

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

PRINTED: 09/21/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/09/2011
NAME OF PROVIDER OR SUPPLIER  GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A standard health survey was initiated on 09/07/11 and concluded on 09/09/11 with regulatory violations cited at the highest scope and severity of an "D". A Life Safety Code survey was conducted on 09/07/11 with regulatory violations cited at the highest scope and severity of an "E".	F 000	The submission of the Plan of Correction does not constitute an admission by the provider of any fact or conclusion set forth in the Statement of Deficiencies. This plan of Correction is being submitted because it is required by law.	
F 371 SS=D	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy on Food Storage and Serving, it was determined the facility did not store and serve food under sanitary conditions. Five (5) food products stored in the walk-in freezer were found to have been opened but not labeled on the initial tour of the kitchen. Two (2) of the five items were unsealed and open to air. One container of thickened milk was not labeled with the open date. One (1) multi-serving pitcher of nectar-thickened milk was placed on the tray serving line at a temperature above the minimum standard of 41 (forty-one) degrees Fahrenheit (F) or below for cold foods.	F 371	1. No specific residents were identified as having been affected by the facility's failure to store and serve food under sanitary conditions. On 9/9/2011 the Dietary Manager did a 100% audit of both the walk in freezer & refrigerator to ensure all opened products were properly labeled & sealed per facility policy. No other products were noted to be without proper labeling & were sealed in accordance with established policy. On 9/9/2011 the Dietary Manager checked all cold food products on the tray line to make sure a temperature of 41°F or lower. No cold food products were found with a temperature above 41°F. On 9/19/2011 the Dietary Manager inserviced 100% of the dietary staff to include the proper ways to open, label and seal food product in the walk-in freezer and walk-in refrigerator as well on 09/26/2011 the Dietary Manager inserviced 100% of Dietary Staff as to the proper way to ensure cold food products are at a temperature of 41°F or lower.  2. All residents partaking of food stored and served in a manner that does not	10/09/11

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

TITLE

(X6) DATE

*[Signature]*

*[Signature]* Administrator

10/06/2011

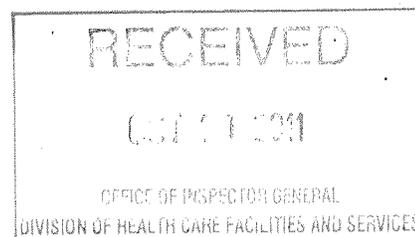
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

LS

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

PRINTED: 09/21/2011  
FORM APPROVED  
OMB NO. 0938-0391

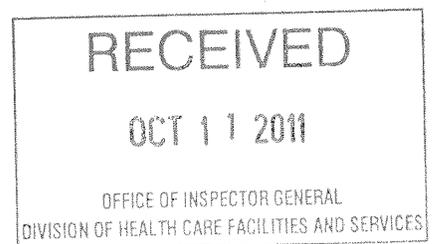
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/09/2011
NAME OF PROVIDER OR SUPPLIER  GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 1  The findings include:  Review of the facility's policy for Food Temperature Record revealed cold food products must leave the kitchen at a minimum of 41 degrees (F) or lower. The facility did not have a policy for dating and sealing opened refrigerated and frozen food products.  Observation, on 09/07/11 at 8:40 AM, during the initial tour revealed one (1) package of frozen cheese, one (1) package of frozen carrots, and one (1) package of lunch meat that was opened and not labeled with the opened date. Observation of the refrigerator revealed one (1) container of opened thickened milk not labeled with open date.  Observation, on 09/08/11 at 9:50 AM, of the walk-in freezer revealed one (1) package of frozen chicken tenders and one (1) package of frozen chicken filets that were opened and not dated, not sealed closed and open to air. The walk-in refrigerator revealed one opened container of whipped topping not labeled with the open date.  Observation, on 09/08/11 at 11:20 AM, revealed nectar-thickened pitcher of milk on the tray line in the North Wing Dining Room with a temperature of 44 degrees (F).  Interview, on 09/09/11 at 2:06 PM, with the Dietary Manager (DM) revealed the Dietary Staff are trained to label food items with the opening date and to seal frozen and refrigerated food items after opening. The DM said she did not	F 371	meet defined sanitary conditions have the potential to be affected. 3. Review of facility policies and procedures reveal the facility did have a policy for proper storage of opened, refrigerated and frozen items. The facility policy has been revised after review and all dietary staff provided training by the Dietary Manager on 9/19/2011 to include the proper storage and service of food in sanitary conditions. Resources utilized in the review and revision of the policy for proper storage of opened, refrigerated and frozen items includes: current facility policy, federal regulations from State Operations Manual Appendix PP, specifically §483.35(i) Sanitary Conditions F371, and policies of contracted dietary consultant. On 9/26/2011 the Dietary staff was provided further education by the Dietary Manager of the policy for Food Temperature Records to ensure cold food products leave the kitchen at a minimum of 41°F or lower. Dietary staff will be held accountable for ensuring compliance with policies on proper storage of opened, refrigerated and frozen items and ensuring cold food products leave the kitchen at a minimum of 41°F or lower. All cold foods and beverages are iced down during meal service and transport. 4. An audit tool has been developed by the contracted dietary consulting vendor in collaboration with the	



