

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

PRINTED: 11/08/2012
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 10/25/2012
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NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1208 ELEVENTH STREET CARROLLTON, KY 41045
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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
F 000	INITIAL COMMENTS	F 000		
F 203 SS=E	<p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the</p>	F 203	<ol style="list-style-type: none"> Residents #5, #9, and #10 were all re-admitted to the facility. Social Services reviewed all transfers for last 30 days to determine any other resident affected. This was completed on 10/26/12. No other resident has been affected. Administrator educated nurses and Social Services on Transfer & Discharge Policy on 10/26/12 and 11/2/12.. "Notice of Transfer" has been added to the nursing transfer packet and will be sent with all transfers. A copy of the notice will be placed in resident's medical record, a copy given to Social Services Director, and a copy will be sent to the resident's family/legal representative, if known. Social Services Director will audit 100% all transfers monthly for three months beginning November 2012, then 25% quarterly to ensure compliance. Social Services Director will present results of audit at QA on 12/07/12 and not less than quarterly thereafter. 	12/07/12

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

TITLE

(X8) DATE

X Alan M. ...

X Administrator 11/19/12

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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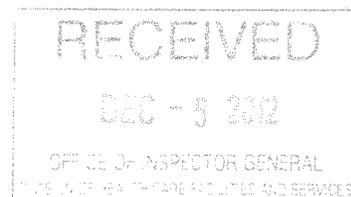
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F 203	Continued From page 1 facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. 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 provide three (3) of twenty (20) sampled residents (Resident 5, 9, 10) with a Notice of Transfer when they were transferred from the facility. The findings include: The facility did not provide a policy on Notice of Transfer.	F 203		
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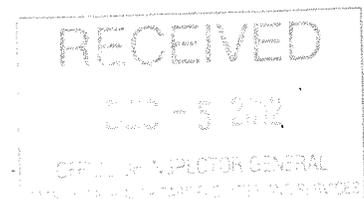
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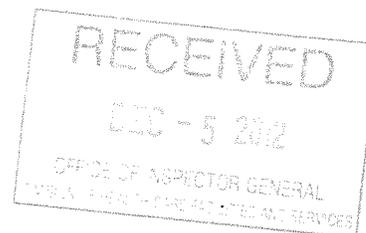
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F 203	Continued From page 2 1. Review of the clinical record for Resident #9, revealed the facility admitted the resident 10/02/12 with diagnoses of End-Stage Renal Disease and Depression. The facility completed an admission Minimum Data Set (MDS) assessment on 10/12/12 which revealed the resident was cognitively intact, had dialysis treatments outside the facility three (3) times a week and required extensive assistance with bathing, dressing and mobility. The facility sent the resident to the hospital emergency room on 10/07/12 and 10/09/12 for assessment of pain. The facility was unable to provide documentation the resident received a Notice of Transfer when sent to the hospital. 2. Review of the clinical record for Resident #5, revealed the facility admitted the resident on 09/25/12 with diagnoses of Post Respiratory Failure and Pneumonia. The facility sent the resident to the hospital emergency room on 10/16/12 for labored breathing and low grade fever. The resident was admitted to the hospital after evaluation in the emergency room. The facility was unable to provide documentation, the resident received a Notice of Transfer when sent to the hospital. 3. Review of the clinical record for Resident #11, revealed the facility admitted the resident on 07/27/11 for Acute Respiratory Failure, Pneumonia, and Dementia. The facility sent the resident to the hospital emergency room on 10/08/12 for evaluation for increased heart rate and respirations and a decrease in the level of consciousness. The facility was unable to to	F 203		



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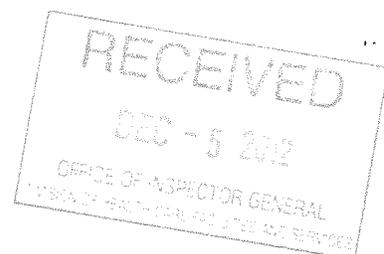
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F 203	Continued From page 3 provide documentation the resident received a Notice of Transfer when sent to the hospital. Interview with Licensed Practical Nurse (LPN) #1, on 10/24/12 at 3:00 PM, revealed the facility did not send a Notice of Transfer when residents left the facility. She stated she was not aware of any form describing the resident's rights to appeal a transfer. Interview with the Director of Nursing, on 10/25/12 at 5:15 PM, revealed residents leaving the facility did not receive a Notice of Transfer. she stated the resident would not know their appeal rights without the Notice of Transfer. Interview with the Administrator, on 10/25/12 at 5:40 PM, revealed the facility did not send a Notice of Transfer when residents left the facility.	F 203		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 274	1. MDS Coordinator completed a significant change assessment for resident #4 on 10/26/12. 2. MDS Coordinator and IDT met and reviewed each resident functional status as compared to the most recent comprehensive assessment to determine if there have been any other significant change assessments missed. This was completed and any necessary corrections made on 11/9/12.	12/07/12



