

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

PRINTED: 06/20/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/07/2012
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NAME OF PROVIDER OR SUPPLIER GREEN ACRES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An annual recertification survey was conducted on 06/05/12 through 06/07/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of a "D."	F 000	Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide services that met professional standards of quality for two residents, (#2 and #8), in the selected sample of fifteen residents. The facility failed to carry-over an order for a change in treatment for Resident #2, resulting in a physician's order not being carried out. The facility failed to discontinue an order for a treatment for Resident #8, resulting in the continuation of the discontinued treatment. Findings include: No evidence of a specific policy or procedure was provided by the facility related to the process for carry-over orders or processing of new orders. 1. A record review revealed the facility admitted Resident #2 on 06/27/11 with diagnoses to include Failure to Thrive, Dementia, Chronic Obstructive Pulmonary Disease, Hypertension, Gastroesophageal Reflux, and Osteoporosis.	F 281	F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility shall meet professional standards of quality. Criteria #1: Resident #2's Treatment Administration Record (TAR) reflects current treatment orders for his/her coccyx wound. The treatment being provided meets professional standards. Resident #8's TAR reflects current treatment orders; there is currently no treatment for the boil. Both residents show evidence of improvement with the skin areas mentioned above. Criteria #2: An audit of all resident TAR's was completed on 6/26/12 by LPN in charge of monthly change over to determine that the current treatment orders are accurately transcribed onto the TAR. Criteria #3: All licensed nursing staff members received in-service education on 7/20/12 by Director of Nursing that included but was not limited to: (1) reviewing TARs at time of monthly change over to determine that they reflect current treatment orders. Criteria #4: The CQI indicator for the monitoring of documentation records (TAR's, MAR's, etc.) shall be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Nursing. Criteria #5: Target Date Substantial compliance	7/21/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Terri D. Humes</i>	TITLE Administrator	(X6) DATE 6/27/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	<p>Continued From page 1</p> <p>A review of a Significant Change Minimum Data Set (MDS), dated 08/04/11, revealed the facility assessed Resident #2's to be severely cognitively impaired and required extensive assistance with bed mobility, transfers, toileting and activities of daily living. The resident was assessed at high risk for falls related to impaired mobility.</p> <p>A review of a physician's order, dated 05/29/12, revealed to cleanse the deep tissue injury to the coccyx with normal saline, cover with Allevyn and change every other day and as needed. Review of a more recent physician's order revealed to clean the unstageable decubitus on the coccyx with wound cleanser, apply Allevyn, and change the dressing every day due to an increase in drainage.</p> <p>A review of Resident #2's Treatment Administration Record (TAR), dated June 2012, revealed no evidence of the current physician's order for treatment of the coccyx wound. The previous order had not been discontinued and Resident #2 was not receiving treatment as ordered.</p> <p>An interview with Registered Nurse (RN) #1, on 06/06/12 at 8:00 AM, revealed the change in treatment order, dated 05/29/12, was not carried over to the June 2012 TAR, and the previous order for treatment every other day continued through the current date.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 06/06/12 at 9:45 AM, revealed she noted the order, on 05/29/12, and made the changes on the May 2012 TAR; however, the</p>	F 281		

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F 281	<p>Continued From page 2</p> <p>change was not carried over to the June 2012 TAR, which resulted in the resident not receiving the treatment as ordered by the physician.</p> <p>An interview with the Director of Nursing Services (DNS), on 06/06/12 at 2:40 PM, revealed the physician's order should have been carried over to the June 2012 TAR and may have been missed due to a new person doing the carry-over job at that time.</p> <p>2. A record review revealed the facility admitted Resident #8 on 02/11/08 with diagnoses to include Fractured Femur, Degenerative Arthritic Knee, Angina Pectoris, Syncope and Collapse, Alzheimer's Disease, Depression, Psychotic Mood Disorder, Anxiety State, HTN, Osteoporosis, and Seizure Disorder.</p> <p>A review of the quarterly MDS assessment, dated 05/02/12, revealed the facility assessed Resident #8 to be cognitively intact.</p> <p>A review of the treatment record, dated 05/22/12, revealed to clean the area on the resident's coccyx and buttocks with wound cleanser, pat dry, and apply Allewyn every other day until healed. Further review revealed the order was discontinued on 05/30/12.</p> <p>A review of a physician's order, dated 05/30/12, revealed "discontinue Allewyn to the sacrum; there's nothing open on the buttocks/sacrum except a boil."</p> <p>A review of the Comprehensive Care Plan for a "Boil," dated 05/30/12, revealed to monitor for</p>	F 281			

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F 281	Continued From page 3 signs and symptoms of infection, medications as ordered, Keflex for ten days, and monitor the wound/lesion's status and progress. A review of the treatment record, dated 06/12, revealed to clean the area on the coccyx and buttocks with wound cleanser, pat dry, and apply Allewyn every other day until healed. Dates of administration on the treatment record were initialed by the staff on 06/01/12, 06/03/12, 06/05/12, and 06/06/12. An observation of a skin assessment, on 06/06/12 at 10:05 AM, revealed the area to the resident's coccyx and sacrum were cleaned with wound cleanser and dried, with Allewyn applied. An interview with RN #2, on 06/07/12 at 1:40 PM, revealed she could not find evidence of a physician's order, stating "there was not an order for it." An interview with the ADON, on 06/07/12 at 9:40 AM revealed the facility did not have a policy, the nurses just notify the physician.	F 281			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was	F 282			