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

PRINTED: 09/21/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/09/2011
NAME OF PROVIDER OR SUPPLIER  GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 371	Continued From page 2 think the facility had a written policy on labeling and sealing frozen and refrigerated foods when opened.	F 371	<p>facility Dietary Manager, contracted Registered Dietitian, Director of Nursing Services, Staff Development Coordinator, Facility Risks Manager and Administrator. The audit tool used will include:</p> <ul style="list-style-type: none"> <li>a. Check of walk-in freezer to ensure food products, if opened reflect                             <ul style="list-style-type: none"> <li>i. Labeled</li> <li>ii. Sealed back properly</li> </ul> </li> <li>b. Check of walk-in refrigerator to ensure food products, if opened reflect                             <ul style="list-style-type: none"> <li>i. Labeled</li> <li>ii. Sealed back properly</li> </ul> </li> <li>c. Check of temperature of cold food product at tray line to ensure temperature of product is at a temperature of a minimum of 41°F or lower.</li> </ul> <p>Audits will be completed on a weekly basis by designated employees that will include:</p> <ul style="list-style-type: none"> <li>• Dietary Manager</li> <li>• Director of Nursing Services</li> <li>• Staff Development Coordinator</li> <li>• Risks Manager</li> <li>• Administrator</li> </ul> <p>Additionally weekly audits will be conducted by contracted Registered Dietitian. Findings of audits will be documented and discussed with the Dietary Manager and immediate actions taken by the Dietary Manager to address any concerns. The Dietary</p>	



CMS-2567 Statement of Deficiencies  
Date Survey Completed: 09/09/2011  
Green Meadows Health Care Center  
Provider Number: 185464

F371 (Cont'd)

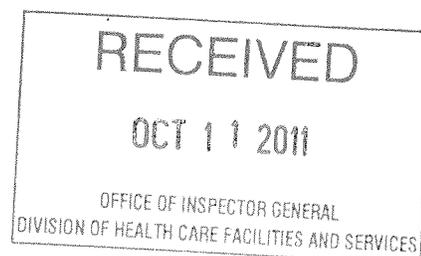
Manager will be responsible for ensuring Dietary Staff compliance with established policies on proper storage of opened, refrigerated and frozen items as well as ensuring cold food products leave the kitchen at a minimum of 41°F or lower. Audits will be conducted a minimum of three days a week in seven day time frames beginning the week of October 09, 2011 through October 15, 2011. These 3-days a week audits will continue for 8 consecutive weeks as follows:

- a. Week 1: 10/09-15/2011
- b. Week 2: 10/16-22/2011
- c. Week 3: 10/23-29/2011
- d. Week 4: 10/30-11/05/11
- e. Week 5: 11/06-12/2011
- f. Week 6: 11/13-19/2011
- g. Week 7: 11/20-26/2011
- h. Week 8: 11/27-12/04/11

Effective December 05, 2011 going forward, audits will be conducted once per week.