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F 274	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to conduct a comprehensive assessment of one (1) of twenty (20) sampled residents (Resident #4) within fourteen (14) days after the facility should have determined there had been a significant improvement in the resident's status. The facility admitted Resident #4 with a gastric tube, an indwelling catheter and a tracheostomy tube. These medical devices were discontinued after the admission Minimum Data Set (MDS) assessment dated 08/01/12.</p> <p>The findings include:</p> <p>The facility utilized the Resident Assessment Instrument (RAI) 3.0 Manual as the policy for completion of MDS assessments.</p> <p>Review of the clinical record for Resident #4, revealed the facility admitted the resident on 09/14/12 with diagnoses of Subdural Hematoma secondary to a Motor Vehicle Accident, Dysphagia and Seizures. The facility completed an admission MDS assessment on 08/01/12 which revealed the resident had a severe cognitive impairment and required extensive assistance of two (2) staff to dress and required total assist to eat and bathe. The resident had a gastric tube for receiving nutrition and took nothing by mouth. The resident had a tracheostomy tube to facilitate adequate oxygen intake.</p>	F 274	<p>3. MDS Coordinator and IDT to be re-educated on significant change criteria and process for monitoring changes by Corporate Consultant. This will be completed by 12/07/12.</p> <p>4. DON will audit all MDS assessments completed each week for 4 weeks, then will audit 25% of all assessments completed monthly for 2 months, then 25% quarterly to ensure that significant change assessments are completed as indicated.; Results of the audits will be reported at QA on 12/07/12, and not less than quarterly thereafter.</p>	



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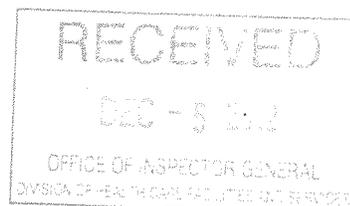
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F 274	Continued From page 5 Observation of Resident #4, on 10/23/12 at 12:15 PM, revealed the resident sitting in a chair at bedside looking out the window. There was no evidence of an indwelling catheter, gastric tube or a tracheostomy tube. Observation of Resident #4, on 10/23/12 at 5:00 PM, revealed the resident up in a wheelchair sitting in the dining room using a scoop plate and feeding self with supervision, assist and cues. Interview with Certified Nurse Aide (CNA) #1, on 10/24/12 at 9:00 AM, revealed Resident #4 no longer required a gastric tube, indwelling catheter or a tracheostomy tube. She stated the resident was now able to eat with some assistance and reminders. She revealed the resident had pulled out the tracheostomy tube and it was not replaced. She stated the resident had no indwelling catheter and was incontinent. Interview with MDS Nurse, on 10/25/12 at 4:00 PM, revealed the facility had not identified the need for a significant change in status assessment for Resident #4. She stated the resident did not meet the requirements for a new MDS even though the resident had significant improvements. Interview with the Director of Nursing, on 10/25/12 at 5:15 PM, revealed Resident #4 may possibly have had enough improvement to possibly warrant a new MDS assessment.	F 274		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		



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F 280	<p>Continued From page 6</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 observation, interview, record review and review of the facility's policy, it was determined the facility failed to revise care plans for two (2) of twenty (20) sampled residents (Residents #4 and #9). Resident #4 had a potential for dehydration which was not addressed. Resident #9 had behaviors related to pain that were not addressed.</p> <p>The findings include:</p> <p>The facility utilized the Resident Assessment</p>	F 280	<ol style="list-style-type: none"> Care Plan Coordinator reviewed and updated care plans for residents #4 and #9 ensuring appropriate assessments and interventions on 10/26/12. MDS Coordinator and IDT Reviewed all current care plans to ensure all specific needs were identified and care planned appropriately. This was completed on 10/29/12. MDS Coordinator and IDT will be re-educated on the MDS process and care plan process by Corporate Consultant by 12/07/12. DON will audit all care plans completed each week for 4 weeks, then will audit 25% of all assessments completed monthly for 2 months, then 25% quarterly to ensure that significant change assessments are completed as indicated.; Results of the audits will be reported at QA on 12/07/12, and not less than quarterly thereafter. 	12/07/12



