

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

PRINTED: 10/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on 09/27/11 - 09/29/11 and a Life Safety Code Survey was conducted on 09/27/11. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. An abbreviated survey was initiated on 09/27/11 and concluded on 09/29/11 to investigate KY17154. The Division of Health Care substantiated the allegation as verified by the evidence. Federal and State deficiencies were cited.	F 000		
F 159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system	F 159	The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. 1. Quarterly financial statements were printed on 9/30/11 and issued to residents or legal representatives of all 39 residents with personal spending accounts by Admissions Coordinator. 2. Quarterly financial statements were printed on 9/30/11 and issued to residents or legal representatives of all 39 residents with personal spending accounts by Admissions Coordinator.	11/11/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

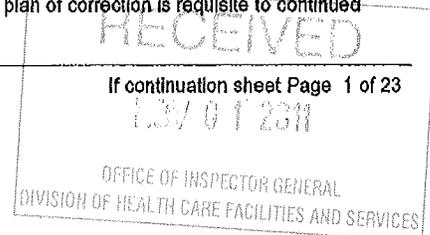
TITLE

(X6) DATE

X Alan Marshall

X Administrator X 10/31/11

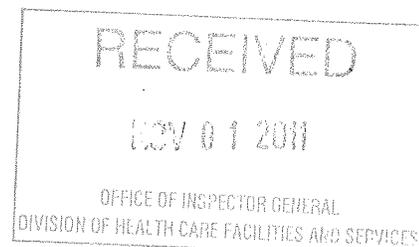
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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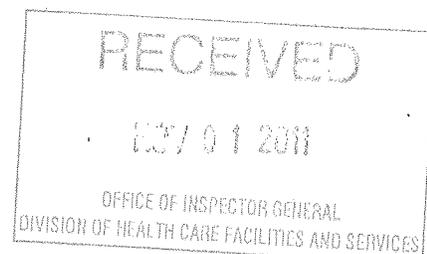
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F 159	<p>Continued From page 1</p> <p>that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and resident account review, it was determined the facility failed to provide quarterly statements in writing to the resident or the resident's representative within thirty (30) days after the end of the quarter for thirty nine (39) of thirty nine (39) resident accounts.</p> <p>The findings include: The facility failed to provide a policy on quarterly statements of resident accounts.</p>	F 159	<p>3. Resident Fund policy amended. "Quarterly statements will be issued to all residents with personal spending accounts, or his or her legal representative, within 30 days of the end of each calendar quarter." Admissions Director re-educated regarding new policy by Administrator on 9/30/11.</p> <p>4. Administrator will audit 25% of all resident accounts quarterly to ensure compliance and will report results to QA on 11/11/11 and not less than quarterly thereafter.</p>	



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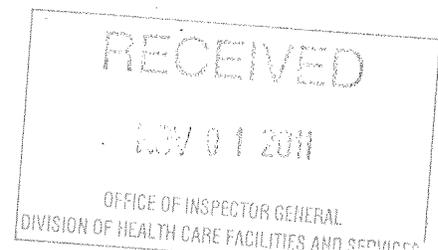
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F 159	Continued From page 2 Review of resident accounts with the Director of Admissions revealed there were thirty nine (39) resident accounts managed by the facility. Interview, on 09/26/11 at 3:30 PM, with Resident #6's Power of Attorney (POA) revealed the business office was not providing the POA with quarterly statement of Resident #6's account. The POA stated he/she was told one would be provided but a statement had never been received. Interview with the Director of Admissions (DA) on, 09/29/11 at 8:45 AM, revealed quarterly statements are sent to residents or the resident's representative by request only. She stated most people just stop by the office if they wanted to know the balance of their account. The DA stated she was unaware statements should be provided in writing to residents or their families quarterly.	F 159		11/11/11	
F 160 SS=C	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview, resident account review and facility policy review, it was determined the facility failed to refund monies due the estate of four (4)	F 160	Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. 1. Status Change Forms sent by Admissions Coordinator to National Data Care on 9/29/11 authorizing release of funds of the 4 sampled residents to the appropriate parties. 2. All residents deceased within the past year who maintained personal fund accounts at the facility Audited by Admissions Coordinator on 9/30/11. There are no additional instances of non-compliance.		



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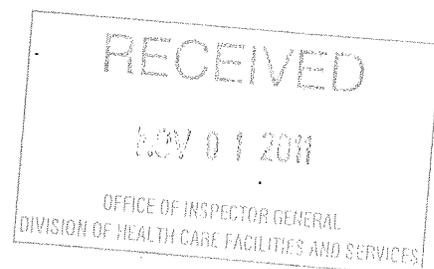
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F 160	<p>Continued From page 3</p> <p>deceased residents of the four (4) sampled within 30 days of the resident's death. Unsampled Residents E, F, G, and H.</p> <p>The findings include:</p> <p>Review of the facility's Refund Policy revealed "Any resident that has expired funds will be returned within 30 days of date of death after all outstanding balances are paid in full."</p> <p>Review of resident account records revealed the following: Unsampled Resident E died on 01/19/10 and had a balance of \$90.00 in the resident account as of 09/29/11; Unsampled Resident F died on 03/12/11 and had a balance of \$90.00 in the resident account as of 09/29/11; Unsampled Resident G died on 01/02/11 and had a balance of \$9.00 in the resident account as of 09/29/11; Unsampled Resident H was discharged from the facility on 03/26/11 to another hospital where he later died. A check was made out to cash in the amount of \$3,207.29 on 08/05/11.</p> <p>Interview with Director of Admissions (DA), on 09/29/11 at 10:30 AM, revealed there was a system error with regard to the conveyance of funds after the death of a resident. She stated she would notify National Datacare after a resident's death and the account would close on her computer. She discovered today, after the interview, that a Status Change Form needed to be faxed to National Datacare in order for them to transfer the closing balance to the facility's checking account. The facility would then release funds in accordance with state probate law and health care facility regulations. She stated she was unaware there were any accounts with</p>	F 160	<p>3. Admissions Director has been re-educated on use of the Resident Fund Management System and re-educated on the regulation regarding conveyance of funds within 30 days by Administrator on 9/30/11.</p> <p>4. Administrator will audit 25% of all accounts of deceased residents quarterly to ensure all funds are conveyed within 30 days, and will report results of audit to QA on 11/11/11 and not less than quarterly thereafter.</p>	