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F 282	<p>Continued From page 4</p> <p>determined the facility failed to ensure services were provided by qualified persons in accordance with each resident's written plan of care related to the failure to update the care plan for one resident (#2), in the selected sample of fifteen residents.</p> <p>Finding include:</p> <p>A review of the facility's policy and procedure, "Development of a Care Plan," undated, revealed the care plan was to be reviewed/revised as per the "Resident Assessment Instrument" (RAI) manual with significant changes, and changes in orders es received by the Minimum Data Set (MDS) Coordinator.</p> <p>A review of an insert for the RAI manual dated October 2011, section 4.7 entitled "The RAI and Care Planning" revealed the care plan should be revised on an ongoing basis to reflect changes in the resident and care the resident received.</p> <p>A record review revealed the facility admitted Resident #2 on 06/27/11 with diagnoses to include Failure to Thrive, Dementia, Chronic Obstructive Pulmonary Disease, Hypertension, Gastroesophageal Reflux, and Osteoporosis.</p> <p>A review of a Significant Change Minimum Data Set (MDS), dated 08/04/11, revealed the facility assessed Resident #2 to be severely cognitively impaired and required extensive assistance with bed mobility, transfers, toileting and activities of daily living. The resident was assessed at high risk for falls related to impaired mobility.</p> <p>A review of an Event Report revealed, on</p>	F 282			

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F 282	<p>Continued From page 5</p> <p>05/25/12 at 6:00 PM, Resident #2 was found lying on the right side beside his/her bed with a silver dollar-sized hematoma on the right side of his/her forehead. The possible causative factor was identified as restlessness related to the dying process. Interventions included a low bed, mats to both sides of the bed, and a medication change by Hospice to decrease anxiety.</p> <p>A review of the facility's Event Review Communication Log, dated 05/30/12, revealed a fall on 05/25/12 at 6:00 PM, and included instructions for the charge nurse to review and complete actions assigned, to place initials and the date in the "Action Completed" column, return the form to the Director of Nursing Services when recommendations were completed, and review with all appropriate staff members with signatures provided. Review of the "Action Completed" column, dated 05/30/12, revealed no initials, and the section for staff signatures included only one signature.</p> <p>A review of the care plan, "At risk for falls," updated 05/30/12, revealed that the falls committee met and a new intervention was added for a mat to bedside. A review of the State Registered Nurse Aide (SRNA) care plan report, dated June 2012, did not include the use of floor mats.</p> <p>An observation, on 06/05/12 at 2:50 PM, revealed Resident #2 sitting upright in bed with a green discoloration on the right side of his/her forehead. A floor mat was observed on the left side of the bed. A blue folding floor mat was noted to be propped against the wall at the foot of the bed. An observation, on 06/06/12 at 8:25 AM, revealed</p>	F 282	<p>F 282 483.20(K)(3)(II) SERVICES PROVIDED BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility shall be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Criteria #1: Resident # 2's fall/injury prevention interventions are in place in accordance with his/her written plan of care and the SRNA Care Plan Record reflects all current fall/injury interventions as outlined on his/her comprehensive care plan.</p> <p>Criteria #2: An audit of all fall/injury prevention devices (i.e., alarms, floor mats, etc.) was completed on 6/26/12 by the Director of Nursing Services to determine that they were being provided in accordance with each resident's written plan of care. An audit of all SRNA Care Plan Records was completed on 6/26/12 by the Director of Nursing Services to determine that they accurately reflected each resident's current fall/injury interventions as outlined on each individual comprehensive care plan.</p> <p>Criteria #3: The facility's protocol for transcribing SRNA Care Plan Record ongoing updates has been revised to facilitate timely, accurate revisions, and communication of such revisions to the direct care staff. All nursing staff members received in-service education on 7/20/2012 by the Director of Nursing Services that included but was not limited to: (1) implementation and monitoring of fall/injury prevention devices (i.e., alarms, floor mats, etc.) in accordance with resident's written plan of care, (2) checking for proper placement of safety devices, and (3) revisions to the protocol for transcribing ongoing updates to the SRNA Care Plan Record.</p> <p>Criteria #4: The CQI indicator for the monitoring of care be provided by qualified persons in accordance with each resident's written plan of care shall be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Nursing.</p> <p>The CQI indicator for the monitoring of SRNA Care Plans shall be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Nursing.</p>	

