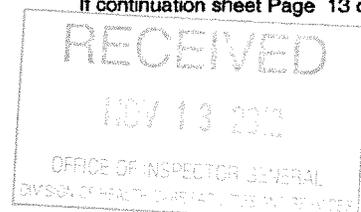
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F 441	<p>Continued From page 12</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to ensure staff practiced proper hand hygiene during a treatment, skin assessment and catheter care for three (3) of twenty-two sampled residents and one unsampled resident. Resident</p>	F 441	<p>gloves. LPN #2 received training by the Director of Nursing on washing hands before and after removing gloves. C.N.A. #4 was provided education on proper catheter care by the Staff Development Coordinator.</p> <p>RESIDENTS POTENTIALLY AFFECTED: All residents have the potential to be affected if staff do not practice proper hand hygiene during the provision of resident care.</p> <p>SYSTEMIC MEASURES: A Catheter Care policy was developed. In-service education prepared to include but not be limited to: catheter care, procedures for cleaning from clean to dirty and proper process for skin assessments, going from clean to dirty. All staff are required to attend a mandatory in-service initiated 11/08/2012 and presented again at two times on 11/09/2012 and again on 11/16/2012. All staff not attending will be removed from the schedule until they attend the in-service. The Staff Development Coordinator will conduct random observations of catheter care being provided by C.N.A.s on a monthly basis. The Wound Care Nurse will conduct random observations of aseptic dressing changes and skin assessments being performed by licensed nurses on a monthly basis.</p> <p>MONITORING MEASURES: The observations by the Staff Development Coordinator and Wound Care Nurse will be documented and findings summarized and presented to the Quality Assessment and Assurance Committee on a quarterly basis by the Staff Development Coordinator and the Wound Care Nurse.</p>	
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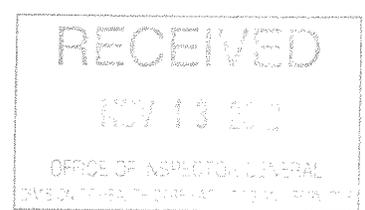
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F 441	<p>Continued From page 13 #6, #10 and #13.</p> <p>The findings include:</p> <p>Review of the Infection Control Policy, dated 01/09, revealed The objectives of the infection control policies and procedures were to prevent and control the spread of communicable/contagious disease.</p> <p>Review of the Hand Washing Policy, dated 06/10, revealed all personnel shall wash their hands to prevent the spread of infections and disease to other residents, personnel and visitors. Hands should be washed by either mechanical or chemical means before and after the use of gloves, gowns, and masks. The use of gloves does not replace hand hygiene</p> <p>1. Observation of a skin assessment performed by Lincensed Practical Nurse (LPN) #7 to Resident #10, on 10/17/12 at 10:19 AM, revealed LPN #7 assessed Resident #10's perineal area. LPN #7 then assessed Resident #10's back and coccyx without changing her gloves or washing her hands.</p> <p>Interview with LPN #7, on 10/17/12 at 10:19 AM, revealed the perineal area was considered a dirty area. LPN #7 stated she realized now that she went from dirty to clean when conducting her skin assessment. LPN #7 stated cross contamination could occur when moving from dirty to clean and not washing her hands or changing her gloves.</p> <p>Interview with the Acting Unit Manager on Orchard Way, on 10/18/12 at 11:30 AM, revealed the perineal area was considered dirty and she</p>	F 441		
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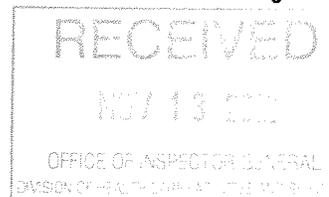
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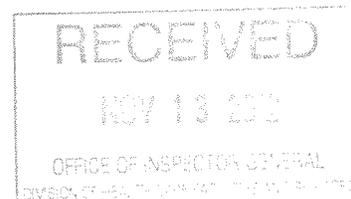
F 441	<p>Continued From page 14</p> <p>would not consider LPN #7's technique the right way to conduct a skin assessment.</p> <p>2. Observation of a skin assessment performed by LPN #6 for Resident #13, on 10/17/12 at 11:06 AM, revealed LPN #6 removed her gloves twice while conducting a skin assessment on Resident #13 and did not wash her hands after glove removal.</p> <p>Interview with LPN #6, on 10/18/12 at 10:15 AM, revealed she was aware she did not wash her hands after glove removal. LPN #6 stated it was the facility's policy to wash hands after the removal of gloves. LPN #6 also stated the nurses were educated to wash their hands after the removal of gloves.</p> <p>Interview with the Acting Unit Manager on Orchard Way, on 10/18/12 at 11:30 AM, revealed it was the facility's policy to wash hands after the removal of gloves. The Acting Unit Manager further stated hands were washed to protect the resident and staff from infection.</p> <p>Interview with the Director of Nursing (DON), on 10/18/12 at 3:34 PM, revealed nurses were educated on infection control and hand hygiene upon orientation and annually. The DON stated the perineal area was considered dirty and it was not appropriate to go from dirty to clean. The DON also stated he was aware of the facility policy which stated staff were to wash their hands after glove removal and the staff were to wash their hands upon glove removal.</p> <p>3. Observation, on 10/17/12 at 1:35 PM, revealed</p>	F 441		
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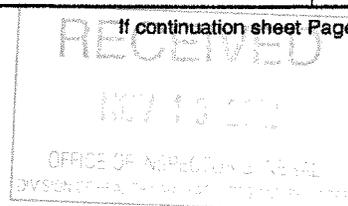
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F 441	<p>Continued From page 15</p> <p>Licensed Practical Nurse (LPN) #2 removed a dressing from the buttock of Resident #6 during a decubitus ulcer treatment with gloved hands. LPN #2 was observed to change gloves before applying a clean dressing to the decubitus ulcer; however, she did not wash her hands between the glove change.</p> <p>Interview, on 10/17/12 at 2:00 PM, with LPN #2 revealed she washed her hands prior to the start of the decubitus ulcer treatment for Resident #6 and when the treatment was completed. However, she stated she did not wash her hands between those times when she changed gloves. LPN #2 revealed she did not know what the facility policy was related to glove change and hand washing. She also revealed she had not had training from the facility on changing gloves as it related to dressing changes.</p> <p>4. The facility did not have a policy on Foley catheter care. The facility utilized the Testing Procedures Manual and Study Guide for the Kentucky Medicaid Nurse Aide, 03/01/2011 version, for their Standard of Practice for Foley catheter care.</p> <p>Review of the Testing Procedures Manual and Study Guide for the Kentucky Medicaid Nurse Aide, 03/01/2011 version, revealed a Foley catheter was to be washed during catheter care by cleaning downward away from the resident with one stroke using soap and water.</p> <p>Resident #6 was admitted to the facility on 09/16/10 with diagnoses of Chronic Airway Obstruction, Dementia, Parkinson's Disease and</p>	F 441		



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F 441	<p>Continued From page 16</p> <p>Dysphagia. Resident #6 was currently being treated for a urinary tract infection (UTI) with the antibiotic Rocephin by intramuscular injection once a day for seven (7) days, which was initiated on 10/13/12.</p> <p>Observation, on 10/17/12 at 1:30 PM, revealed Certified Nursing Assistant (CNA) #4 performed catheter care on Resident #6 using Rediflush flushable wipes. CNA #4 cleansed the resident's perineal area from front to back. The resident had stool on that area which was removed and the area was cleansed. The Foley catheter tube itself was not cleansed.</p> <p>Interview, on 10/17/12 at 1:35 PM, with CNA #4 revealed she had completed the Foley catheter care when asked if she was finished.</p> <p>Interview, on 10/18/12 at 2:45 PM, with CNA #11 revealed a Foley catheter tube was to be cleansed front to back using the wipes. She revealed you clean the Foley catheter tube to prevent urinary tract infections. She also revealed she had not been trained by the facility but had learned catheter care in school.</p> <p>Interview, on 10/18/12 at 3:20 PM, with CNA #12 revealed Foley catheter care was done using the wipes from next to the body outward on the catheter. She stated this was to prevent a UTI and to not introduce bacteria into the body. She stated she had been in-serviced on Foley catheter care by the facility.</p> <p>interview, on 10/18/12 at 3:25 PM, with CNA #13 revealed to perform Foley catheter care you clean around the tube, hold the tube at the base and</p>	F 441		