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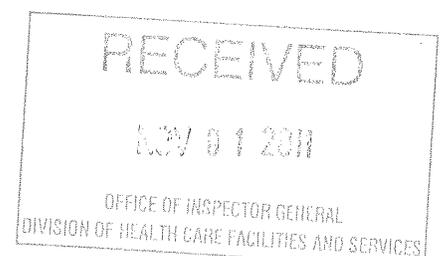
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F 160 F 225 SS=E	Continued From page 4 outstanding balances for deceased residents. 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 160 F 225	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. 1. All employee records were Audited by Human Resources Coordinator on 10/12/11 to ensure all criminal background checks and abuse registry checks were completed prior to hire, and corrected as necessary. 2. All employee records were Audited by Human Resources Coordinator on 10/12/11 to ensure all criminal background checks and abuse registry checks were completed prior to hire, and corrected as necessary.	11/11/11



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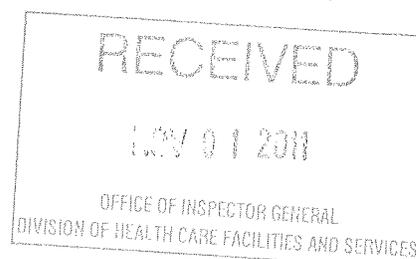
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F 225	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review it was determined the facility failed to follow their policy and failed to complete a nurse aide abuse registry check on two (2) of eleven (11) sampled employees prior to their hire date. The findings include: Review of the facility's policy, Abuse Prohibition, revealed all individuals/applicants would be interviewed and might be hired after an investigation that included measures within the facilities control: #4. Inquiries would be made to determine the individual's status on the Kentucky Abuse Registry. Record review of the employee personnel file for Nurse Aide #1 revealed a hire date of 09/01/11, a Kentucky Abuse Registry check dated 09/02/11 and a Missouri Abuse Registry check dated 09/07/11. Record review of the employee personnel file for Nurse Aide #2 revealed a hire date of 09/01/11, and a Kentucky Abuse Registry check dated 09/02/11. Interview with the Administrator, on 09/29/11 at 3:00 PM, revealed the purpose of abuse registry checks were to protect the residents from potential abuse. He stated he thought as long as the employee did not have resident contact that	F 225	3. Human Resources Director re-educated by Administrator on 9/30/11 that all potential employees must have a criminal background and abuse registry checks prior to employment. 4. Administrator will audit all new hires monthly for 3 months, then Human Resources Coordinator will audit all employee records every month for 6 months to ensure all criminal background checks and nurse aide abuse registry checks are completed prior to hire date. Audits will be reported to the facility QA committee on 11/11/11 and not less than quarterly to ensure sustained compliance.	



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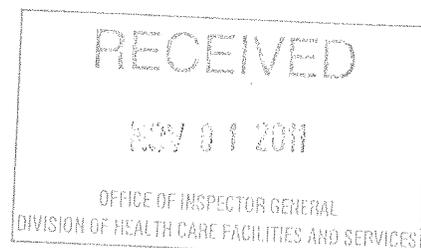
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F 225	Continued From page 6	F 225		
F 280 SS=E	<p>was okay to complete those checks after date of hire.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, facility records and policy review, it was determined the facility failed to involve the resident's families in the care planning process in five (5) of sixteen (16) sampled residents.</p> <p>The findings include: Review of the facility's policy RAI Process and</p>	F 280	<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>1. Families of all 5 cited residents were contacted by Social Services Director by phone on 9/30/11 and 10/3/11 and asked to share any care concerns and if they wish to schedule a care plan meeting.</p>	11/11/11