Findings of these audits and actions taken will be presented in writing by the Dietary Manager to the Quality Assessment and Assurance Committee (QAA) on a monthly basis. The QAA Committee will provide direction on a monthly basis for actions to be taken relative to ensuring the proper storage and serving of food under sanitary conditions.

---



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

PRINTED: 09/21/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  09/07/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1990</p> <p>SURVEY UNDER: 2000 Exsting</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (000)</p> <p>SMOKE COMPARTMENTS: Nine (9)</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Automatic (dry) sprinkler system, hydraulically designed</p> <p>GENERATOR: Type II generator. Fuel source is diesel</p> <p>A standard Life Safety Code survey was conducted on 09/07/11. Green Meadows Health Care Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one-hundred and twenty-two (122) beds and the census was one-hundred and five (105) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>The submission of the Plan of Correction does not constitute an admission by the provider of any fact or conclusion set forth in the Statement of Deficiencies. This plan of Correction is being submitted because it is required by law.</p> <ol style="list-style-type: none"> <li>No specific residents were identified as having been affected by the facility's failure to ensure there were no impediments to the closing of corridor doors, according to NFPA standards.</li> <li>All residents have the potential to be affected if they are in the smoke compartments where the facility failed to ensure there were no impediments to the closing of corridor doors, according to NFPA standards.</li> <li>The wedge holding the corridor door to the beauty shop open was removed on 09/07/2011. The beautician was notified on 09/08/2011 by the Administrator that corridor doors cannot have any impediments to their closing, specifically the beauty shop. The door closure was removed on 9/7/2011 allowing the door to remain open without the need of a wedge. The Director of Maintenance and his staff was provided in-servicing on K018 on 09/07/2011 by the Administrator. The Director of Maintenance conducted a check of all corridor doors throughout the facility on 09/07/2011 to ensure all corridor</li> </ol>	10/09/11
-------	--	-------	--	----------

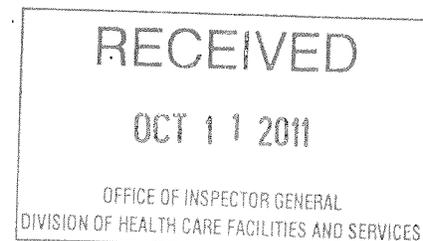
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 10/06/2011
---	------------------------	-------------------------

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 required to continued program participation.

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

PRINTED: 09/21/2011  
FORM APPROVED  
OMB NO. 0938-0391

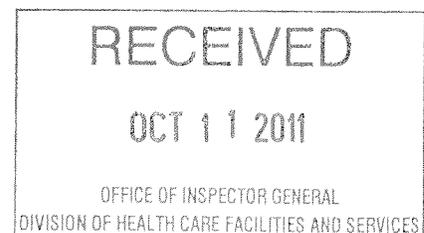
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  09/07/2011
NAME OF PROVIDER OR SUPPLIER  GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 000	Continued From page 1 Fire)	K 000	doors were free of any impediments to closing. Additionally the Administrator provided training to all Department Heads/Administrative staff on 09/09/2011 on K018 standards.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors, according to NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke departments, approximately twenty-five (25) residents, staff and visitors. The facility is	K 018	4. The Director of Maintenance will check all corridor doors throughout the facility on a weekly basis beginning the week of October 02, 2011 through October 08, 2011 to ensure all corridor doors are free from impediments. Weekly audits will be conducted by the Director of Maintenance for the next 8 weeks as follows:  a. Week 1: 10/02-08/2011 b. Week 2: 10/09-15/2011 c. Week 3: 10/16-22/2011 d. Week 4: 10/23-29/2011 e. Week 5: 10/30-11/05/11 f. Week 6: 11/06-12/2011 g. Week 7: 11/13-19/2011 h. Week 8: 11/20-26/2011  Effective November 27, 2011 going forward, the audits will be conducted once per month.  Findings of these audits will be presented in writing by the Director of Maintenance to the Quality Assessment and Assurance Committee (QAA) on a monthly basis. The QAA Committee will provide direction for actions to be taken relative to ensuring there are no impediments to the	10/09/11