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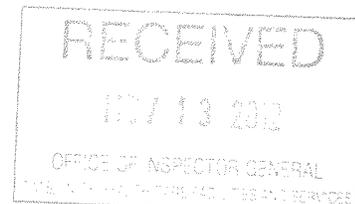
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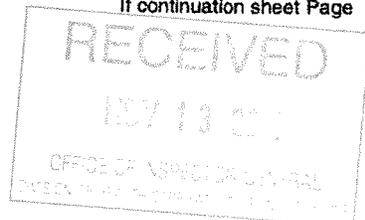
F 441	Continued From page 17 wipe away using the perineal wipes. She revealed failure to do so could cause the resident an infection. Interview, on 10/18/12 at 2:42 PM, with Licensed Practical Nurse (LPN) #8 revealed to perform catheter care you start at the beginning (where the tube exits the body) and go outward with soap and water, then dry and secure the tube to the resident's leg. Interview, on 10/18/12 at 3:15 PM, with Registered Nurse (RN) #1 revealed the catheter tube was to be cleansed starting from where it came out of the body, moving along the tube, with soap and water. He had been in-serviced on Foley catheter care by the facility and stated if stool were present it may introduce unwanted organisms into the resident. He stated he monitors the CNAs on his shift for appropriate catheter care. Interview, on 10/18/12 at 2:40 PM, with the Director of Nursing revealed Foley catheter care was to be done with soap and water by first grasping the catheter and cleaning downward. He stated the nurses were responsible to monitor the catheter care. He revealed an annual in-service was held in December to educate staff on Foley catheter care. In addition, he revealed a UTI may occur if appropriate catheter care was not done.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465	RESIDENTS AFFECTED: No specific residents were identified as having been affected by the deficient practice. The improperly stored pillows and containers of water were properly stored on 10/19/2012. RESIDENTS POTENTIALLY AFFECTED:	11/27/2012



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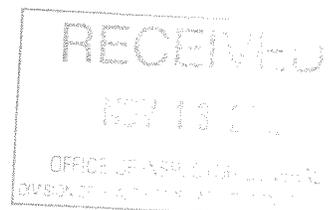
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F 465	<p>Continued From page 18 residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a safe, functional and sanitary environment. Improperly stored pillows and water containers were found in one (1) of the one (1) facility's linen closet.</p> <p>The findings include: A policy on linen storage was not provided by the facility.</p> <p>Observation during the environmental tour, on 10/18/12 at 8:37 AM, revealed a plastic bag filled with three (3) pillows stored on the floor, four (4) filled water cooler containers stored on the floor, and several boxes stored on the floor of the Oak Lane linen storage room. The Administrator, the Director of Maintenance, and the Director of Housekeeping were in attendance during the environmental tour.</p> <p>Interview with the Director of Maintenance, on 10/18/12 at 10:45 AM, revealed the water containers had been in the closet since March of 2012 during a water advisory. The Director of Maintenance revealed the facility ordered extra water during that time and stored it in the linen storage area.</p> <p>Interview with the Director of Housekeeping, on 10/18/12 at 10:45 AM, revealed pillows should have been stored on the top shelf of the shelving unit to prevent contamination.</p>	F 465	<p>All residents have the potential to be affected if facility improperly stores equipment or supplies.</p> <p>SYSTEMIC MEASURES: The facility Supplies and Equipment Policy was reviewed and revised to reflect that all supplies or equipment, other than those with wheels, will be stored up and off the floor. All staff are required to attend a mandatory in-service initiated 11/08/2012 and presented again at two times on 11/09/2012 and again on 11/16/2012. All staff not attending will be removed from the schedule until they attend the in-service. The Nurse Staffing Scheduler/ Central Supplies Clerk will complete monthly audits that will include but not be limited to ensuring no equipment and supplies, other than those with wheels are stored on the floor. The audits will be done in the Linen Room on Transition, Supply Room on Orchard, and the Central Supply Room.</p> <p>MONITORING MEASURES: The findings of these monthly audits will be presented to the Director of Nursing. The Director of Nursing will summarize the audit findings and present to the Quality Assessment and Assurance Committee on a quarterly basis.</p>	



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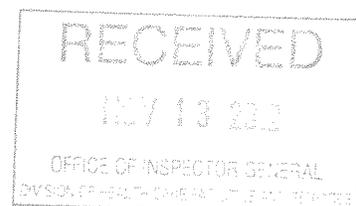
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/18/2012
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F 465	Continued From page 19	F 465		
F 502 SS=E	<p>Interview with the Administrator, on 10/18/12 at 10:45 AM, revealed he was not aware the water bottles were in the linen storage room, and stated the water containers should have been stored in the back of the building.</p> <p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined, the facility failed to check dates and discard expired laboratory Vacutainers and specimen tubes from two (2) of two (2) medication rooms. The Transition Unit and North Unit medication rooms.</p> <p>The findings include:</p> <p>Observation, on 10/17/12, on the Transition Unit there was one (1) package of blue top tubes, containing eighty-four (84) tubes, that had expired on August 2012. On the North Unit there were four (4) blood culture kits expired on 11/21/11. In addition, it was noted one (1) stool specimen kit expired July 2012, thirteen (13) complete blood count tubes expired August 2012, four (4) yellow top tubes expired June 2012, and five (5) purple top tubes expired June 2012.</p> <p>Interviews with the managers of the Transition and North Units, on 10/17/12 at 2:30 PM,</p>	F 502	<p>RESIDENTS AFFECTED: No residents were identified as having been affected by the deficient practice. All items identified were removed from the facility on October 19, 2012.</p> <p>RESIDENTS POTENTIALLY AFFECTED: All residents have the potential to be affected should the facility fail to verify expiration dates on laboratory Vacutainers and specimen tubes and discard when outside expiration dates.</p> <p>SYSTEMIC MEASURES: The Director of Nursing completed a 100% audit of all laboratory supplies on Orchard and Transition Way. All staff are required to attend a mandatory in-service initiated 11/08/2012 and presented again at two times on 11/09/2012 and again on 11/16/2012. All staff not attending will be removed from the schedule until they attend the in-service. Licensed nurses, as part of the in-service were directed to review all laboratory supplies for expiration dates prior to use. The Director of Nursing will complete monthly audits on both Orchard and Transition Way Medication Rooms to ensure all laboratory supplies are within expiration dates.</p> <p>MONITORING MEASURES: The Director of Nursing will present to the Quality Assessment and Assurance Committee the findings of the audits on a quarterly basis.</p>	11/27/2012



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F 502	Continued From page 20 revealed they checked expiration dates prior to drawing a blood specimen. Both managers stated, if their staff had drawn a specimen in an expired Vacutainer the laboratory would check the Vacutainer for an expiration date and not run the test. If the laboratory failed to check for an expiration date on a Vacutainer or specimen tube, the test results would not be accurate. Each manager agreed using an expired Vacutainer or specimen tube would result in an inaccurate result or the resident requiring a second blood specimen draw or specimen collection.	F 502			



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1990</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: one (1) story, Type III (000)</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was initiated on 10/16/12 and concluded on 10/17/12. Green Meadows Health Care Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has one hundred twenty two (122) certified beds with a census of one hundred nine (109) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State laws.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE X Administrator	(X6) DATE X 11/12/2012
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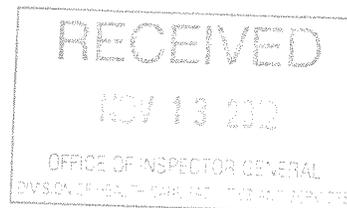
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