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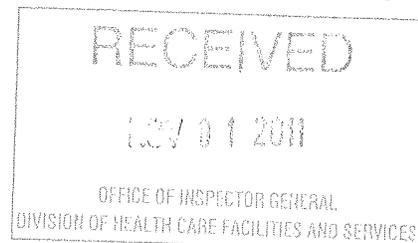
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F 280	Continued From page 7 Care Planning revealed the family and the resident are to be involved in planning the care of the resident. Review of the facility Care Plan Tracking Tool for the year 2011, revealed Resident #1's family was notified by mail for care plan meetings held 01/19/11, 04/13/11, and 09/28/11. There was no notification of a care plan meeting between 04/13/11 and 09/28/11. Resident #5's family was notified by mail for care plan meetings held 02/09/11 and 04/13/11. There were no further notifications of care plan meetings held through 09/29/11. Resident #6's family was notified by mail for care plan meetings held 01/12/11 and 03/30/11. There were no further notifications of care plan meetings held through 09/29/11. Resident #7's family was notified by mail for care plan meetings held 05/18/11 and 08/03/11. There were no notifications of by mail care plan meetings held 01/01/11 to 05/18/11. Resident #10's family was notified by mail for care plan meeting held 08/31/11. There were no notifications by mail of care plan meetings held 01/01/11 to 08/31/11. Interview with the Director of Social Services, on 09/29/11 at 9:20 AM, revealed all families were notified by letter of upcoming care plan meetings. She stated they did not keep a copy of the letter; however, they did keep a log of when the letters were mailed for each resident. The DSS stated she was unsure why some of the families were not notified of upcoming care plan meetings. She stated it was important for families to be involved in their loved one's care.	F 280	2. The care plan family notification log was audited by Social Services Director on 9/30/11 to identify any additional resident families not notified of care plan meetings, and families contacted as necessary. 3. Policy and Procedure for resident and family/responsible party notification of care plan meetings was reviewed by Administrator on 9/30/11. Social Services Director re-educated by Administrator on 9/30/11 regarding policy and procedure for notifying resident and family/responsible party of care plan meetings. 4. Administrator will audit care plan notification log quarterly to ensure compliance and will reports results of audit at 11/11/11 QA and not less than quarterly thereafter.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		



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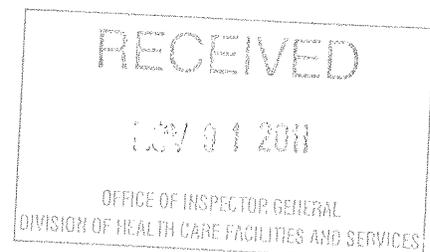
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F 309	<p>Continued From page 8</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility did not follow Physician orders for one (1) resident of the sixteen (16) sampled residents. Resident #3 had a Physician's order for Thrombo Embolic Deterrent (TED) hose and an order for Heel Lift Boots that were not followed.</p> <p>The findings include:</p> <p>Review of the clinical record for Resident #3 revealed a Physician's order was received on 01/22/09 for TED hose to be applied every morning and to be off in the PM. A Physician's order was received on 09/08/09 for Heel Lift Boots on at all times to bilateral (both) feet while in bed. The facility admitted Resident #3 to the facility from the hospital on 04/15/07. Resident #3's diagnoses included Alzheimer Disease, Cerebral Vascular Disease, Diabetes, Chronic Renal Failure and a Hip Joint Replacement.</p> <p>Record review of the Treatment Administration Record (TAR) for Resident #3 revealed documentation on 09/27/11 and on 09/28/11 that nursing had verified the TED Hose had been</p>	F 309	<p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <ol style="list-style-type: none"> 1. Resident #3 TED hose and heel boots removed by wound nurse with surveyor on 9/28 and not reapplied. TED Hose and heel boots applied by NA #4 per doctor's order on 9/29/11. 2. Full audit of all resident MD orders, care plans, and NA care plans to ensure that all required equipment and devices were identified completed by ADON on 10/12/11. Rounds completed by ADON on 10/12/11 to observe for application of all equipment and devices per MD order/care plan. 	11/11/11



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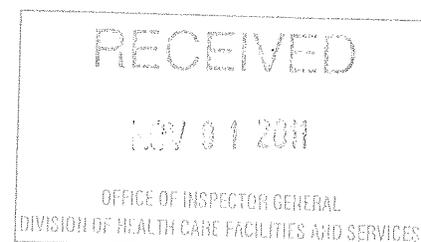
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/29/2011
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
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F 309	<p>Continued From page 9 applied every morning and had been taken off every evening at bedtime.</p> <p>Observation, on 09/27/11 at 04:00 PM, revealed the resident lying in bed with no TED hose or Heel Lift Boots in place. Continued observation at 05:50 PM revealed Resident #3 sitting in his wheel chair with no TED hose in place.</p> <p>Observation, on 09/28/11 at 09:15 AM, revealed Resident #3 lying in bed with no TED Hose or Heel Lift Boots in place. Continued observation at 10:00 AM, 10:45 AM, and 4:30 PM revealed Resident #3 lying in bed with no TED Hose or Heel Lift Boots in place. The Heel Lift Boots were observed on the seat of Resident #3's recliner chair at these times.</p> <p>Interview, on 09/29/11 at 2:45 PM, with LPN #4 revealed she was not aware of an order for TED Hose or aware that the TED Hose were care planned for Resident #3. LPN #4 said she had only worked at the facility four weeks and, the Treatment Nurse was responsible for verifying placement of the TED hose and the Heel Lift Boots on Resident #3 today and yesterday. LPN #4 stated she had verified the TAR on 09/27/11 that the TED Hose and Heel Lift Boot were in place for Resident #3.</p> <p>Interview, on 09/29/11 at 2:55 PM, with LPN #5 revealed she was aware she should have checked to make certain the CNA had placed the TED Hose and the Heel Lift Boots on Resident #3 before she initialed the TAR confirming their placement. LPN #5 revealed she was uncertain whether or not the TED Hose or the Heel Lift Boots were in place on Resident #3.</p>	F 309	<p>3. Director of Nursing re-educated staff on placement of equipment and devices per MD order/care plan. Staff nurses re-educated to observe for application of equipment and devices while making rounds by DON on 10/19/11.</p> <p>4. ADON will make rounds x5/week for 2 weeks beginning 10/24/11, then weekly for 4 weeks to observe for application of equipment and devices per MD order/care plan. These audits will be reported to DON and QA committee for review.</p>		