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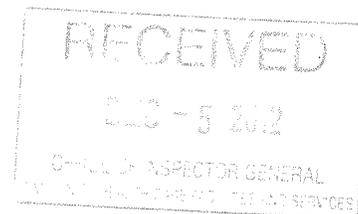
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F 280	<p>Continued From page 7</p> <p>Instrument (RAI) 3.0 Manual for policies regarding assessment and care planning.</p> <p>1. Observation of Resident #4, on 10/23/12 at 12:00 PM, revealed the resident in the dining room and was served food and fluids.</p> <p>Review of the clinical record for Resident #4, revealed the facility admitted the resident on 07/26/12 with diagnoses of Dysphagia and a Subdural Hematoma. The facility completed an admission MDS assessment on 08/01/12 which revealed the resident had a gastric tube and took no food or drink by mouth.</p> <p>Continued review of the clinical record for Resident #4, revealed the resident removed the gastric tube on 08/31/12 and the tube was not replaced. Review of the care plan revealed the facility identified the resident to be NPO (nothing by mouth), however, the resident's status was changed to an oral diet on 08/31/12.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 10/25/12 at 2:00 PM, revealed the resident had orders for an oral diet and required encouragement to eat and drink since the gastric tube was discontinued.</p> <p>2. Review of the clinical record for Resident #9, revealed the facility admitted the resident with diagnoses of End-Stage Renal Disease and Depression. The facility completed an admission MDS assessment on 10/12/12 which revealed the resident was cognitively intact and had frequent pain. The facility sent the resident to the hospital emergency room on 10/07/12 and 10/09/12 for complaints of pain unrelieved by medications</p>	F 280		
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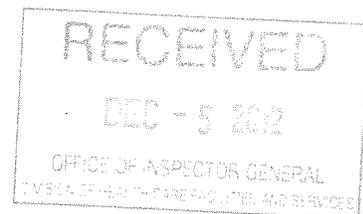
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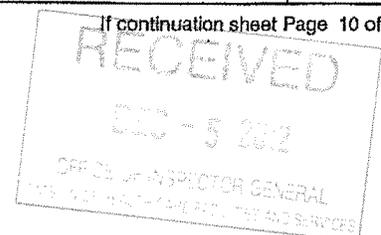
F 280	<p>Continued From page 8</p> <p>administered by the facility. The resident exhibited agitation and was upset until the physician ordered the facility to send the resident out to the emergency room.</p> <p>Continued review of the clinical records for Resident #9, revealed on 10/13/12, a nurse discovered the resident with a bottle of pills. The resident was found to have bottles of Percocet (pain), Xanax (anxiety) and Ambien (sleep) in a bag in the room. These prescriptions were filled by an outside pharmacy from 09/18/12 to 09/29/12. On 10/23/12, the physician ordered a psychiatric consultation.</p> <p>Review of the care plan for Resident #9, revealed a care plan problem for frequent complaints of pain, however, there was no documentation of the resident's behaviors when in pain or monitoring the resident for possession of medications not prescribed by the physician.</p> <p>Interview with LPN #2, on 10/25/12 at 10:00 AM, revealed the physician ordered a psychiatric consult for Resident #9 for drug seeking behaviors. She stated the care plan was not updated to reflect the issues with medications and behaviors and should have been revised.</p>	F 280		
F 309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</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>	F 309	<p>1. Interim Director of Nursing reviewed admission orders and all orders received since admission for residents #8, #9, #11, #12, #14, #15 and #16. Orders were then verified with MD to ensure accuracy. This was completed on 10/29/12.</p>	12/07/12



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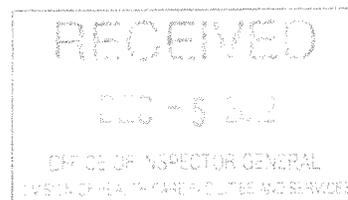
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F 309	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure admission orders and renewal orders from the physician were accurate and complete for seven (7) of twenty (20) sampled residents (Residents #8, 9, 11, 12, 14, 15, and 16). The facility failed to ensure residents' admission and renewal orders included orders for a diet, resuscitation status, orders for tuberculosis testing, diagnoses and medical reasons to administer as needed medications.</p> <p>The findings include: The facility did not provide a policy for physician orders.</p> <p>Interview with the Director of Nursing (DON), on 10/25/12 at 5:15 PM, revealed the facility had no policy on physician orders. She stated Renewal orders were placed on the clinical records every thirty (30) days. She indicated these orders were reviewed by the medical records staff and signed by the attending physician every thirty (30) days.</p> <p>1. Review of the clinical record for Resident #9, revealed the facility admitted the resident on 10/02/12. The admission orders contained medications to be given as needed, however, there were no medical reasons provided to direct when these medications were to be administered.</p>	F 309	<p>2. Interim Director of Nursing reviewed admission orders and all orders received since admission for all residents admitted within the past 30 days to ensure orders were completed appropriately on admission. This was completed on 10/31/12.</p> <p>3. Interim Director of Nursing re-educated all nurses regarding procedures for obtaining valid admission and renewal orders on 10/26/12. Assistant Director of Nursing will review all admission and renewal orders within 72 hours for accuracy beginning 11/01/12..</p> <p>4. Director of Nursing will audit 10% of all admission and renewal orders monthly, then 25 % quarterly, for accuracy beginning November 2012 and will report results to QA on 12/07/12 and not less than quarterly thereafter.</p>	