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F 282	Continued From page 6 Resident #2 was in bed with a mat only on the left side of the bed. An interview with the Assistant Director of Nursing (ADON) , on 06/06/12 at 1:45 PM, revealed Resident #2 should have mats on both sides of the bed when he/she was in bed, and the SRNA care plan should have addressed the use of mats on both sides of the bed. An interview with the Director of Nursing Services (DNS), on 06/06/12 at 2:40 PM, revealed the Interdisciplinary Team reviewed incidents in morning meeting, and the floor nurse was responsible for implementing the changes, updating the nursing care plan, and updating the SRNA care plan. After the nurse took care of the changes, they initialed the communication form and gave it back to the MDS Coordinator. The DNS stated she updated the master copies at the beginning of the month. An interview with the Administrator, on 06/07/12 at 3:40 PM, revealed she expected the unit nurses to update the SRNA care plans, and the DNS was ultimately responsible to ensure the updates were implemented.	F 282	Criteria #5: Target Date Substantial Compliance	7/21/2012
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315	F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment the facility shall ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible: Criteria #1: Resident #4's catheter bag is kept in a dignity bag and off of the floor. Criteria #2: An audit of all resident's with indwelling catheters was completed on 6/8/12 by the Director of Nursing Services to determine that their catheter bags were placed in a dignity bag and up off of the floor. Criteria #3: All nursing staff members received in-service education on 7/20/12 as provided by the Director of Nursing Services on the facility's policy for UTI prevention in regards to maintaining catheter bags on dignity bags and off of the floor. Criteria #4: The CQI indicator for the monitoring of catheter bag placement shall be utilized monthly X 2 and then quarterly as per established CQI calendar under the supervision of the Director of Nursing. Criteria #5: Target Date Substantial Compliance	7/21/12

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F 315	<p>Continued From page 7</p> <p>infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of the facility's policy/procedure, it was determined the facility failed to provide the appropriate services and treatment to prevent infections for one resident (#4), in the selected sample of fifteen residents. The facility failed to ensure the resident's catheter bag did not touch the floor or was placed in a dignity bag.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure revealed that a cover bag should be used to provide dignity and to prevent the bag or tubing from touching the floor.</p> <p>A record review revealed the facility admitted Resident #4 on 02/24/99, and re-admitted on 04/25/11, with diagnoses to include Hemiplegia, Visual Disturbance, Aspiration Pneumonia, Psychotic Mood Disorder, and a Closed Head Injury.</p> <p>Observations, on 06/05/12 at 11:30 AM, 3:00 PM, on 06/06/12 at 7:55 AM, 8:55 AM, 10:30 AM, 12:30 PM, 1:30 PM, 2:30 PM, 3:30 PM, and on 06/07/12 at 9:00 AM, revealed Resident #4's catheter bag was touching the floor and was not in a dignity bag.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 06/07/12 at 9:17 AM, revealed catheter bags</p>	F 315			

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F 315	Continued From page 8 or tubing should not touch the floor and the bags should be covered with a dignity bag. Interview with State Registered Nurse Aides (SRNAs) #1, #2, #3, #4, and #5, on 06/07/12 at 9:30 AM, 9:35 AM, 9:45 AM, 9:50 AM, and 9:55 AM, respectively, revealed a catheter bag should not touch the floor and should be in a dignity bag. Interview with the Assistant Director of Nursing (ADON) and the Director of Nursing Services (DNS), on 06/07/12 at 9:40 AM and 10:40 AM, respectively, revealed that catheter bags should not touch the floor and should be in a privacy bag.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the residents' environment remains as free from accident hazards as is possible for two residents (#2 and #5), in the selected sample of fifteen residents. Resident #2, who was assessed as high risk for falls was observed without a safety mat in place as per the resident's care plan.	F 323	F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility shall ensure that each resident receives adequate supervision and assistant devices to prevent accidents. Criteria #1: Resident # 2's fall/injury prevention interventions are in place in accordance with his/her comprehensive care plan; and his/her SRNA Care Plan Record reflect all current fall/injury interventions. Resident #5's wheelchair alarm is in place and functioning when up in the wheelchair in accordance with his/her comprehensive care plan. Criteria #2: An audit of all fall/injury prevention devices (i.e., alarms, floor mats, wheelchair alarms, etc.) was completed on 6/26/12 by (the Director of Nursing Services to determine that they were utilized and functioning in accordance with each resident's written plan of care. An audit of all SRNA Care Plan Records was completed on 6/26/12 by The Director of Nursing Services to determine that they accurately reflected each resident's current fall/injury interventions as outlined on each individual comprehensive care plan. Criteria #3: All nursing staff members received in-service education on 7/20/12 by The Director of Nursing Services that included but was not limited to: (1) implementation and monitoring of fall/injury prevention devices (i.e., alarms, floor mats, etc.) in accordance with resident's written plan of care, (2) monitoring proper function of safety alarms in accordance with facility policy, (3) checking for proper placement of safety devices on resident wheelchairs after visits to the beauty shop, therapy department, etc. The facility's protocol for transcribing SRNA Care Plan Record ongoing updates has been revised to facilitate timely, accurate revisions, and communication of such revisions to the direct care staff. All nursing staff members received in-service education on 7/20/12 by the Director of Nursing Services on the revised protocol.	