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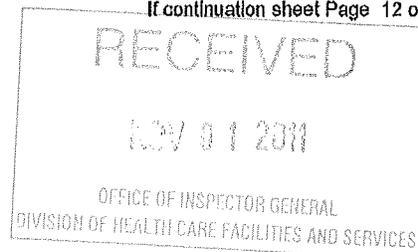
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F 309	Continued From page 10 Interview, on 09/29/11 at 3:05 PM, with CNA #4 revealed she looked at the CNA Care Plan every day, but she was unaware Resident #3 was care planned for the TED Hose and the Heel Lift Boots and did not put them on Resident #3 on 09/28/11 or on 09/29/11. CNA #4 stated she cared for Resident #3 on 09/28/11 and on 09/29/11 and stated, "I guarantee this will never happen again". Interview, on 09/29/11 at 4:50 PM, with Assistant Director of Nursing (ADON) revealed the Nurse and the CNA are responsible to carry out Physician's orders and to follow care plans. The ADON revealed she audited CNA and Nursing Care Plans and it would be a good idea to pull physicians' orders to update the Nursing and CNA Care Plans during a full audit. Interview with the Director of Nurse (DON), on 09/29/11 at 5:00 PM, revealed she was furious to know that a nurse in her facility documented on a TAR that a treatment was completed that actually was not done. The DON revealed she was ultimately responsible for physicians' orders and care plans being implemented. The DON stated not having the TED Hose in place could cause the resident to have edema or pain and not having on protective Heel Lift Boots while in bed could cause heel sheering.	F 309		
F 334 SS=D	483.26(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the Influenza Immunization, each resident, or the resident's legal representative receives education regarding the	F 334	The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during that time period;	11/11/11



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F 334	Continued From page 11 benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the	F 334	(iii) The resident or resident's legal representative has the opportunity to refuse immunization; (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. 1. Resident #11 received flu vaccine on 9/29/11. 2. A full audit of all resident flu and pneumovacs completed by ADON on 10/13/11. There are no additional instances of non-compliance. 3. Director of Nursing will in-service all nursing staff regarding flu and pneumavac requirements on 10/19/11. 4. Assistant Director of Nursing will audit 25% of all charts quarterly to ensure all vaccines given accurately and timely and will report results of audit at QA 11/11/11 and not less than quarterly thereafter.	



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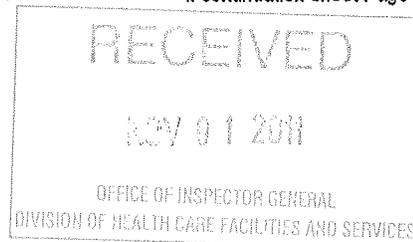
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F 334	<p>Continued From page 12 following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy it was determined the facility failed to educate and/or offer the Influenza and pneumococcal vaccine to one (1) of sixteen (16) sampled residents. Resident #11.</p> <p>The findings include:</p> <p>Review of the facility's policy on Flu/Pneumonia Vaccines revealed the facility was required to offer the resident vaccination against Influenza and pneumococcal disease.</p> <p>Review of the resident list provided, of all residents who had been offered and received or declined the influenza and pneumococcal</p>	F 334			

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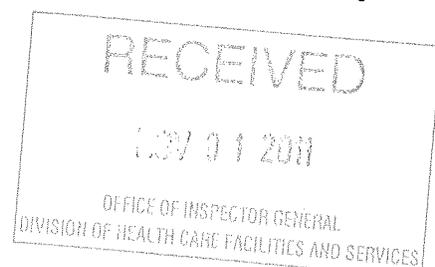
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F 334	Continued From page 13 vaccine, revealed Resident #11 was on the list and had not been offered, declined or received the vaccines. All spaces on the list to fill in which note the dates offered, declined and/or received by the name of Resident #11 were blank. Interview, on 09/29/11 at 11:00 AM, with the Assistant Director of Nursing (ADON) revealed she was responsible for the influenza and pneumococcal vaccines in the facility. She stated she was new to the responsibility of the vaccines and did not have a program in place at this time to monitor who had received the vaccinations. She revealed she had not had any training on providing the residents with vaccinations, other than what was taught in nursing school. She reviewed the list of residents who were offered and received or declined the influenza and pneumococcal vaccines and stated Resident #11 was on the list and all areas by the residents' name were blank. It was further revealed failure to receive the vaccinations may result in the resident becoming infected or ill.	F 334			
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review	F 369	The facility must provide special eating equipment and utensils for residents who need them.	11/11/11	