NOV 13 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITY SERVICES

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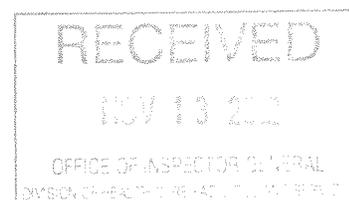
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K 000	Continued From page 1 Fire)	K 000		
K 018 SS=D	Deficiencies were cited with the highest deficiency identified at F level. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors protecting corridor openings were constructed to resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, residents, staff and visitors. The	K 018	RESIDENTS AFFECTED: The gaps at the top of the corridor doors to rooms #1, 12 and 36 have been addressed and minimized so they now resist the passage of smoke. The hardware device to corridor door to room #33 has been adjusted and now keeps the door fully closed when pressure is applied at the latch edge of the door. RESIDENTS POTENTIALLY AFFECTED: All residents of the facility have the potential to be affected if any corridor door has a gap at the top of the door that will not resist the passage of smoke and if doors do not latch when shut and tested. SYSTEMIC MEASURES: All corridor doors in the facility have been checked by the Director and Assistant Director of Maintenance to assess the gap at the top of the doors to ensure resistance to the passage of smoke. All corridor doors in the facility have been checked to ensure the doors remain fully closed when pressure is applied at the latch edge of the doors. All corridor doors will be checked by the Director and Assistant Director of Maintenance on a monthly basis utilizing a form that includes sections for corridor door identification, findings/actions taken, signature area for person checking/taking action, and date when audit completed and actions taken. All staff are required to attend a mandatory in-service initiated 11/08/2012 and presented again at two times on 11/09/2012, and again on 11/16/2012. All staff not attending will be	11/30/2012



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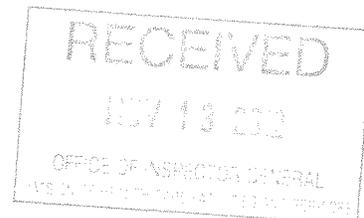
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K 018	<p>Continued From page 2</p> <p>facility has one hundred twenty two (122) certified beds with a census of one hundred nine (109) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/17/12 between 9:20 AM and 11:40 AM, with the Maintenance Director and the Assistant Maintenance Director revealed the corridor doors to rooms #1, 12, and 36 had a gap at the top of the door that would not resist the passage of smoke. Further observation revealed the corridor door to room #33 would not latch when tested.</p> <p>Interview, on 10/17/12 between 9:20 AM and 11:40 AM, with the Maintenance Director and the Assistant Maintenance Director revealed they were not aware the doors had a gap too large. Further interview revealed they were not aware the door to room #33 would not latch.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall</p>	K 018	<p>removed from the schedule until they attend the in-service.</p> <p>MONITORING MEASURES: The Director of Maintenance will present in writing the audits of all corridor doors to the Quality Assessment and Assurance Committee (QA&A) on a quarterly basis with findings presented in a monthly basis format.</p>	



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K 018	Continued From page 3 not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted	K 025	RESIDENTS AFFECTED: The Quick Foam that was in place in the smoke partition in the attic above room #44 at the end of Maple Lane was removed and replaced with properly rated material. The pipe sleeve in the smoke partition in the attic above room #44 at the end of Maple Lane was properly sealed. The Quick Foam that was in place in the smoke partition in the attic around the main sprinkler pipe above room #40 in Transitions was removed and replaced with properly rated	11/30/2012



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K 025	Continued From page 4 heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect five (5) of seven (7) smoke compartments, residents, staff and visitors. The facility has one hundred twenty two (122) certified beds with a census of one hundred nine (109) on the day of the survey. The findings include: Observations, on 10/16/12 between 9:00 AM and 3:30 PM, with the Maintenance Director and the Assistant Maintenance Director revealed: the smoke partitions, extending above the ceiling had multiple penetrations of pipes and wires, and the use of unrated quick foam. The penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. The penetrations and unrated material were noted in the following locations: 1) The use of quick foam and a pipe sleeve not sealed located in the attic above room #44 at the end of Maple Lane. 2) The use of quick foam and a penetration around the main sprinkler pipe located above room #40 in Transitions.	K 025	material. The penetration around the main sprinkler pipe above room #40 in Transitions was filled with properly rated material. The Quick Foam that was in place in the smoke partition in the attic around main sprinkler pipe in the Orchard Way located by the Therapy Room was removed and replaced with properly rated material. The open pipe sleeve in the smoke partition in the attic located by the Therapy Room was properly sealed. The Quick Foam that was in place in the smoke partition in the attic around the sprinkler pipe the Cherry Hall above room #22 was removed and replaced with properly rated material. The penetrations around smaller pipes in the smoke partition in the attic located in the Cherry Hall above room #22 were sealed with properly rated material. RESIDENTS POTENTIALLY AFFECTED: All residents of the facility have the potential to be affected if smoke barriers are not maintained to resist the passage of smoke between smoke compartments. SYSTEMIC MEASURES: All smoke partitions in the attic extending above the ceilings in the attic were checked by the Director and Assistant Director of Maintenance to identify all penetrations of pipes and wires to ensure penetrations were filled with material rated equal to the partition that can resist the passage of smoke. Quick Foam was removed and replaced with properly rated material. Pipe sleeves that are in use were properly sealed. The Director and Assistant Director of Maintenance will check all smoke partitions in the facility extending above the ceilings in the attic on a monthly basis to ensure penetrations are filled with	



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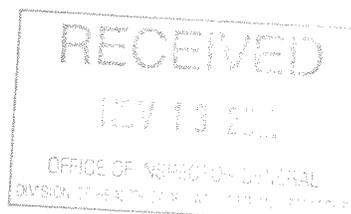
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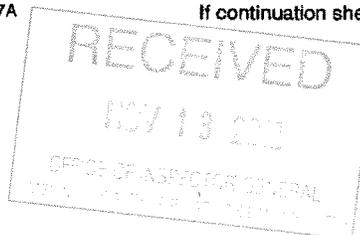
K 025	<p>Continued From page 5</p> <p>3) The use of quick foam around the main sprinkler pipe and an open pipe sleeve in the Orchard Way smoke partition located by the Therapy Room.</p> <p>4) The use of quick foam around the main sprinkler pipe and penetrations around smaller pipes located in the Cherry Hall above room #22.</p> <p>Interview, on 10/16/12 between 9:00 AM and 3:30 PM, with the Maintenance Director and the Assistant Maintenance Director revealed: they were not aware of the penetrations, or that the quick foam was not rated for use in a smoke partition. The facility did not have a schedule in place to check smoke partitions for penetrations. Further Interview with the Administrator at the exit conference revealed he was also not aware of the penetrations in the smoke partitions.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to</p>	K 025	<p>material rated equal to the partition that can resist the passage of smoke. The Director and Assistant Director of Maintenance will, in addition, check all smoke partitions in the facility extending above the attic immediately following any contracted vendor entering the attic who may create penetrations and/or work with penetrations through the smoke partitions and possibly destabilize the security of smoke resistance seals. The Director and Assistant Director of Maintenance will document these checks utilizing a form that includes sections for smoke partition identification, findings/ actions taken, signature area for person checking/taking action and date when audit completed and actions taken.</p> <p>MONITORING MEASURES: The Director of Maintenance will present in writing the audits of all smoke partitions extending above the ceilings in the attic to the Quality Assessment and Assurance Committee on a quarterly basis with findings categorized in a monthly report format.</p>	
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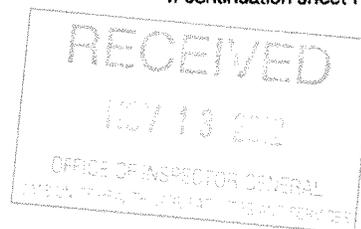
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K 025	Continued From page 6 penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, residents, staff and visitors. The facility has one hundred twenty two (122) certified beds with a census of one hundred nine (109) on	K 027	RESIDENTS AFFECTED: A coordinating device was installed on the cross-corridor doors located next to the employee break room to ensure the doors without the t-astragal closes first after the initial close. This installation addresses the two (2) affected smoke compartments identified. RESIDENTS POTENTIALLY AFFECTED: All residents of the facility have the potential to be affected should the cross-corridor doors located in a smoke barrier not resist the passage of smoke. SYSTEMIC MEASURES: All cross-corridor doors within the facility have been inspected to determine if a coordinating device is necessary. No other cross-corridor doors are equipped with an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches. The Director and Assistant Director of Maintenance will perform a monthly check of all cross-corridor doors that are equipped with an astragal or projecting latch bolt to ensure a coordinating device is in place that prevents the inactive door from closing	11/30/2012