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F 323	<p>Continued From page 9</p> <p>Resident #5 sustained two falls in which the safety alarms were not in place or functioning at the time.</p> <p>Findings include:</p> <p>1. A review of the facility's policy and procedure, "Resident Safe Environment," dated 12/07, revealed it was the facility's policy to evaluate residents and implement interventions outlined in the recommendations for each level of risks identified.</p> <p>A record review revealed the facility admitted Resident #2 on 06/27/11 with diagnoses to include Failure to Thrive, Dementia, Chronic Obstructive Pulmonary Disease, Hypertension, Gastroesophageal Reflux, and Osteoporosis.</p> <p>A review of a Significant Change Minimum Data Set (MDS), dated 08/04/11, revealed the facility assessed Resident #2 to be severely cognitively impaired and required extensive assistance with bed mobility, transfers, toileting and activities of daily living. The resident was assessed at high risk for falls related to impaired mobility.</p> <p>A review of an Event Report revealed, on 05/25/12 at 6:00 PM, Resident #2 was found lying on the right side beside his/her bed with a silver dollar-sized hematoma on the right side of his/her forehead. The possible causative factor was identified as restlessness related to the dying process. Interventions included a low bed, mats to both sides of the bed, and a medication change by Hospice to decrease anxiety.</p> <p>A review of the care plan, "At risk for falls,"</p>	F 323	<p>Criteria #4: The CQI indicator for the monitoring of care be provided by qualified persons in accordance with each resident's written plan of care shall be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Nursing.</p> <p>The CQI indicator for the monitoring of SRNA Care Plans shall be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Nursing.</p> <p>Criteria #5: Target Date Substantial Compliance</p>	7/21/12	

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PRINTED: 06/20/2012
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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER GREEN ACRES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066		
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F 323	<p>Continued From page 10</p> <p>updated 05/30/12, revealed that the falls committee met and a new intervention was added for a mat to bedside. A review of the State Registered Nurse Aide (SRNA) care plan report, dated June 2012, did not include the use of floor mats.</p> <p>An observation, on 06/05/12 at 2:50 PM, revealed Resident #2 sitting upright in bed with a green discoloration on the right side of his/her forehead. A floor mat was observed on the left side of the bed. A blue folding floor mat was noted to be propped against the wall at the foot of the bed. An observation, on 06/06/12 at 8:25 AM, revealed Resident #2 was in bed with a mat only on the left side of the bed.</p> <p>An interview with the Assistant Director of Nursing (ADON) , on 06/06/12 at 1:45 PM, revealed Resident #2 should have mats on both sides of the bed when he/she was in bed, and the SRNA care plan should have addressed the use of mats on both sides of the bed.</p> <p>An interview with the Administrator, on 06/07/12 at 3:40 PM, revealed she expected the staff to ensure safety interventions were in place when rounds were made.</p> <p>2. No evidence of a specific policy or procedure was provided by the facility related to the use of safety alarm devices.</p> <p>A record review revealed the facility admitted Resident #5 on 04/08/11 with diagnoses to include Alzheimer's Disease, Dementia, Hypertension, Diabetes Mellitus, and Cardiac Dysrhythmia.</p>	F 323			

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F 323	<p>Continued From page 11</p> <p>A review of the quarterly MDS assessment, dated 04/14/12, revealed the resident was cognitively impaired, required extensive assistance with transfers and activities of daily living, and at high risk for falls due to poor safety awareness.</p> <p>A review of the care plan, "At risk for Falls," dated 04/26/11, revealed interventions for "self-release seat belt to chair" and "educate the staff to ensure alarm is on and working."</p> <p>A review of a nurse's note, dated 03/19/12 at 8:05 AM, revealed Resident #5 was found sitting on the floor in his/her room in front of his/her chair. No injuries were noted. A review of the Event Report, dated 03/19/12 at 8:05 AM, revealed the alarm was in place; however, the staff did not turn the alarm on. Inservicing was provided to the staff, on 03/20/12, related to checking placement and functioning of alarms when making rounds.</p> <p>A review of a nurse's note, dated 05/30/12, no time indicated, revealed documentation that the physician and family were notified that Resident #5 was found in the floor and no injuries were noted. Review of the Event Report, dated 05/30/12, revealed the resident was found in the floor of his/her room and the safety alarm was turned off.</p> <p>An interview with the facility's Beautician, on 06/07/12 at 12:30 PM, revealed, on 05/30/12, she provided hair care to Resident #5. The Beautician revealed she assisted Resident #5 to the hall by his/her room and an SRNA then took the resident to his/her room. Additionally, the Beautician revealed SRNAs did not bring</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>residents to the beauty shop area. She usually went to get the resident from their rooms and would take them to the beauty shop area. She assisted them to the hall when she completed the beauty services, and she notified the SRNA or nurse at that time. The Beaulician stated she was unaware about Resident #5's personal safety alarm. Additionally, she stated she was unaware that the resident sustained a fall, and no one had informed her about it.</p> <p>An interview with the Director of Nursing Services (DNS), and the ADON, on 06/07/12 at 1:00 PM, revealed it was determined the staff did not engage Resident #5's safety alarm on 03/19/12. The Nurse Aides were responsible to ensure safety alarms were in place and functioning, and they were to document this information at the end of the shift. The DNS and the ADON revealed, on 05/31/12, the facility's hairdresser had the resident in a regular wheelchair instead of the specialized chair in which the resident was care planned because the specialized chair would not work at the sink or the hair dryer. They revealed the safety alarm could not be moved from one chair to another. It was ultimately the responsibility of the nurse supervisor to ensure residents' safety devices were in place and functioning.</p> <p>An interview with the Administrator, on 06/07/12 at 10:20 AM, revealed she expected the staff to ensure safety alarms were in place and functioning when rounds were made and anytime a resident was transferred.</p>	F 323			