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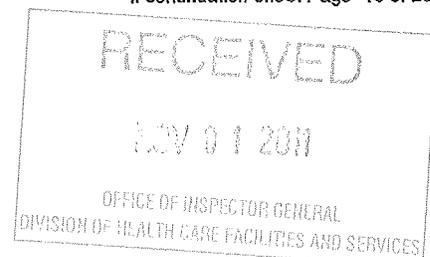
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F 369	<p>Continued From page 14</p> <p>and review of the resident's dietary tray card, it was determined the facility failed to provide one (1) resident (#4) of sixteen (16) sampled residents special drinking equipment ordered by the physician based on the Request/Screen for Rehabilitation Assessment.</p> <p>The findings include:</p> <p>The facility could not provide a policy regarding specialized eating equipment.</p> <p>Record review revealed the facility admitted Resident #4 with diagnoses of Congestive Heart Failure (CHF), Osteoarthritis, Severe Degenerative Arthrosis Left Knee and Moderate Degenerative Arthrosis Right Knee. The facility assessed the resident, utilizing the Quarterly Minimum Data Set (MDS) dated 08/09/11, as cognitively intact.</p> <p>Review of the Occupational Therapy Assessment, dated 02/12/11, revealed Resident #4 had bilateral hand tremors and was at risk for spillage. The resident was to have a two handle cup with a lid as needed at all meals.</p> <p>Observation of Resident #4, during lunch meal service, on 09/27/11 and 09/28/11 at 11:40 AM and 11:30 AM revealed, Resident #4 was drinking coffee from a white one handle cup, without a lid.</p> <p>Interview with Dietary Manager, on 09/28/11 at 5:00 PM, revealed Resident #4's name was listed on the the Self Help Device List. She further stated, dietary prepared the meal according to the tray card and the CNA's are responsible for</p>	F 369	<ol style="list-style-type: none"> 1. Resident #4 offered sippy cup with next meal. 2. All residents with adaptive eating devices reviewed and updated as necessary by Dietary Manager on 9/30/11. Care plans checked for accuracy. 3. Nursing staff educated and reeducated on appropriate uses of assistive devices and appropriate procedures for assessing and removing assistive devices by DON on 10/19/11. Tray cards revised for residents with adaptive devices with the device highlighted in pink by Dietary Manager On 9/30/11. Adaptive equipment audit revised to include a checklist for care plan, NA care plan, and physician orders. Dietary department will now place devices on trays and have been in-serviced. 4. Dietary Manager will observe all residents eating with assistive devices weekly for two weeks, then monthly, to ensure appropriateness of device and report any issues to the Director of Nursing. Dietary Manager will report results of audit to QA on 11/11/11 and no less than quarterly thereafter. 	



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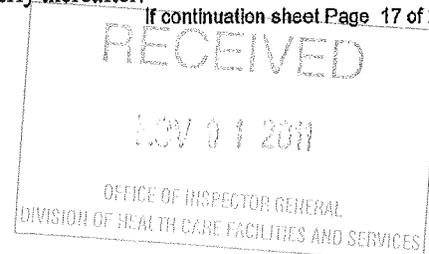
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F 369	Continued From page 15 ensuring adaptive/specialized equipment is used. Interview with Restorative CNA#3, on 09/29/11 and 09/28/11 at 4:30 PM, revealed she had also been trained on dietary assistive equipment. She stated Resident #4's two (2) handle sippy cup was used when Resident #4 had shaking episodes. She further stated the tray card did not specify a sippy cup as needed and the resident should have been given a two (2) handle sippy cup as ordered. Interview with Resident #4, on 09/29/11 at 10:15 AM, revealed he/she liked having the two handle sippy cup to prevent spillage, due to his/her arthritic hands. He/she further stated no staff had offered him/her the use of the two handle cup with a lid. Interview with Resident #4's daughter, on 09/29/11 at 10:30 AM, revealed she visits her family member daily and observes one to two (1-2) meals a day. She further indicated she only saw the two (2) handle sippy cup twice. Once several months after the admission and this morning at breakfast. She further stated the two handle cup gave her family member better control, due to his/her arthritic hands. Review of the Occupational Therapy Assessment, dated 02/12/11, revealed Resident #4 had bilateral hand tremors and was at risk for spillage. The resident was to have a two handle cup with a lid as needed at all meals.	F 369			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			



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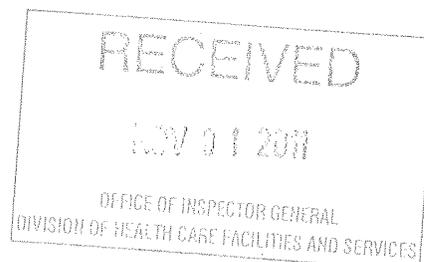
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F 441	Continued From page 16 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and Infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as Isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1. On 9/28/11, Nursing Supervisor replaced and dated all nebulizer and oxygen tubing for residents # 1, 7, 11, A, and B. All new equipment was placed in clean storage bags. 2. A full building audit of all oxygen and respiratory equipment was performed by Nursing Supervisor on 9/28/11. All outdated or improperly stored equipment was disposed of and replaced. 3. Director of Nursing and consultant pharmacist will in-service all nursing staff on 10/19/11 on proper procedures for administering, cleaning, dating, and storing all respiratory equipment. 4. Director of Nursing, Assistant Director of Nursing, and/or Charge Nurse will audit 100% of all respiratory equipment weekly for three months, then re-assess the frequency of the audits. Director of Nursing will report results of audits to QA on 11/11/11 and not less than quarterly thereafter.	11/11/11