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

PRINTED: 09/21/2011  
FORM APPROVED  
OMB NO. 0938-0391

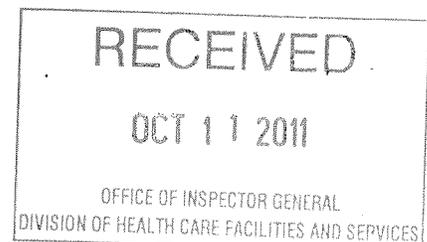
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  09/07/2011
NAME OF PROVIDER OR SUPPLIER  GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 2 licensed for one-hundred and twenty-two (122) beds and the census was one-hundred and five (105) on the day of the survey.  The findings include:  Observations, on 09/07/11 at 2:20 PM, with the Maintenance Director and Maintenance Assistant revealed a wedge holding the corridor door to the beauty shop open.  Interview, on 09/07/11 at 2:20 PM, with the Maintenance Director and the Maintenance Assistant revealed they were unaware that a wedge was being used to hold the door in the open position.  Reference: NFPA 101 (2000 Edition)  19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.  A. 19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.  NFPA 101 LIFE SAFETY CODE STANDARD	K 018	closing of corridor doors, according to NFPA standards.	
K 029 SS=D	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	K 029	1. No specific residents were identified as having been affected by the facility's failure to ensure hazardous areas were maintained according to	10/09/11



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

PRINTED: 09/21/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  09/07/2011
NAME OF PROVIDER OR SUPPLIER  GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 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  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments; residents, staff, and visitors. The facility is licensed for one-hundred and twenty-two (122) beds, and the census was one-hundred and five (105) on the day of the survey.  The findings include:  Observation, on 09/07/11 at 1:20 PM, with the Maintenance Director and the Maintenance Assistant revealed the Mechanical Room in the Physical Therapy Department had holes around the pipe penetrations in the walls and ceiling. The room was not sealed to resist the passage of smoke.  Interview, on 09/07/11 at 1:20 PM, with the Maintenance Director and the Maintenance Assistant revealed they were unaware the holes in the walls and ceiling had not been sealed	K 029	National Fire Protection Association (NFPA) standards. 2. All residents have the potential to be affected if there are holes around pipe penetrations in the walls and ceilings and the rooms not sealed to resist the passage of smoke. 3. The Administrator provided education to the Director of Maintenance and other maintenance staff on Thursday, September 08, 2011 addressing the requirement that all holes around pipe penetrations in the walls and ceilings must be sealed to resist the passage of smoke. An inspection of all areas of the facility was conducted by the Director of Maintenance on 09/08/2011 to ensure any holes found are repaired to comply with NFPA standards. The holes found in the Mechanical Room in the Physical Therapy Department around the pipe penetrations in the walls and ceiling were repaired and are sealed to resist the passage of smoke. The Director of Maintenance will check all areas of the facility throughout the facility on a monthly basis beginning the month of October 2011. 4. The Director of Maintenance will check all areas of the facility throughout the facility on a monthly basis beginning the month of October 2011.  Findings of these audits will be presented in writing by the Director of Maintenance	



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

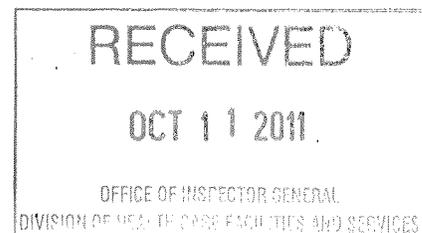
PRINTED: 09/21/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  09/07/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
--	---