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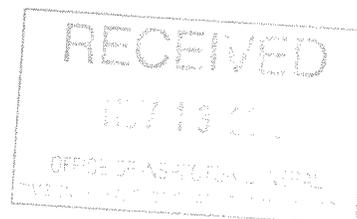
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/17/2012
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
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K 027	Continued From page 7 the day of the survey. The findings include: Observation, on 10/17/12 at 10:13 AM, with the Maintenance Director and the Assistant Maintenance Director revealed the cross-corridor doors located next to the employee break room would not close completely when tested. This was due to the doors not having a coordinating device to ensure the door without the t-astragal would close first after the initial close. Interview, on 10/17/12 at 10:13 AM, with the Maintenance Director and the Assistant Maintenance Director revealed they were unaware the doors needed a coordinator to ensure the doors would close properly in the event of an emergency. NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke. Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027	and latching before the active door closes and latches. MONITORING MEASURES: The findings of the monthly check of all cross-corridor doors will be documented and presented by the Director of Maintenance to the Quality Assessment and Assurance Committee on a quarterly basis with findings categorized in a monthly report format.	



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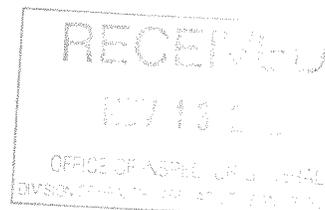
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K 027	Continued From page 8	K 027		
K 029 SS=E	<p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of seven (7) smoke compartments, residents, staff and visitors. The facility has one hundred twenty two (122) certified beds with a census of one hundred nine (109) on the day of the survey.</p>	K 029	<p>RESIDENTS AFFECTED: The following doors, located in three (3) of seven (7) smoke compartments, have had self-closing devices installed:</p> <ol style="list-style-type: none"> 1. Central Storage located in the Kitchen, 2. Janitor Closet located in the Kitchen, 3. Stock Room located in the Kitchen, 4. Activity Office, 5. Closet in Activity Office, 6. Medical Records, 7. Janitor Closet located in the Laundry, 8. Laundry Room Door to the Clean Linen Room, 9. Laundry Room Door to the Soiled Linen Room, 10. Central Storage located in the Orchard Hall, 11. Closet located in Orchard Way Nurses Station Med Room <p>RESIDENTS POTENTIALLY AFFECTED: All residents have the potential to be affected should doors to rooms containing hazardous storage not have self-closing devices installed.</p> <p>SYSTEMIC MEASURES: The Director and Assistant Director of Maintenance, using the definition of Hazardous Areas provided as reference in the Statement of Deficiencies ((NFPA 101 (2000 Edition) 19.3.2.1)) has inspected the facility to determine</p>	11/30/2012



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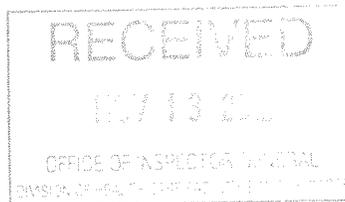
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K 029	<p>Continued From page 9</p> <p>The findings include:</p> <p>Observation, on 10/17/12 between 9:30 AM and 11:30 AM, with the Maintenance Director and the Assistant Maintenance Director revealed doors without self-closing devices to rooms containing hazardous storage in the following locations:</p> <ol style="list-style-type: none"> 1) Central Storage located in the Kitchen. 2) Janitor Closet located in the Kitchen. 3) Stock Room located in the Kitchen. 4) Activity Office. 5) Closet in Activity Office. 6) Medical Records. 7) Janitor Closet located in the Laundry. 8) Laundry Room door to the Clean Linen Room. 9) Laundry Room door to the Soiled Linen Room. 10) Central Storage located in the Orchard Hall. 11) Closet located in Orchard Way Nurses Station Med Room. <p>Interview, on 10/17/12 between 9:30 AM and 11:30 AM, with the Maintenance Director and the Assistant Maintenance Director revealed they were unaware the doors were required to be self-closing due to the storage within each room.</p> <p>18.3.2 Protection from Hazards. 18.3.2.1* Hazardous Areas. Any hazardous area shall be protected in accordance with Section 8.4. The areas described in Table 18.3.2.1 shall be protected as indicated.</p>	K 029	<p>if other doors need self-closing devices installed. Those doors identified as needing self-closing devices installed have had self-closing devices installed. This inspection addresses how the facility has identified other residents having the potential to be affected should doors required to have self-closing devices in place do not have them installed. The Director and Assistant Director of Maintenance will conduct monthly audits of all doors equipped with self-closing devices to ensure they are functioning properly.</p> <p>MONITORING MEASURES: The Director of Maintenance will present findings in writing of the monthly audits of doors equipped with self-closing devices to the Quality Assessment and Assurance Committee on a quarterly basis with findings categorized in a monthly report format. The Director of Maintenance will discuss with the Quality Assessment and Assurance Committee any areas that possibly meet the definition of Hazardous Areas based on observations and reports from the members of the QA&A Committee that storage in a specific area has the potential to meet the definition of Hazardous Areas.</p>	



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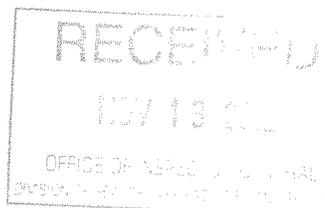
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K 029	Continued From page 10 Table 18.3.2.1 Hazardous Area Protection Hazardous Area Description Separation/Protection Boiler and fuel-fired heater rooms 1 hour Central/bulk laundries larger than 100 ft2 (9.3 m2) 1 hour Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard See 18.3.6.3.4 Laboratories that use hazardous materials that would be classified as a severe hazard in accordance with NFPA 99, Standard for Health Care Facilities 1 hour Paint shops employing hazardous substances and materials in quantities less than those that would be classified as a severe hazard 1 hour Physical plant maintenance shops 1 hour Soiled linen rooms 1 hour Storage rooms larger than 50 ft2 (4.6 m2) but not exceeding 100 ft2 (9.3 m2) storing combustible material See 18.3.6.3.4 Storage rooms larger than 100 ft2 (9.3 m2) storing combustible material 1 hour Trash collection rooms 1 hour 8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.	K 029		



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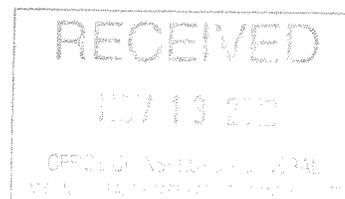
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K 029	Continued From page 11 Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous	K 029		