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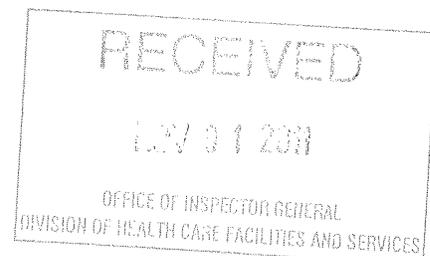
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F 441	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review and review of the facility's policies it was determined the facility failed to maintain an infection control program providing a sanitary environment for the prevention of the spread of infection for three (3) residents of the sixteen (16) sampled residents and two (2) unsampled. Resident #1, #7, #11, A and B. The facility left Nebulizer masks and oxygen equipment out unclean, uncovered and undated in resident rooms.</p> <p>The findings include:</p> <p>Review of the facility's policy on Infection Control revealed the purpose of the Infection Control Committee included provision of a sanitary environment. In addition, the committee was to monitor staff performance to ensure Policies and Procedures were executed.</p> <p>Review of the facility's Policy/Procedure for Cleaning/Storing Nebulizer Equipment revealed all nebulizer equipment would be cleaned after each use, air dried and stored in a plastic bag.</p> <p>Observation during the facility tour, on 09/27/11 which began at 9:15 AM, revealed Resident #11's room had an uncovered, undated nebulizer mask with reservoir at the bedside. In addition, a nasal cannula and tubing were on a bedside table uncovered and undated. Resident B's room had a nebulizer mask with reservoir and tubing in a basin next to the sink, co-mingled with deodorant, powder and mouthwash. It was uncovered and undated. Resident #1's room, had sitting on the</p>	F 441			



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F 441	<p>Continued From page 18</p> <p>bedside table, an uncovered, undated nebulizer mask with droplets in the reservoir, and tubing that was uncovered and undated. Resident #7 had in his/her room, a nebulizer face mask with reservoir and tubing sitting under soft leg wraps on a bedside table. In addition, Resident A had a nebulizer with reservoir and tubing uncovered and undated on the bedside table.</p> <p>Observation, on 09/27/11 at 12:00 PM, revealed Resident #1 had an uncovered, undated nebulizer mask with reservoir and tubing. This was observed again 5:25 PM the same day. Droplets were observed in the reservoir of the nebulizer.</p> <p>Observation, on 09/28/11 at 7:40 AM, revealed Resident #1 continued to have an uncovered, undated nebulizer mask with reservoir and tubing.</p> <p>Review of the medical record for Resident #1 revealed a physician's order for the resident to receive two (2) different nebulizer treatments twice a day. The resident had a history of pneumonia. A nursing assessment charted, at 09/27/11 at 9:02 AM, revealed the resident had lung sounds with wheezes.</p> <p>Observation, on 09/27/11 at 5:37 PM, revealed Resident #7's room had a nebulizer mask with reservoir and tubing on a bedside table uncovered and undated.</p> <p>Observation, on 09/28/11 at 7:42 AM, revealed in the room of Resident #7 there remained an uncovered, undated nebulizer mask with the reservoir and tubing.</p> <p>Review of the medical record for Resident #7</p>	F 441			



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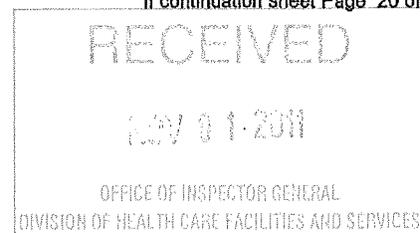
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2011
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NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045
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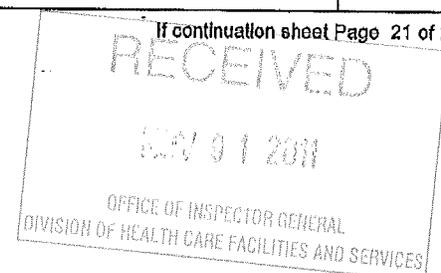
F 441	<p>Continued From page 19</p> <p>revealed a physician's order for the resident to receive a nebulizer treatment four times a day as needed. The last treatment documented was on 09/01/11.</p> <p>Interview, on 09/28/11 at 10:15 AM, the Licensed Practical Nurse (LPN) #3 Floor Supervisor revealed not all nurses wash the nebulizer equipment after use. She revealed that a lot of the time with the nebulizer mask and equipment the nurse would "just put it back in the bag". She stated some nurses do wash and cover the equipment. She revealed she is responsible to monitor the proper care of the equipment and added anyone else can also monitor. The oxygen equipment is changed out once a week by "the oxygen guy" and is "supposed to be" dated when changed.</p> <p>Interview, on 09/28/11 at 4:00 PM, with the Assistant Director of Nursing (ADON) revealed after a nebulizer treatment the equipment was to be rinsed out and dried. The nurse administering the treatment was responsible for that. She stated it was the floor nurse, the ADON and the Director of Nursing (DON) who was responsible to ensure this occurred. "Infection" could be a consequence of the failure to do this. Training for staff on the respiratory equipment occurs during orientation and at an annual in-service. She stated the equipment was changed "monthly" by the oxygen company, the facility had contracted, and you can tell the equipment had been changed because it would have a tag with the date on the tubing. "Date everything" is how you know it was changed, she stated.</p> <p>Interview, on 09/29/11 at 7:10 AM, with</p>	F 441		
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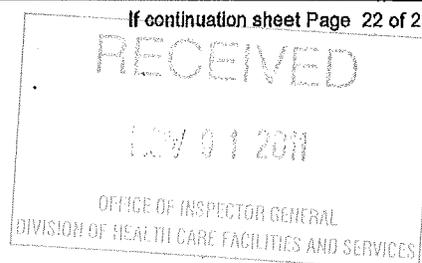
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F 441	Continued From page 20 Registered Nurse (RN) #1 revealed the nurse or the individual giving the nebulzer treatment was responsible to clean the mask. The nurse was also to place the mask in a bag. She stated there are germs and infection that could result as a failure to cover the equipment. The oxygen company comes in on Wednesdays to replace the oxygen equipment and just leaves the equipment in the resident room. The nurse is responsible to change the equipment out. No one is designated responsible to ensure the oxygen equipment was appropriately stored on the 7:00 PM to 7:00 AM shift. Interview, on 09/29/11 at 8:20 AM, with the DON revealed the nurse was responsible for cleaning the nebulzer equipment after use and described it as standard protocol procedure. She stated the nurses are in-serviced on the "respiratory process" upon hire and annually. It is the responsibility of the nurse who used the equipment last to cover it. All the staff is responsible to ensure this was done and whoever makes rounds was responsible to ensure the nurses are doing it. In addition, she verified the contracted oxygen equipment company does replace equipment for the resident by placing it in the resident's room. The next nebulzer treatment given by the nurse would then utilize the new equipment which had been placed in the resident's room. Infection was a consequence of the nebulzer mask and reservoir sitting out in the open and not being cleaned.	F 441			
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520			