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K 000	Continued From page 1 The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000	Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
K 018 SS=D	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 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 doors to resident rooms would latch properly in accordance with NFPA standards. The deficiency	K 018	K 018 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 Criteria #1: Corridor doors to rooms 228, 229, 230, and 231 have been repaired and are latching properly by the Maintenance Supervisor on 6/8/12 Criteria #2: An audit of all corridor doors to determine that there were no other corridors doors that were not latching properly on 6/8/12 by the Maintenance Supervisor. Criteria #3: Maintenance personnel and housekeeping personnel have been in-serviced on ensuring corridor doors are latching properly and the necessity of reporting noted issues to the Maintenance supervisor immediately by the Administrator on 7/5/12. Criteria #4: The CQI indicator for the monitoring of doors windows etc... shall be used monthly x 2 months and then per CQI calendar under the supervision of the Administrator. Criteria #5: Target Date Substantial compliance	7/21/12

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K 018	<p>Continued From page 2</p> <p>had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy-three (73) beds with a census of sixty-eight (68) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 06/05/12 at 1:15 PM, with the Maintenance Supervisor revealed the corridor doors to rooms 228, 229, 230, and 231 would not latch properly.</p> <p>Interviews, on 06/05/12 at 1:15 PM, with the Maintenance Supervisor confirmed the observation of the doors not latching and revealed the building had settled in this area which could have affected the door jambs..</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p>	K 018			

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K 018	Continued From page 3 Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025		

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K 025	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy-three (73) beds with a census of sixty-eight (68) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 06/05/12 between 10:00 AM and 11:00 AM, with the Maintenance Supervisor revealed the smoke partitions, extending above the ceiling had multiple penetrations due to wires and quick foam. All four smoke barrier walls were penetrated and the spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. The fire quick foam that was used does not have a Fire Resistive Rating therefore is not approved for use in the smoke barrier.</p> <p>Interview, on 06/05/12 between 10:00 AM and 11:00 AM, with the Maintenance Supervisor revealed he was not aware of the penetrations and that he had thought all the smoke barrier walls were sealed properly with the fire quick foam.</p>	K 025			

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K 025	Continued From page 5 Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025	K 025 NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Criteria #1: All penetrations have been sealed with approved Fire Resistive materials. Quick Foam was removed and fire resistive barrier was applied by the Maintenance Supervisor on 6/13/12 Criteria #2: An audit of all smoke partitions and barriers was conducted on 6/8/12 by the Maintenance Supervisor to ensure no further penetrations existed. Criteria #3: Maintenance personnel have been instructed by the Administrator on 6/13/12 to only use caulking to seal partitions or barriers that has a fire resistive rating. Criteria #4: The CQI indicator for the monitoring of physical plant specific to penetrations in smoke barriers/partitions will be utilized monthly x 2 and then per the CQI schedule under the supervision of the Administrator Criteria #5: Target Date Substantial Compliance	
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6,	K 027		7/21/12

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K 027	<p>Continued From page 6 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy-three (73) beds with a census of sixty-eight (68) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/05/12 at 11:40 AM, with the Maintenance Supervisor revealed the cross-corridor doors, located at the front of the east hall, would not close completely when tested. This was due to the doors not having a coordinator to ensure the door with the t-asiragal would close first after the initial close.</p> <p>Interview, on 06/05/12 at 11:40 AM, with the Maintenance Supervisor revealed they were unaware the doors needed a coordinator to ensure the doors would close properly in the event of an emergency.</p> <p>NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.</p>	K 027			

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K 027	Continued From page 7 Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027	K 027 NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Criteria #1: The cross-corridor doors, located at the front of the east hall, have had a coordinator installed to ensure the doors will close properly in the event of an emergency on 6/25/12 by the maintenance supervisor. Criteria #2: An audit of all corridor doors was done to ensure that any doors with a t-astragal would close first after the initial close and closed properly on 6/8/12 by the Maintenance Supervisor. Criteria #3: Maintenance Personnel were in-serviced on the necessity of corridor doors closing properly in the event of an emergency and those doors with the t-astragal requiring a door coordinator to ensure the door closes properly after the initial close on 7/5/12 by the Administrator. Criteria #4: The CQI indicator for the monitoring of corridor doors will be utilized monthly x 2 months and then per the CQI schedule under the supervision of the Administrator Criteria #5: Target Date Substantial Compliance	7/21/12
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 3/4 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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and	K 029		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/05/2012
NAME OF PROVIDER OR SUPPLIER GREEN ACRES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066		
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K 029	<p>Continued From page 8</p> <p>visitors. The facility is licensed for seventy-three (73) beds with a census of sixty-eight (68) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/05/12 between 11:00 AM and 2:30 PM, with the Maintenance Supervisor revealed:</p> <ol style="list-style-type: none"> 1) The sprinkler riser room did not have a door closer that was needed due to the storage in the room. 2) The new linen room in the laundry area had no door closer and the ceiling was not sealed. <p>Interview, on 06/05/12 between 11:00 AM and 2:30 PM, with the Maintenance Supervisor revealed he was not aware the areas listed above were considered hazardous storage thus requiring a door, a self-closer, and separation.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</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</p>	K 029			