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PRINTED: 11/08/2012
FORM APPROVED
OMB NO. 0938-0391

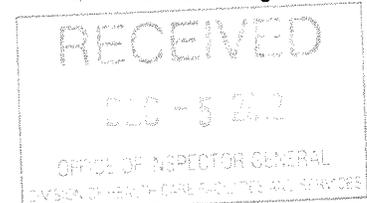
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2012
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
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F 309	<p>Continued From page 10</p> <p>2. Review of the clinical record for Resident #12, revealed the facility admitted the resident on 08/31/12. The admission orders were in effect for thirty (30) days then the orders expired. The renewal orders were in the clinical record and were signed by the physician, however, orders for the resident's code status had expired as they were not carried over to the renewal orders and signed by the physician.</p> <p>3. Review of the clinical record for Resident #14, revealed the facility admitted the resident on 09/14/12 and received verbal orders from the physician for care. These orders were effective for thirty (30) days from 09/14/12. The resident received a tuberculin skin test on 09/14/12, however, an order from the physician for the skin test was not located. No order for a level of care for the resident was provided.</p> <p>Continued review of the orders for Resident #14, revealed the family of the resident signed a document on 09/17/12 which stated the resident was to have no cardiopulmonary resuscitation (CPR) in the event of the resident's death. The physician reviewed this document and signed an acknowledgement on 09/19/12. The facility placed renewal orders on the clinical record for the month of October 2012 indicating the resident was a full code. These orders were then signed by the physician on 10/16/12. The facility was not able to provide documentation of the family deciding to ask for the resident to receive a full code and have CPR in the event of death.</p> <p>4. Review of the clinical record for Resident #15, revealed the facility admitted the resident on 09/12/12. The admission orders did not include a</p>	F 309			



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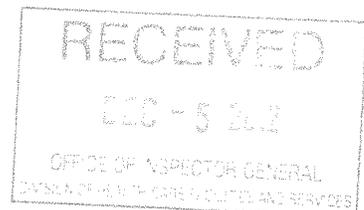
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F 309	<p>Continued From page 11</p> <p>level of care designation for the resident. The admission orders on 09/12/12 did not include a diet and was not clarified until 09/13/12, when the facility contacted the physician for a diet order. In addition, a resuscitation status order was not included in the admission orders. The resident signed a document on 09/13/12 indicating CPR was to be performed in the event of death. Verbal notification and acknowledgement of the resident's wishes was not obtained until 09/14/12.</p> <p>5. Review of the clinical record for Resident #16, revealed the facility admitted the resident on 08/16/12. The admission orders did not contain information regarding the resident's diagnoses. A level of care order was not located and the resident's resuscitation status was not included. Physician orders for as needed medications did not contain information regarding when these medications were to be administered.</p> <p>Continued review of the clinical records for Resident #16, revealed renewal orders were placed on the clinical record on 08/29/12 for September of 2012. The resident's diagnoses, resuscitation status and medical reason to administer some as needed medications were not located.</p> <p>6. Review of the clinical record for Resident #8, revealed the facility admitted the resident on 05/16/12 with a diagnoses of Mood Disorder and Lymphedema. Review of the admission orders revealed an annual PPD skin test was not ordered. The resident was given a PPD skin test on the day of admission 05/16/12.</p> <p>7. Review of the clinical record for Resident #11,</p>	F 309			