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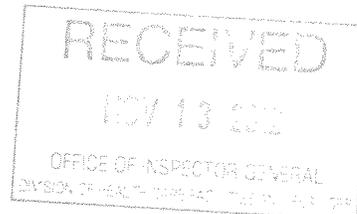
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K 029	Continued From page 12 by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029		
K 046 SS=F	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on staff interview and testing of emergency lighting record review, it was determined the facility failed to test emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility has one hundred twenty two (122) certified beds with a census of one hundred nine (109) on the day of the survey. The findings include: Observation and record review, on 10/16/12 at 11:20 AM, with the Maintenance Director and the Assistant Maintenance Director revealed they did not have documentation that the battery emergency lighting in the facility was tested for 1-1/2 hours within the last year. Interview, on 10/16/12 at 11:20 AM, with the Maintenance Director and the Assistant	K 046	RESIDENTS AFFECTED: The Director and Assistant Director of Maintenance completed an annual test of all emergency lighting equipment within the facility. RESIDENTS POTENTIALLY AFFECTED: All residents of the facility have the potential to be affected by the facility's failure to annually test all emergency lighting equipment to ensure emergency lighting equipment is operational for not less than 1 1/2 hours. SYSTEMIC MEASURES: A review of the facility policy was completed and a policy was created for periodic testing of emergency lighting equipment that directs an annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the Director of Maintenance for inspection by the authority having jurisdiction. MONITORING MEASURES: The Director Of Maintenance will document the annual testing of all emergency lighting equipment and present the findings and any actions necessary to the Quality Assessment	11/30/2012



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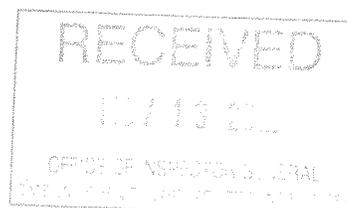
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K 046	Continued From page 13 Maintenance Director revealed they were not aware the annual test for the battery emergency light for 1-1/2 hours had to be documented. Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by	K 046	and Assurance Committee on a quarterly basis that reflects the date of the annual inspection.	



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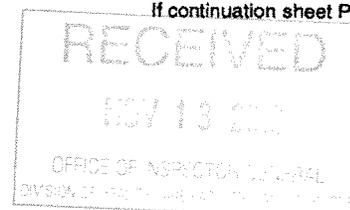
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K 046	Continued From page 14 a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility has one hundred twenty two (122) certified beds with a census of one hundred nine (109) on the day of the survey. The findings include: Observation, on 10/16/12 at 1:56 PM, with the Maintenance Director and the Assistant Maintenance Director revealed the exit door located in the Therapy Department had conflicting signage. The door had an exit sign above the door and a sign on the door that stated not an exit. Interview, on 10/16/12 at 1:56 PM, with the Maintenance Director and the Assistant	K 047	RESIDENTS AFFECTED: The signage on the door that stated "not an exit" has been removed by the Director of Maintenance on 10/18/2012. RESIDENTS POTENTIALLY AFFECTED: All residents of the facility had the potential to be affected by the conflicting signage on the exit door located in the Therapy Department. SYSTEMIC MEASURES: The Director and Assistant Director of Maintenance checked all other exit doors on 10/18/2012 in the facility to ensure exit doors that obviously and clearly are identified as exits are marked by an approved sign readily visible from any direction of exit access and that there is no conflicting signage. The Director of Maintenance is responsible for any changes to exit doors signage and will ensure no changes are made that present conflicting signage. The reason for the conflicting signage has been determined and occurred when the exit door was no longer used as an alternate entry into the facility in March 2012. All facility employees will be provided in-service training on 11/08, 09 with makeup in-service 11/16/12. The Director and Assistant Director of Maintenance will check all exit doors on a monthly basis. MONITORING MEASURES: Director of Maintenance presenting findings to the Quality Assessment and Assurance Committee on a quarterly basis with findings categorized in a monthly report format.	11/30/2012



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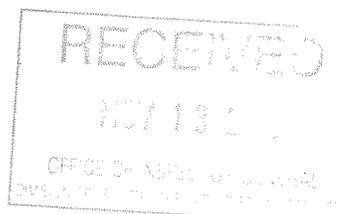
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K 047	Continued From page 15 Maintenance Director revealed they confirmed the observation that the signage was conflicting. Reference: NFPA 101 (2000 edition) 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047			
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff and visitors. The	K 050	RESIDENTS AFFECTED: The Director of Maintenance has created a schedule of fire drills that will ensure fire drills are held at unexpected times under varying conditions at least quarterly on each shift. This schedule will be maintained in a confidential manner to ensure fire drills are unexpected. The documentation was not found that reflects the facility conducted a fire drill in the 4th quarter of 2011 on 1st shift. The newly established schedule of fire drills will address the corrective action to be accomplished for those residents found to have been affected by the deficient practice as well as address how the facility identifies other residents having the potential to be affected. RESIDENTS POTENTIALLY AFFECTED: All residents of the facility have the potential to be affected. SYSTEMIC MEASURES: The newly established schedule of fire drills will address the corrective action to be accomplished for those residents found to have	11/30/2012	



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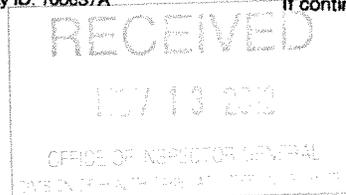
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/17/2012
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	<p>Continued From page 16</p> <p>facility has one hundred twenty two (122) certified beds with a census of one hundred nine (109) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 10/16/12 at 11:25 AM, with the Maintenance Director and the Assistant Maintenance Director revealed the facility did not conduct fire drills at unexpected times on all shifts. Further record review revealed the facility did not conduct a fire drill in the 4th quarter of 2011 on 1st shift.</p> <p>Interview, on 10/16/12 at 11:25 AM, with the Maintenance Director and the Assistant Maintenance Director revealed they were not aware the fire drills were not being conducted as required. Further interview revealed they were not aware the fire drill in the 4th quarter of 2011 was not conducted.</p> <p>Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p> <p>Reference: NFPA 101 Life Safety Code (2000 Edition). 18.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns,</p>	K 050	<p>been affected by the deficient practice as well as address how the facility identifies other residents having the potential to be affected.</p> <p>SYSTEMIC MEASURES: The Director of Maintenance will provide a report to the Quality Assessment and Assurance Committee of the fire drills conducted as a way for the facility's Quality Assessment and Assurance Committee to monitor its performance to ensure that solutions are sustained. The report will be made on a quarterly basis in a monthly report format.</p>	



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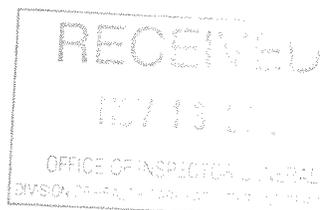
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K 050	Continued From page 17 maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, sprinkler testing record review, and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility has one hundred twenty two (122) certified beds with a census of one hundred nine (109) on the day of the survey. The findings Include: Observation and sprinkler testing record review, on 10/16/12 between 9:30 AM and 3:30 PM, with the Maintenance Director and the Assistant Maintenance Director revealed:	K 062	RESIDENTS AFFECTED: Kentuckiana Sprinkler came to the facility and inspected all sprinkler heads and provided a listing of sprinkler heads that need to be replaced. The sprinkler heads with paint will be replaced. All sprinkler heads in the attic were inspected on and any insulation or buildup was removed by the Director and Assistant Director of Maintenance. The items stored in the Therapy Office Closet were removed and rearranged to ensure nothing was stored within 18 inches of the sprinkler head. The bathroom fan cover was removed from the sprinkler head located in the bathroom of room #44 and securely mounted to the ceiling on 10/18/2012 to prevent cover from falling onto sprinkler head in the future. The items stored in the walk-in cooler in the Kitchen were removed and rearranged to ensure nothing was stored within 18 inches of the sprinkler head. The sprinkler head wrench was placed in the sprinkler riser room in a designated area easily accessible. The sprinkler gauges were calibrated by Kentuckiana Sprinkler with documentation of calibration given to Director of Maintenance.	11/30/2012