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

K 029	<p>Continued From page 4 smoke light.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ul style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)</li> <li>(3) Paint shops</li> <li>(4) Repair shops</li> <li>(5) Soiled linen rooms</li> <li>(6) Trash collection rooms</li> <li>(7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</li> <li>(8) Laboratories employing flammable or</li> </ul>	K 029	<p>to the Quality Assessment and Assurance Committee (QAA) on a monthly basis. The QAA Committee will provide direction for actions to be taken relative to ensuring hazardous areas are maintained according to NFPA standards so areas are sealed to prevent the passage of smoke.</p>	
-------	---	-------	--	--



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

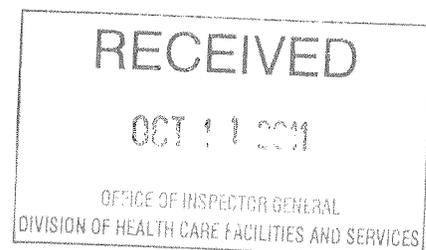
PRINTED: 09/21/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  09/07/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
--	---

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

K 029	Continued From page 6 combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029	1. No specific residents were identified as having been affected by the facility's failure to ensure Alcohol Based Hand Rub dispensers were not installed over or adjacent to an ignition source, per NFPA standards.	
K 211 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms). o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure Alcohol	K 211	2. All residents have the potential to be affected if Alcohol Based Hand Rub dispensers are installed over or adjacent to an ignition source, per NFPA standards. 3. The Administrator provided education to the Director of Maintenance and maintenance employees on Thursday, September 23, 2011 addressing the requirement that Alcohol Based Hand Rub (ABHR) dispensers are properly installed according to NFPA 101 Life Safety Code Standards. The Director of Maintenance and maintenance staff is the only employees who will be installing (ABHR) dispensers. On 09/07/2011 the improperly installed ABHR dispensers were taken down and properly installed according to standard. An inspection of all walls throughout the facility was conducted by the Director of Maintenance on 09/07/2011 to ensure no Alcohol Based Hand Rub dispensers were not installed over or adjacent to an ignition source, per NFPA standards 4. The Director of Maintenance will check all areas of the facility throughout the facility on a monthly basis beginning the month of October 2011 to ensure compliance.	10/08/11



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

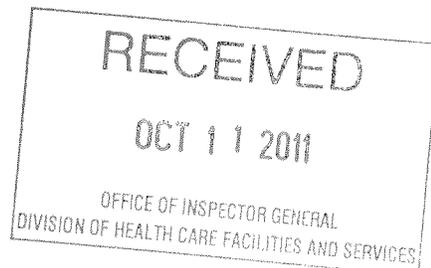
PRINTED: 09/21/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  09/07/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K-211	<p>Continued From page 6</p> <p>Based Hand Rub dispensers were not installed over or adjacent to an ignition source, per NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and twenty-two (122) beds and the census was one-hundred and five (105) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 09/07/11 between 1:50 PM and 2:00 PM, with the Maintenance Director and the Maintenance Assistant revealed Alcohol Based Hand Rub dispensers were installed over the light switches in the dining area, and in the Staff break room.</p> <p>Interview, on 09/07/11 at 1:50 PM, with the Maintenance Director and the Maintenance Assistant, revealed they were unaware that Alcohol Based Hand Rub dispensers were not permitted to be installed over or adjacent to an electrical ignition source.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> <li>o The corridor is at least 6 feet wide</li> <li>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)</li> <li>o The dispensers have a minimum spacing of 4 ft from each other</li> </ul>	K 211	<p>Findings of these audits will be presented in writing by the Director of Maintenance to the Quality Assessment and Assurance Committee (QAA) on a monthly basis. The QAA Committee will provide direction for actions to be taken relative to ensuring Alcohol Based Hand Rub dispensers are not installed over or adjacent to an ignition source, per NFPA standards.</p>	
-------	---	-------	---	--



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

PRINTED: 09/21/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105464	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  09/07/2011
NAME OF PROVIDER OR SUPPLIER  GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 211	Continued From page 7 o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinkled. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211		