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F 309	<p>Continued From page 12</p> <p>revealed the facility re-admitted the resident on 10/12/12 with a diagnosis of Aspiration Pneumonia. Review of the re-admission orders revealed an annual skin test was not ordered. The resident was given a PPD skin test on the day of re-admission.</p> <p>Interview with the Director of Nursing (DON), on 10/25/12 at 5:00 PM, revealed the admission order for Resident #8 and the re-admission order for Resident #11 were not completed accurately. Orders for the PPD skin tests were omitted for both residents. The facility should have orders before administering any medication.</p> <p>Interview with Certified Medication Aide (CMT) #3, on 10/23/12 at 3:45 PM, revealed she was responsible for reviewing renewal orders on residents every thirty (30) days to ensure the orders were correct. She stated she checked medication orders against the physician orders; however, she had received no training on ensuring the non-medication orders were complete. She stated the prior DON had given this task to her and she was not to have nurses assisting her.</p> <p>Interview with the Medical Records Clerk, on 10/23/12 at 4:00 PM, revealed she was also directed to review renewal orders and had received no training on how to know if the orders were correct.</p> <p>Interview the Administrator, on 10/25/12 at 5:40 PM, revealed a nurse was responsible for reviewing admission orders seventy-two (72) hours after admission and the nurse turned in a</p>	F 309		



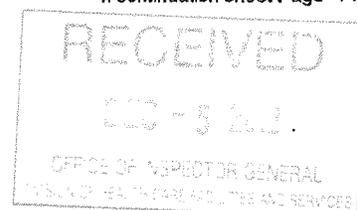
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F 309	<p>Continued From page 13 checklist to him for review. He stated the nurse had not identified any concerns.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 10/25/12 at 6:00 PM, revealed she reviewed all admission orders within seventy-two (72) hours of the admission. She stated she was aware all admission orders were missing content; however, she did not report this to the DON or the Administrator. She stated she knew she should have talked to someone so residents' orders were accurate and complete to ensure proper care to residents.</p>	F 309		



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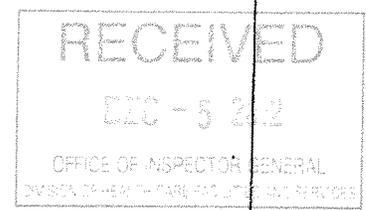
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/24/2012
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NAME 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 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 10/24/12. Green Valley Health and Rehabilitation was found not in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has seventy-eight (78) certified beds and the census was seventy-six (76) 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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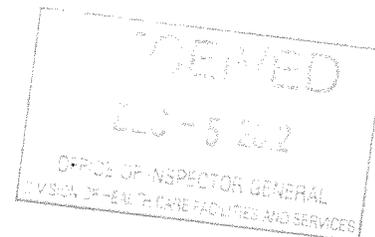
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* DATE: *11/14/12*

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		12/07/12
K 029 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "D" level.</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 for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, approximately twenty (20) residents, staff and visitors. The facility has seventy-eight (78) certified beds and the census was seventy-six (76) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/24/12 at 1:05 PM, with the Maintenance Director revealed the door to the Medical Records Room did not have a</p>	K 029	<ol style="list-style-type: none"> Automatic door closers installed by Maintenance Director on the Medical Records office and kitchen dry storage room on 10/26/12. All doors in facility leading to potentially hazardous areas checked to ensure automatic door closers in place and functioning properly by Maintenance Director on 10/26/12. Maintenance Director in-serviced on regulation by Corporate Maintenance Director on 11/14/12 and will add inspection of automatic door closers to his monthly preventative maintenance checklist. Administrator will audit monthly inspections beginning November 2012 and will report results at QA on 12/07/12 and not less than quarterly thereafter. 	



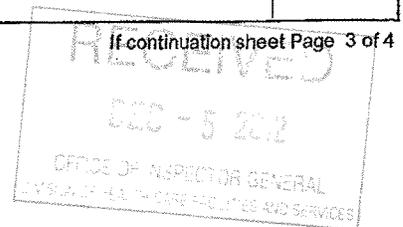
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K 029	<p>Continued From page 2</p> <p>self-closing device installed on the door. The closer had been removed from the door.</p> <p>Interview, on 10/24/12 at 1:05 PM, with the Maintenance Director revealed the closer on the door to the Medical Records Room had been removed when a desk and chair were located within the room to create a combination Office and Medical Records Room. The amount of open shelf space filled with paper records, classified the room as a hazardous storage space.</p> <p>Observation, on 10/24/12 at 2:10 PM, with the Maintenance Director revealed the door to the Dry Storage Room, located in the Kitchen, was not equipped with a self-closing device.</p> <p>Interview, on 10/24/12 at 2:10 PM, with the Maintenance Director revealed the door to the Dry Storage Room had never been equipped with a self-closing device, but was always closed and latched. He was not aware of the door being required to have a self-closing device.</p> <p>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</p>	K 029		



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K 029	Continued From page 3 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 by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.	K 029		