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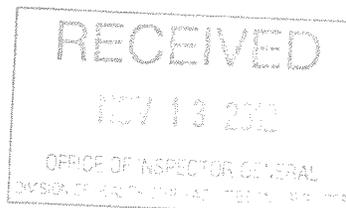
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K 062	Continued From page 18 1) Paint was noted on sprinkler heads located throughout the facility. 2) A sprinkler head was covered in insulation located in the attic above room #11. 3) Storage within 18 inches of a sprinkler head located in the Therapy Office Closet. 4) A bathroom fan cover was lying on a sprinkler head located in the bathroom of room #44. 5) Storage within 18 inches of a sprinkler head located in the walk-in cooler of the Kitchen. 6) No sprinkler head wrench located in the sprinkler riser room. 7) No documentation the sprinkler gauges had been calibrated or replaced within the last five years. Interview, on 10/16/12 between 9:30 AM and 3:30 PM, with the Maintenance Director and the Assistant Maintenance Director revealed he was not aware sprinkler heads had to be completely free from paint. Further interview revealed they were not aware of the insulation on the sprinkler head or the storage within 18 inches of the sprinkler heads. Further interview revealed they were not aware the gauges had to be calibrated every five years or the sprinkler head wrench was missing. Reference: NFPA 13 (1999 Edition)	K 062	RESIDENTS POTENTIALLY AFFECTED: Each resident of the facility was identified as having the potential to be affected by the facility's failure to maintain the sprinkler system in accordance with NFPA standards. SYSTEMIC MEASURES: The Director and Assistant Director of Maintenance will inspect all sprinkler heads within the facility on a monthly basis. The Director of Maintenance will provide a report to the Quality Assessment and Assurance Committee on a quarterly basis to reflect findings. The Director of Nursing and Administrator will conduct random inspections of twenty (20) sprinkler heads each on a monthly basis and document findings. Areas of concern will immediately be brought to the attention of the Director of Maintenance to be addressed. All staff are required to attend a mandatory in-service initiated 11/08/2012 and presented again at two times on 11/09/2012 and again on 11/16/2012. All staff not attending will be removed from the schedule until they attend the in-service. MONITORING MEASURES: The Director of Maintenance will provide a report to the Quality Assessment and Assurance Committee on a quarterly basis to reflect findings.	



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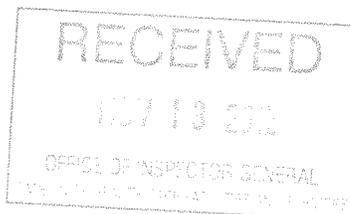
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K 062	Continued From page 19 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all	K 062		



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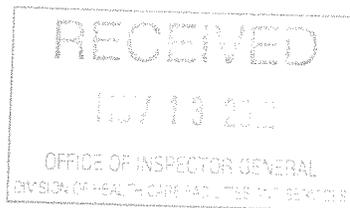
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K 062	<p>Continued From page 20 sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of</p>	K 062			



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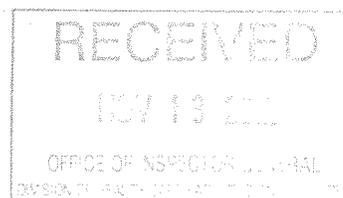
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K 062	Continued From page 21 sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years	K 062		



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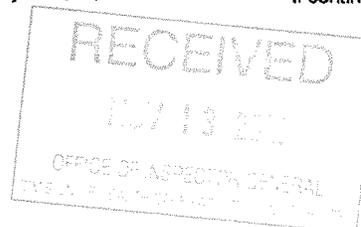
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K 062	Continued From page 22 thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10	K 062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the installation of portable fire extinguishers per NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff, and visitors. The facility has one hundred twenty two (122) certified beds with a census of one hundred nine (109) on the day of the survey. Findings include: Observation, on 10/16/12 between 9:30 AM and 3:30 PM, with the Maintenance Director and the Assistant Maintenance Director revealed the wall mounted, portable fire extinguishers located in the designated smoking area was not mounted but sitting on the ground.	K 064	RESIDENTS AFFECTED: The wall-mounted, portable fire extinguisher located in the designated smoking area was properly mounted within the height range per NFPA standards by the Director of Maintenance on 10/22/2012. A placard was placed near the wall-mounted, K-Class portable fire extinguisher located in the Kitchen that indicates the fire suppression system shall be activated before the extinguisher is to be used. This placard was placed on 10/19/2012. RESIDENTS POTENTIALLY AFFECTED: The Director and Assistant Director of Maintenance conducted an inspection of all fire extinguishers on 10/19/12 to ensure they were properly mounted and in place without any obstructions. All residents have the potential to be affected should the facility fail to maintain the installation of portable fire extinguishers per NFPA standards. SYSTEMIC MEASURES: The Director and Assistant Director of Maintenance inspects the fire extinguishers on a monthly basis and the inspection form has been revised to reflect the fire extinguishers are checked for proper mounting and signage. All employees provided in-service training on November 8, 9 and 16, 2012.	11/30/2012



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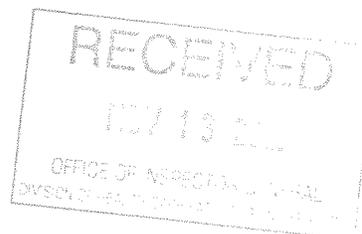
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K 064	Continued From page 23 Interview, on 10/16/12 between 9:30 AM and 3:30 PM, with the Maintenance Director and the Assistant Maintenance Director revealed that they were not aware of the installation requirements for wall mounted portable fire extinguishers. Observation, on 10/16/12 between 9:30 AM and 3:30 PM, with the Maintenance Director and the Assistant Maintenance Director revealed the wall mounted, K class portable fire extinguishers located in the Kitchen did not have a placard placed near the extinguisher indicating the fire suppression system shall be activated before the extinguisher was to be used. Interview, on 10/16/12 between 9:30 AM and 3:30 PM, with the Maintenance Director and the Assistant Maintenance Director revealed that they were not aware of the placard requirements for wall mounted portable fire extinguishers located in the Kitchen. Reference NFPA 10 (1998 Edition). 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the	K 064	MONITORING MEASURES: The Director of Maintenance will present in writing to the Quality Assessment and Assurance Committee on a quarterly basis the findings of monthly inspections with report in a monthly report format.	



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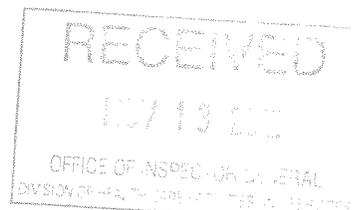
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K 064	Continued From page 24 bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm). Reference: NFPA 10 (1998 Edition). 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher. Reference: NFPA 10 1999	K 064		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	RESIDENTS AFFECTED: The Director of Maintenance, on 10/22/2012, ordered a metal container with a self-closing lid to dump the ashtrays to be placed in the one designated smoking area. RESIDENTS POTENTIALLY AFFECTED: All residents of the facility have the potential to be affected should the facility not ensure the use of approved ashtrays in the smoking area in accordance with NFPA standards. SYSTEMIC MEASURES: All facility employees will be provided in-service training on November 8, 9 and 16, 2012. Employees not attending one of the mandatory in-services will be removed from the schedule until they receive in-service training. The Director and Assistant Director of Maintenance will check the smoking area on a weekly basis. MONITORING MEASURES: The Director of Maintenance will provide a monthly report to the QA&A Committee of his findings to monitor the facility's performance and ensure solutions are sustained.	11/30/2012



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K 066	Continued From page 25 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect staff and visitors. The facility has one hundred twenty two (122) certified beds with a census of one hundred nine (109) on the day of the survey. The findings include: Observation, on 10/16/12 at 11:53 AM, with the Maintenance Director and the Assistant Maintenance Director revealed the facility did not provide a metal container with a self-closing lid to dump the ashtrays, located in the designated smoking area. Interview, on 10/16/12 at 11:53 AM, with the Maintenance Director and the Assistant Maintenance Director revealed they were not aware of the requirement for metal containers with a self-closing lid for ashtrays. Reference: NFPA Standard 101 (2000 Edition). 19.7.4 Smoking (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		
K 068 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and	K 068	RESIDENTS AFFECTED: The vents in the following locations will be properly routed to the outside rather than into the attic:	11/30/2012