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K 029	Continued From page 9 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. 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	K 029 NFPA 101 LIFE SAFETY CODE STANDARD 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 Criteria #1: A door closer has been installed on the sprinkler riser room and the new linen room in the laundry area and the ceiling has been sealed in the new linen room in the laundry area, by the Maintenance Supervisor on 6/28/12 Criteria #2: An audit was completed of hazardous areas to ensure door closures were in place and ceilings were sealed by the Maintenance Supervisor on 6/28/12. Criteria #3: The Maintenance personnel were in-serviced on what hazardous areas are and the importance of having a door, a self-closer, and separation, by the Administrator on 7/5/12. Criteria #4: The CQI indicator for the monitoring of hazardous areas will be utilized monthly X 2 months then per CQI schedule under the supervision of the Administrator. Criteria #5: Target Date Substantial Compliance		
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA	K 045	K 045 NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Criteria #1: The exit lighting fixtures on the exterior of the east and west hall exits have been changed to a two bulb fixture and arranged so the failure of a single bulb will not leave the exit in complete darkness, by the Maintenance Supervisor on 6/26/12 Criteria #2: All exterior exits were audited to ensure	7/21/12	

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K 045	Continued From page 10 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-three (73) beds with a census of sixty-eight (68) on the day of the survey. The findings include: Observation, on 06/05/12 between 11:30 AM and 3:30 PM, with the Maintenance Supervisor revealed the east and west hall exits were equipped with a single bulb for illuminating egress path to the public way from the exit. Interview, on 06/05/12 between 11:30 AM and 3:30 PM, with the Maintenance Supervisor revealed he was unaware the lighting fixtures serving the exterior exits must include more than one bulb. Exit lighting must be arranged so the failure of a single bulb will not leave the exit in complete darkness. Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045	two bulb fixtures were in place by the Maintenance Supervisor on 6/26/12. Criteria #3: Maintenance personnel have been in serviced that lighting for means of egress, should be equipped with more than one bulb and arranged in such a fashion that the failure of one bulb does not result in the area being in complete darkness, by the Administrator on 7/5/12. Criteria #4: The CQI Indicator for the monitoring for exit lighting shall be utilized monthly x 2 months then per the CQI schedule under the supervision of the Administrator. Criteria #5: Target Date Substantial Compliance	7/21/12
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9. 19.2.9.1.	K 046	K 046 NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9. 19.2.9.1 Criteria #1: The emergency light with battery backup located at the generator transfer switch was replaced by the Maintenance Supervisor on 6/8/12. Criteria #2: An audit was done to ensure all other emergency lights with battery backup were functioning, by the Maintenance Supervisor on 6/8/12. Criteria #3: The Maintenance personnel have been in-serviced on the importance of ensuring emergency lights with battery backup are functioning properly, by the Administrator on 7/5/12. Criteria #4: The CQI tool for the monitoring of emergency lighting will be utilized monthly x 2 months and then per the CQI schedule under the supervision of the Administrator Criteria #5: Target Date Substantial Compliance	7/21/12

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K 046	<p>Continued From page 11</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and observation, it was determined the facility failed to provide emergency lighting in accordance with NFPA 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-three (73) beds with a census of sixty-eight (68) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/05/12 at 12:45 PM, with the Maintenance Supervisor revealed that an emergency light with battery backup located at the generator transfer switch did not function properly leaving the potential for the generator transfer switch to be in complete darkness.</p> <p>Interview, on 06/05/12 at 12:45 PM, with the Maintenance Supervisor revealed he was unaware the light was not functioning properly. He stated that he tests the light weekly by turning the light off to ensure that it would work.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at</p>	K 046			

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K 046	Continued From page 12 floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.	K 046			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA 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-three (73) beds with a census of sixty-eight (68) on the day of the survey. The findings include: Paperwork Review, on 06/05/12 between 1:00 PM and 2:00 PM, with the Administrator revealed the last interior pipe inspection was done in 2003. This inspection must be done once every five years. Further observation showed one of the gauges on the sprinkler riser had not been changed or calibrated within the last five years.	K 062			