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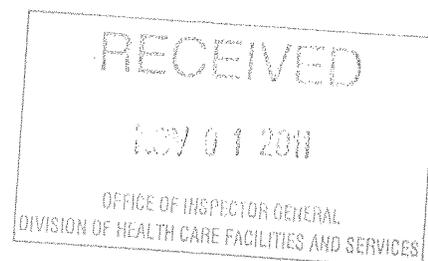
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F 520	<p>Continued From page 21</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to have an effective Quality Assurance (QA) Committee that was structured to ensure the plan of correction developed for previous deficient practices identified during the survey dated 08/12/10 in the areas of F-226, F-309, and F-369 were maintained. The facility deemed compliance on 09/24/10 for these deficiencies. The facility was found to be non-compliant in the same areas during the Standard Health Survey concluded on 09/29/11.</p>	F 520	<p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff. The quality assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <ol style="list-style-type: none"> All repeat deficiencies from 2010 survey identified and addressed at 10/11/11 QA. Facility now in compliance. All deficiencies from 2010 survey will be addressed for substantial compliance at QA on 11/11/11. Administrator revised audit forms to ensure sustained compliance with all 2011 survey deficiencies. Audit forms will be reviewed by the Administrator at each quarterly QA and deficient practices addressed. 	11/11/11	



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F 520	Continued From page 22 The findings include: Interview, on 09/29/11 at 6:15 PM, with the Administrator revealed at each Quality Assurance (QA) meeting the identified concerns from the last Standard Health Survey were reviewed. The Department responsible for the identified deficiencies reported on their audit at each QA meeting. He stated he thought the QA system was working; however, then stated the system was not working since the identified deficiencies still existed.	F 520	4. Administrator will review all audit forms for substantial compliance and will address at QA on 11/11/11 and not less than quarterly thereafter.		



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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: 1977, 1989, 2007</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V Unprotected</p> <p>SMOKE COMPARTMENTS: Five (5) 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 installed in 2005. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 09/27/11. Green Valley Health and Rehabilitation was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for seventy eight (78) beds and the census was seventy eight (78) 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 Fire).</p>	K 000		

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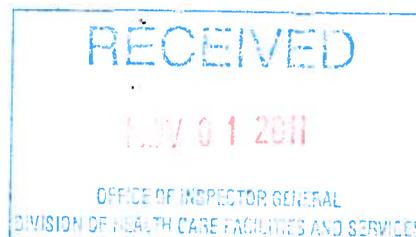
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *X Alan M. Wade* TITLE *X Administrator* (X6) DATE *10/3/11*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1	K 000		
K 056 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy eight (78) beds with a census of seventy eight (78) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 09/27/11 between 11:30 AM and</p>	K 056	<p>If there is a sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system.</p> <ol style="list-style-type: none"> 1. Simplex Grinnell called on 9/29/11 to install 3 sprinkler heads in the cited areas. Installation will be 11/2/11. 2. Simplex Grinnell called on 9/29/11 to install 3 sprinkler heads in the cited areas. Installation will be 11/2/11. 3. Simplex Grinnell called on 9/29/11 to install 3 sprinkler heads in the cited areas. 	11/11/11



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K 056	Continued From page 2 4:30 PM, with the Projects Director and the Maintenance Director revealed three (3) porches located in the North, South, and South Skilled corridors. The porches were found to be extended out four (4) feet or greater, made of combustible materials, and were not sprinkler protected. Interview, on 09/27/11 between 11:30 AM and 4:30 PM, with the Projects Director and the Maintenance Director revealed they were not aware the porches needed to be sprinkler protected. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction. Reference: NFPA 13 (1999 Edition) 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 and interview it was determined the facility failed to maintain the sprinkler system in accordance with NFPA	K 056	4. Maintenance Director will add inspection of new sprinkler heads to Preventative Maintenance checklist.	
K 062 SS=F	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 and interview it was determined the facility failed to maintain the sprinkler system in accordance with NFPA	K 062	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 1. Sprinkler head wrench purchased by Maintenance Director on 9/29/11. Insulation removed from sprinkler head in attic above Skilled area on 9/27/11.	11/11/11