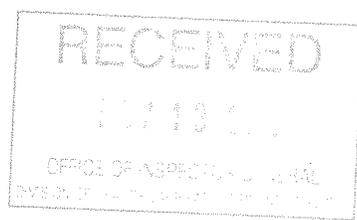


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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/17/2012
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	

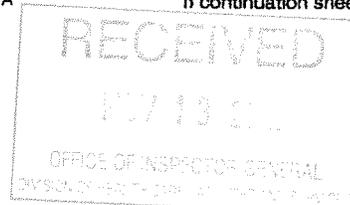
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K 068	<p>Continued From page 26 discharged to the outside air. 19.5.2.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, and heater rooms were installed in accordance with NFPA standards. The deficiency had the potential to affect four (4) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty two (122) beds with a census of one hundred nine (109) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/17/12 between 9:30 AM and 11:30 AM, with the Maintenance Director and the Assistant Maintenance Director revealed vents in mechanical rooms with gas fired equipment did not vent to the outside but instead were open to the attic in the following locations:</p> <ol style="list-style-type: none"> 1) Mechanical Room located in Oak Hall. 2) Mechanical Room located in the Dining Room. 3) Mechanical Room located in the Laundry Room. 4) Mechanical Room located in Apple Lane. <p>Interview, on 10/16/12 between 9:30 PM and 11:30 AM with the Maintenance Director and the Assistant Maintenance Director revealed they were unaware the vents were not to be open to</p>	K 068	<ol style="list-style-type: none"> 1. Mechanical Room located in Oak Hall. 2. Mechanical Room located in the Dining Room. 3. Mechanical Room located in the Laundry Room. 4. Mechanical Room located in Apple Lane. <p>RESIDENTS POTENTIALLY AFFECTED: All residents were determined to have the potential to be affected by the facility's failure to ensure combustion air and ventilation for boilers, incinerators, and heater rooms were installed in accordance with NFPA standards.</p> <p>SYSTEMIC MEASURES: The Director and Assistant Director of Maintenance checked all other Mechanical Rooms within the facility to assess for areas of concern on 10/19/2012. The Director and Assistant Director of Maintenance will check all Mechanical Rooms on a monthly basis to ensure proper venting to the outside rather than into the attic.</p> <p>MONITORING MEASURES: The Director of Maintenance will report findings of monthly checks to the Quality Assessment and Assurance Committee on a quarterly basis in a monthly report format.</p>	



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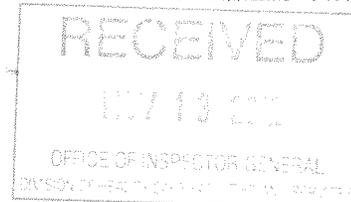
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K 068	Continued From page 27 the attic. Reference: NFPA 101 Life Safety Code (2000 edition) Section 19.5 Building Services 19.5.2.2 Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure. NFPA 101 LIFE SAFETY CODE STANDARD 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 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	K 068		
K 072 SS=E		K 072	RESIDENTS AFFECTED: The trash carts, med carts, linen carts and chairs were removed from the corridors upon identification. RESIDENTS POTENTIALLY AFFECTED: All residents have the potential to be affected if the means of egress are not continuously maintained free of all obstructions or impediments to full instant use in the case of a fire or other emergency. SYSTEMIC MEASURES: All facility staff was provided in-service training on the need to continuously maintain means of egress free of all obstructions or	11/30/2012



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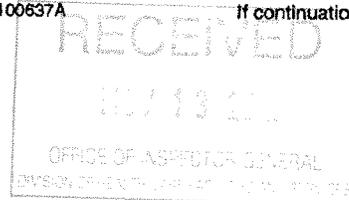
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K 072	Continued From page 28 deficiency had the potential to affect six (6) of seven (7) smoke compartments, residents, staff and visitors. The facility has one hundred twenty two (122) beds with a census of one hundred nine (109) on the day of the survey. The findings include: Observation, on 10/16/12 between 9:30 AM and 3:30 PM, with the Maintenance Director and the Assistant Maintenance Director revealed trash carts, med carts, linen carts and chairs stored in all corridors except the Center Hall. Interview, on 10/16/12 between 9:30 AM and 3:30 PM, with the Maintenance Director and the Assistant Maintenance Director revealed these items were routinely stored in the corridors. 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.	K 072	impediments to full instant use in the case of fire or other emergency. The mandatory in-service was presented on November 8, 9, and 16, 2012. Employees not attending the in-service by November 19, 2012 will be removed from the schedule until receiving education. All corridors will be inspected on a daily basis by the Director and Assistant Director of Maintenance Monday through Friday. The weekend nurse supervisor, the second and third shift nurse supervisor will observe all corridors and ensure reliability of means of egress. MONITORING MEASURES: The Director of Maintenance will present a quarterly report to the Quality Assessment and Assurance Committee summarizing the observations that reflects areas of concern, actions taken and progress in a monthly format.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076	RESIDENTS AFFECTED: The combustible storage was moved outside five (5) feet of the oxygen cylinders in the Med Room next to the Transitions Nurses Station. RESIDENTS POTENTIALLY AFFECTED: The other oxygen storage rooms in the facility were checked to ensure no combustibles were stored within five (5) feet of the oxygen cylinders. All residents of the facility had the potential to be affected if oxygen storage areas were not protected in accordance with NFPA standards.	11/30/2012



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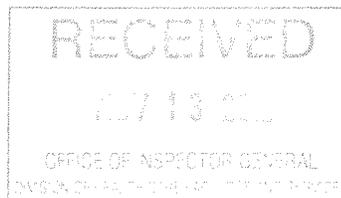
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K 076	Continued From page 29 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility has one hundred twenty two (122) certified beds with a census of one hundred nine (109) on the day of the survey. The findings include: Observation, on 10/16/12 at 2:55 PM, with the Maintenance Director and the Assistant Maintenance Director revealed in the oxygen storage room located in the Med Room next to the Transitions Nurses Station to have combustible storage within five (5) feet of the oxygen cylinders. Combustibles cannot be stored within five (5) feet of oxygen storage due to fire spread. Interview, on 10/16/12 at 2:55 PM, with the Maintenance Director and the Assistant Maintenance Director revealed they were unaware oxygen tanks could not be stored within five (5) feet of combustible materials.	K 076	SYSTEMIC MEASURES: The representative of the vendor providing the oxygen to the facility came to the facility on 11/09/2012 to assess for proper storage of oxygen, meeting with the Director of Nursing and Director of Maintenance to provide direction for proper oxygen storage. All facility staff was provided in-service training on the need to ensure oxygen storage areas were protected according to NFPA standards.. The mandatory in-service was presented on November 8, 9, and 16, 2012. Employees not attending the in-service by November 19, 2012 will be removed from the schedule until receiving education. The Director and Assistant Director of Maintenance will check all oxygen storage areas on a monthly basis to ensure no combustibles are stored within five (5) feet of oxygen storage. MONITORING MEASURES: The Director of Maintenance will notify the Director of Nursing when any concerns with oxygen storage are observed so they can be addressed. Quarterly, the Director of Maintenance will present a summary of the inspections of oxygen storage to the Quality Assessment and Assurance Committee.	