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K 062	<p>Continued From page 13</p> <p>Interview, on 06/05/12 between 1:00 PM and 2:00 PM, with the Administrator revealed she was not aware the interior pipe and the gauge were to be done once every five years and thought her vendors would take care of these inspections.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.</p> <p>Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance</p> <table border="1"> <thead> <tr> <th>Item</th> <th>Activity</th> <th>Frequency</th> <th>Reference</th> </tr> </thead> <tbody> <tr> <td>Gauges (dry, preaction deluge systems)</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>2-2.4.2</td> </tr> <tr> <td>Control valves</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>Table 9-1</td> </tr> <tr> <td>Alarm devices</td> <td>Inspection</td> <td>Quarterly</td> <td>2-2.6</td> </tr> <tr> <td>Gauges (wet pipe systems)</td> <td>Inspection</td> <td>Monthly</td> <td>2-2.4.1</td> </tr> <tr> <td>Hydraulic nameplate</td> <td>Inspection</td> <td>Quarterly</td> <td>2-2.7</td> </tr> <tr> <td>Buildings</td> <td>Inspection</td> <td>Annually (prior to freezing weather)</td> <td></td> </tr> </tbody> </table>	Item	Activity	Frequency	Reference	Gauges (dry, preaction deluge systems)	Inspection	Weekly/monthly	2-2.4.2	Control valves	Inspection	Weekly/monthly	Table 9-1	Alarm devices	Inspection	Quarterly	2-2.6	Gauges (wet pipe systems)	Inspection	Monthly	2-2.4.1	Hydraulic nameplate	Inspection	Quarterly	2-2.7	Buildings	Inspection	Annually (prior to freezing weather)		K 062		
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K 062	Continued From page 14 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1. Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10 9-4.2.1 9-4.2.1 Inspection. Valves shall be inspected internally every 5 years to verify that all components operate properly, move freely, and are in good condition.	K 062	K 062 NFPA 1010 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, NFPA13, NFPA 25,79.7.5: Criteria #1: The interior pipe inspection was completed on 6/11/12 by the facility inspection company, the gauge on the sprinkler riser was changed by the facility vendor responsible for doing so on 6/11/12 Criteria #2: An audit was done on all equipment requiring inspections to ensure required inspections were done. Criteria #3: The Maintenance Supervisor has been in-serviced on the importance of monitoring and tracking required inspections conducted by outside vendors, particularly those not done annually by the Administrator on 6/11/12. Criteria #4: The CQI Monitoring tool for required inspections by vendors will be utilized monthly x 3 months and then per the CQI schedule under the supervision of the Administrator Criteria #5: Target Date for Substantial Compliance K 064 NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1 Criteria #1: The signage stating that the hood suppression system must be used before the class K fire extinguisher has been placed on the wall in the kitchen. The wall mounted portable fire extinguishers located throughout the facility have been moved to the maximum allowable height of five (5) feet above the finish floor by the Maintenance Supervisor on 6/8/12 Criteria #2: An audit was conducted to ensure required signage was in place and items were hung at the regulated height by the Maintenance Supervisor on 6/8/12. Criteria #3: An in-serviced was done with the Maintenance and Dietary personnel on the posting of	7/21/12
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064		

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K 064	Continued From page 15 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire extinguishers were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy-three (73) beds with a census of sixty-eight (68) on the day of the survey. The findings include: Observation, on 06/05/12 at 2:10 PM, with the Maintenance Supervisor revealed there was no signage stating that the hood suppression system must be used before the class K fire extinguisher. This type of extinguisher is used as a secondary measure to the range hood extinguishing system. Interview, on 06/05/12 at 2:10 PM, with the Maintenance Supervisor revealed he was unaware of the signage requirement. Further interview with kitchen staff revealed if a grease fire started the first action was to turn off the stove and then get the class-k fire extinguisher. Observation, on 06/05/12 between 11:30 AM to 3:30 PM, with the Maintenance Supervisor revealed the wall mounted, portable fire extinguishers located throughout the facility, were mounted above the maximum allowable height of five (5) feet above the finish floor. Interview, on 06/05/12 between 11:30 AM to 3:30	K 064	signs in areas that have hood suppressions systems that the state the hood suppression system must be used before the class K fire extinguisher is used, and that the class K fire extinguisher is used as a secondary measure to the range hood extinguishing system, by the Administrator on 7/5/12. The Maintenance Personnel were in-serviced on the mounting height of portable fire extinguishers, in that they can not be mounted above the maximum allowable height of 5 feet above the finish floor for extinguishers having a gross weight of 40 lbs or less and no more that 3 ½ feet above the floor for those greater than 40 lbs. by the Administrator on 7/20/12 Criteria #4: The CQI monitoring tool for fire safety as it relates to extinguishers and signage will be utilized monthly, x 2 months then per CQI schedule under the direction of the Administrator. Criteria #5: Target Date Substantial Compliance	7/21/12

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K 064	Continued From page 16 PM, with the Maintenance Supervisor revealed that he was unaware of the height limitations for wall mounted portable fire extinguishers and acknowledged that they were mounted above the height of five (5) feet above the finish floor. Reference: NFPA 10 (1998 Edition). 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher. Reference NFPA 10 (1998 Edition). 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064			
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.	K 066			

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K 066	<p>Continued From page 17</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays at an entrance, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy-three (73) beds with a census of sixty-eight (68) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/05/12 at 2:03 PM, with the Maintenance Supervisor revealed the ashtray located at the front entrance to the building was not of the unapproved type. The ashtray did not have a metal container with a self-closing lid.</p>	K 066			

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PRINTED: 06/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/05/2012
NAME OF PROVIDER OR SUPPLIER GREEN ACRES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066		
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K 066	<p>Continued From page 18</p> <p>Interview, on 06/05/12 at 2:03 PM, with the Maintenance Supervisor revealed he was not aware of the requirement for self-closing ashtrays.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <p>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.</p> <p>(2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily</p>	K 066			

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K 066	Continued From page 19 available to all areas where smoking is permitted.	K 066	<p>K 066 NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking permitted 19.7.4 Criteria #1: The appropriate approved ashtray has been placed at the front entrance to the building by the Maintenance Supervisor on 6/27/12 Criteria #2: All areas where smoking is permitted were audited to ensure appropriate ashtrays were in place by the Maintenance Supervisor on 6/27/12. Criteria #3: the Maintenance Personnel have been in-serviced on the approved types of ashtrays that can be utilized in smoking areas by the Administrator on 6/8/12. Criteria #4: The CQI tool for Smoking regulations specific to types of ashtrays will be utilized monthly x 2 months and then per the CQI schedule under the supervision of the Administrator Criteria #5: Target Date for Substantial Compliance</p> <p>K 072 NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p>	7/21/12
K 072 SS=E	<p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy-three (73) beds with a census of sixty-eight (68) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/05/12 between 10:30 AM and 12:00 PM, with the Maintenance Supervisor revealed lifts, linen carts, med carts, rolling tables, and wheelchairs were stored in the corridor until the Administrator arrived at 12:00 PM. Further observation showed the laundry exit was blocked by a table and two rolling carts.</p> <p>Interview, on 06/05/12 between 10:30 AM and 12:00 PM, with the Maintenance Supervisor revealed he thought the facility could store items in the corridor as long as they were on one side of</p>	K 072		