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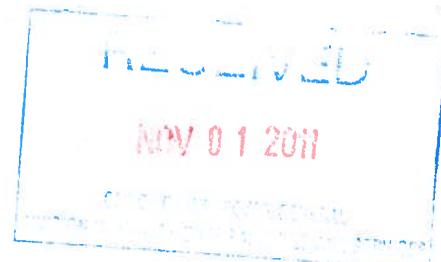
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K 062	<p>Continued From page 3 standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy eight (78) beds with a census of seventy eight (78) on the day of the survey.</p> <p>The Findings Include:</p> <p>Observation, on 09/27/11 at 2:50 PM, with the Projects Director and the Maintenance Director revealed the facility failed to provide a sprinkler head wrench in accordance with NFPA requirements.</p> <p>Interview, on 09/27/11 at 2:50 PM, with the Projects Director and the Maintenance Director revealed they were not aware the wrench was missing from the sprinkler head cabinet.</p> <p>Observation, on 09/27/11 at 3:15 PM, with the Projects Director and the Maintenance Director revealed insulation had fallen on the sprinkler heads located in the attic above the Skilled Corridor.</p> <p>Interview, on 09/27/11 at 3:15 PM, with the Projects Director and the Maintenance Director revealed they were not aware of the insulation on the sprinkler heads.</p> <p>Reference: NFPA 13 (1999 edition)</p> <p>6.2.9.6 A special sprinkler wrench shall be</p>	K 062	<ol style="list-style-type: none"> 2. All attic sprinkler heads inspected by Maintenance Director to ensure all are free from insulation on 9/29/11. 3. Keeping attic sprinkler heads free from insulation has been added to the Preventative Maintenance checklist and will be inspected by Maintenance Director not less than quarterly. Maintenance staff re-educated on 9/29/11. 4. Maintenance Director will report results of quarterly inspections at QA on 11/11/11 and not less than quarterly thereafter. 	



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K 062	Continued From page 4 provided and kept in the cabinet to be used in the removal and installation of sprinklers. One sprinkler wrench shall be provided for each type of sprinkler installed. Reference: NFPA 13 (1999 Edition) 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.	K 062		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress. This deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy eight (78) beds, with a census of seventy eight (78) on the day of the survey. The findings include: Observation, on 09/27/11 at 11:55 AM, with the	K 130	Other LSC deficiency not on 2786 1. Unapproved locks removed by Maintenance Director from resident rooms #15 and #16 on 9/27/11. 2. All doors in facility inspected by Maintenance Director on 9/27/11 with no additional unapproved locks located.	11/11/11



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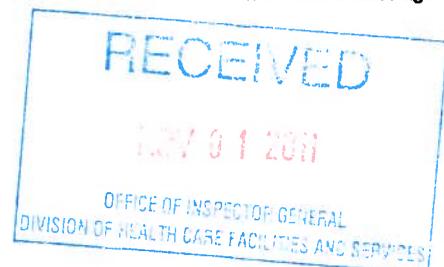
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K 130	Continued From page 5 Projects Director and the Maintenance Director revealed an unapproved lock (slide bolt type) was installed on the egress side of bathroom doors located in resident rooms #15, and 16. Interview, on 09/27/11 at 11:55 AM, with the Projects Director and the Maintenance Director revealed he was not aware the locks had not been removed since the rooms had just recently been converted back to resident rooms from offices. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130	3. Maintenance staff re-educated regarding approved locking devices by Administrator on 9/27/11. 4. Maintenance Director will add door lock inspections to quarterly Preventative Maintenance checklist, and will report results of inspections at QA on 11/11/11 and not less than quarterly thereafter.	
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 four (4) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy eight (78) beds with a census of seventy eight (78) on the day of the survey.	K 147	Electrical wiring is in accordance with NFPA 70, National Electrical Code 9.1.2. 1. Second power strip removed at receptionist desk and extension cord in server room removed by Maintenance Director on 9/27/11. Electrical junction box in attic closed by Maintenance Director on 9/27/11. All powered assistive devices, nursing equipment, and refrigerators removed from power strips by Maintenance Director on 9/27/11.	11/11/11



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NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045	
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K 147	<p>Continued From page 6</p> <p>The findings include:</p> <p>Observation, on 09/27/11 between 11:30 AM and 4:30 PM, with the Projects Director and the Maintenance Director revealed:</p> <ol style="list-style-type: none"> 1) Two (2) power strips plugged into each other located at the Receptionists Desk. 2) A power strip plugged into an extension cord located in the Server Room. 3) A resident bed plugged into a power strip located in resident rooms #4, 27, and 42. 4) A resident bed, a feeding machine, and a mini nebulizer were plugged into a power strip located in Resident Room #13. 5) A refrigerator plugged into a power strip located in resident room #8. 6) A refrigerator plugged into a power strip located in the Therapy Office. 7) A feeding machine, mini nebulizer, and a suction pump were plugged into a power strip located in resident room #41. 8) A mini nebulizer plugged into a power strip located in resident room #37. 9) An open electrical junction box in the attic above the North and South Shower Rooms. 10) A mini nebulizer and a refrigerator were plugged into a power strip located in resident room #12. <p>Interview, on 09/27/11 between 11:30 AM and 4:30 PM, with the Projects Director and the Maintenance Director revealed they were unaware of the misuse of power strips, and the open electrical junction boxes.</p>	K 147	<ol style="list-style-type: none"> 2. All areas of the building inspected for improper equipment plugged into power strips, improper use of power strips, extension cords, and open junction boxes, and corrected as necessary by Maintenance Director on 9/27/11. 3. Maintenance Director re-educated by Administrator on 9/27/11 regarding proper use of power strips, use of extension cords, and inspection of junction boxes. 4. Maintenance Director will inspect all areas of the facility for compliance monthly and will report results of inspection at QA on 11/11/11 and not less than quarterly thereafter. 	



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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/27/2011
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K 147	<p>Continued From page 7</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: NFPA 70 (1999 edition) 370.28(c) Covers.</p> <p>All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.</p>	K 147		
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