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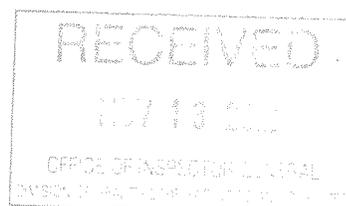
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K 076	Continued From page 30 Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.	K 076		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by:	K 130	RESIDENTS AFFECTED: The heavy build-up of lint in the top and bottom of the dryers was removed by the Director and Assistant Director of Maintenance on October 26, 2012. RESIDENTS POTENTIALLY AFFECTED: All residents have the potential to be affected if the facility does not maintain the dryers in a way to prevent a build-up of lint in the top and	11/30/2012



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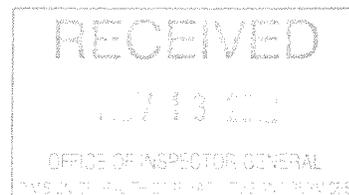
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K 130	Continued From page 31 Based on observation and interview, the facility failed to maintain the hazardous areas in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility has one hundred twenty two (122) certified beds with a census of one hundred nine (109) on the day of the survey. The findings include: Observation, on 10/17/12 at 10:06 AM, with the Maintenance Director and the Assistant Maintenance Director revealed a heavy build-up of lint in the top and bottom of the dryers located in the Laundry Room. Interview, on 10/17/12 at 10:06 AM, with the Maintenance Director and the Assistant Maintenance Director revealed they clean the top of the dryers regularly but he was not aware the lint build up was so excessive. NFPA 101 (2000 Edition) 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.	K 130	bottom of the dryers located in the Laundry Room. SYSTEMIC MEASURES: The Director and Assistant Director of Maintenance will check and remove lint from the top and bottom of the dryers to ensure safety on a weekly basis. The Laundry Attendant will continue to remove lint from the lint screen of all dryers in the Laundry Room every shift. The cleaning of the top and bottom of the dryers by the Director and Assistant Director of Maintenance as well as the removal of lint from the lint screen by the Laundry Attendant will be documented. All facility staff was provided in-service training on the need to maintain the dryers in such a way that they are free of lint build-up. The mandatory in-service was presented on November 8, 9, and 16, 2012. Employees not attending the in-service by November 19, 2012 will be removed from the schedule until receiving education. MONITORING MEASURES: The Director of Maintenance will present a report of inspections of the dryers to the Quality Assessment and Assurance Committee on a quarterly basis.		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144	RESIDENTS AFFECTED: The Director of Maintenance removed the	11/30/2012	



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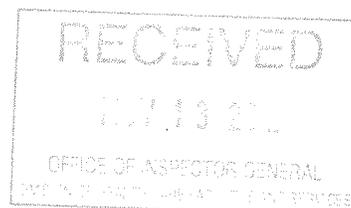
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K 144 SS=F	<p>Continued From page 32</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility has one hundred twenty two (122) certified beds with a census of one hundred nine (109) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/16/12 at 11:44 AM, with the Maintenance Director and the Assistant Maintenance Director revealed the facility was equipped with an emergency generator. Stored inside the generator enclosure were three (3), one (1) quart containers of oil.</p> <p>Interview, on 10/16/12 at 11:44 AM, with the Maintenance Director and the Assistant Maintenance Director revealed they were not aware the items were being stored inside the generator enclosure.</p>	K 144	<p>three quarts of oil stored in the emergency generator enclosure on 10/18/2012. Both the Director and Assistant Director of Maintenance are now aware that no other equipment, including architectural appurtenances, except those that serve this space, shall be permitted in the emergency generator's enclosure.</p> <p>RESIDENTS POTENTIALLY AFFECTED: All residents of the facility could have been and all residents of the facility had the potential to have been affected for failure to maintain the emergency generator in accordance with NFPA standards by storing inside the generator enclosure three (3), one (1) quart containers of oil.</p> <p>SYSTEMIC MEASURES: The Director and Assistant Director of Maintenance will inspect the emergency generator enclosed area to ensure no items are stored in this area on a monthly basis.</p> <p>MONITORING MEASURES: The Director of Maintenance will report his audits to the Quality Assessment and Assurance Committee on a quarterly basis reflecting the findings of his audits in a monthly format.</p>		



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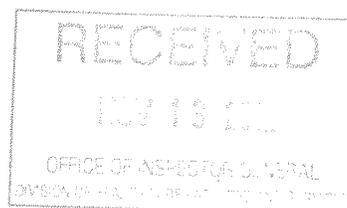
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K 144	Continued From page 33 Reference: NFPA 110 (1999 Edition) 5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. No other equipment, including architectural appurtenances, except those that serve this space, shall be permitted in this room.	K 144		
K 147 SS=E	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 NFPA standards. The deficiency had the potential to affect five (5) of seven (7) smoke compartments, residents, staff, and visitors. The facility has one hundred twenty two (122) certified beds with a census of one hundred nine (109) on the day of the survey.	K 147	RESIDENTS AFFECTED: The Director and Assistant Director of Maintenance addressed the following identified concerns by removing the extension cord and power strip that was being used in the employee lounge to power the refrigerator and vending machine on 10/18/2012. They removed the Heat Tape wrapped around water lines plugged into an extension cord located in the Mechanical Room in the Therapy Department on 10/19/2012. They removed the extension cord plugged into a power strip located in the Business Office on 10/18/2012. They removed the power strip and cords passing through a cabinet to power the range hood in the Therapy Kitchen on 10/23/2012. They removed the storage in front of the electrical panel located in the Therapy Kitchen on 10/18/2012. They replaced the receptacle	11/30/2012



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K 147	Continued From page 34 The findings include: Observations, on 10/16/12 between 9:00 AM and 3:30 PM, with the Maintenance Director and the Assistant Maintenance Director revealed: 1) A refrigerator and a vending machine were plugged into a power strip that was plugged into an extension cord located in the employee lounge. 2) Heat Tape was wrapped around water lines to a water heater and plugged into an extension cord located in the Mechanical Room in the Therapy Department. 3) A power strip was plugged into an extension cord located in the Business Office. 4) A range hood was plugged into a power strip and the cords were passing through the cabinet located in the Therapy Kitchen. 5) Storage in front of an electrical panel located in the Therapy Kitchen. 6) A hydrocollator was not plugged into a ground fault circuit interrupter (GFCI) receptacle located in the Therapy Kitchen. 7) A 24 volt battery charger was plugged into a power strip located in Shower Room #2. 8) Open electrical junction boxes were noted in the attic above room #44. Interview, on 10/16/12 between 9:00 AM and 3:30 PM, with the Maintenance Director and the Assistant Maintenance Director revealed they were not aware of the open electrical junction box above the ceiling. Further interview revealed he was aware of the proper use of power strips and extension cord, but not aware they had been	K 147	in the Therapy Kitchen where the hydrocollator was plugged into with a ground fault circuit interrupter (GFCI) on 10/23/2012. They removed the 24-volt battery charger that was plugged into a power strip located in Shower Room #2 on 10/18/2012 and stored in another location. They installed proper electrical junction boxes in the attic above room #44 on October 22, 2012. They repaired the open electrical junction box in the ceiling located in Shower Room #2, Orchard Way on 10/22/2012. They removed the power strip where mini-nebulizer was plugged into in rooms #22 and #35 on 10/18/2012. RESIDENTS POTENTIALLY AFFECTED: All residents have the potential to be affected if the facility does not ensure electrical wiring is maintained according to NFPA standards. SYSTEMIC MEASURES: The Director and Assistant Director of Maintenance completed a facility audit on 10/19/12 to check to see that the facility was in compliance with electrical wiring and use of power strips, extension cords, covers, and proper receptacles. The Director and Assistant Director of Maintenance will conduct monthly audits to check to see that the facility is in compliance with electrical wiring and use of power strips, extension cords, covers and receptacles. MONITORING MEASURES: The Director of Maintenance will present the findings of the monthly audits to the Quality Assessment and Assurance Committee on a quarterly basis.	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/17/2012
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 35 installed and misused. Observations, on 10/17/12 between 9:00 AM and 11:40 AM, with the with the Maintenance Director and the Assistant Maintenance Director revealed: 1) An open electrical junction box in the ceiling located in Shower Room #2, Orchard Way. 2) A mini nebulizer was plugged into a power strip located in room #22, and #35. Interview, on 10/17/12 between 9:00 AM and 11:40 AM, with the Maintenance Director and the Assistant Maintenance Director revealed they were aware medical equipment could not be plugged into power strips but not aware who had plugged in the mini nebulizers to the power strips. Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147		