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K 072	Continued From page 20 the corridor. Further interview with the Administrator revealed she was aware the corridors should be free and clear of all obstructions. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	halfway by Administrator on 6/8/12 The laundry table and rolling carts were moved away from the door by the Maintenance Supervisor on 6/25/12. Criteria #2 An audit was done of all means of egress to ensure exit access was maintained by the Administrator on 6/25/12. Criteria #3 All Staff have been in-serviced on maintaining clear exit access and not storing items in corridors or in front of the laundry door leading to the outside by the Administrator on 7/20/12. Criteria #4 The CQI Monitoring tool for means of egress, maintaining clear exit access and not storing items in corridors will be utilized weekly x 1 month and then monthly x 2 months and then per the CQI schedule under the supervision of Administrator Criteria #5 Target Date Substantial Compliance	7/21/12
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy-three (73) beds with a census of sixty-eight (68) on the day of the survey. The findings include:	K 144	K 144 NFPA LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99 3.4.4.1 Criteria #1: The Alarm Annunciator panel for the emergency generator has been replaced by the generator vendor under the supervision of the Maintenance Supervisor on 6/27/12. Criteria #2 An audit was done of all remote annunciator panels to ensure they function properly by the Maintenance Supervisor on 6/08/12. Criteria #3: An in-service was done with all staff on visually checking to ensure the annunciator panels are functioning by the Administrator on 7/20/12. Criteria #4: The CQI tool for the monitoring of annunciator panel will be utilized weekly X 1 month then monthly X 2 months then per the CQI schedule under the direction of the Administrator. Criteria #5: Target Date Substantial Compliance	7/21/12

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NAME OF PROVIDER OR SUPPLIER GREEN ACRES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066		
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K 144	<p>Continued From page 21</p> <p>Observation, on 06/05/12 at 2:27 PM, with the Maintenance Supervisor revealed the facility was equipped with an emergency generator. The generator is equipped with an annunciation panel that is in a 24 hour monitored area to make staff aware of alarm conditions with the generators. The annunciator panel was not functioning and would not show any trouble lights for the generator.</p> <p>Interview, on 06/05/12 at 2:27 PM, with the Maintenance Supervisor confirmed the observation that the annunciation panel was not working and revealed they had problems with the panel in the past.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure</p>	K 144			

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K 144	Continued From page 22 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]	K 144	K 147 NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy-three (73) beds with a census of sixty-eight (68) on the day of the survey. The findings include:	K 147	K 147 NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2 Criteria # 1: Item #2, 3, 4, 5, 6, 7, 8, 9, and 10 were removed by the maintenance supervisor on 6/8/12. Item #1 was placed into an approved GFI receptacle by the Maintenance Supervisor on 6/12/12. Additional plugs were installed as indicated by a licensed Electrician under the supervision of The Maintenance Supervisor on 6/25/12. Criteria #2: An audit was done of all patient care areas to ensure the appropriate number of plugs and appropriate use of power strips by the Maintenance Supervisor on 6/12/12 Criteria #3: All staff was in-serviced on the proper use of plugs and the appropriate use of power strips and that extension cords are only used for temporary use by the Administrator on 7/5/12. The Maintenance personnel were in-serviced on the appropriate plug type to use when an electrical device is plugged in near a water source by the Administrator on 7/05/12. Criteria # 4: The CQI monitoring tool for electrical safety will be utilized weekly x 1 month then monthly x 2 months and the per CQI schedule under the direction of the Administrator Criteria #5: Target Date Substantial Compliance	7/21/12

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K 147	<p>Continued From page 23</p> <p>Observations, on 06/05/12 between 10:45 AM and 3:30 PM, with the Maintenance Supervisor revealed:</p> <ol style="list-style-type: none"> 1) A hydro collator was plugged into a standard plug in the therapy area. 2) An extension cord was plugged into a wax warmer in the DON ' s office. 3) A microwave was plugged into a power strip in the activities office. 4) A hair dryer and two curling irons were plugged into a power strip in the beauty salon. 5) A mini nebulizer was plugged into a power strip located in room# 105. 6) A mini nebulizer was plugged into a power strip located in room# 106. 7) A mini nebulizer was plugged into a power strip located in room# 107. 8) A mini nebulizer was plugged into a power strip located in room# 1114. 9) An extension cord was plugged into a television and a radio in room# 117. 10) An extension cord was mounted to the trusses above the ceiling in the east hall for lighting. <p>Interview, on 06/05/12 between 10:45 AM and 3:30 PM, with the Maintenance Supervisor revealed he was not aware the extension cords were only for temporary use, or the power strips were being misused.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p>	K 147		

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PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

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K 147	Continued From page 24 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.	K 147			