

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

PRINTED: 07/18/2013
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 07/03/2013
NAME OF PROVIDER OR SUPPLIER GREEN ACRES HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066	
(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 F 279 SS=D	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted on 07/01/13 through 07/03/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of an "F".</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review it was determined the facility failed to develop a care plan for behaviors for one (1) resident (#10), in the selected sample</p>	F 000 F 279	<p>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.</p> <p>F 279 Resident Assessment The facility shall develop a comprehensive care plan for each resident that includes measureable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Criteria #1: A care plan to address 'hoarding' tendencies was developed by the care plan team on</p>



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

Toni D. Hume

TITLE

Administrator

(X6) DATE

7-24-13

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 279	<p>Continued From page 1 of fifteen (15) residents.</p> <p>Findings include:</p> <p>A review of the policy and procedure titled "Development of a Care Plan", revealed "care plans are to be created by the interdisciplinary care plan team within seven (7) days of completion of the comprehensive MDS assessment." The Social Services Director was responsible for the behavior section of the MDS and for care planning triggered behavior symptoms.</p> <p>A record review revealed Resident #10 was admitted to the facility on 04/14/11 with diagnoses to include Generalized Anxiety, Depression, and Mental Retardation.</p> <p>Observations of Resident #10's room on 07/01/13, 07/02/13, and 07/03/13 revealed the resident's room was extremely cluttered with craft supplies, clothing and food items. There was also a three tiered shelf of shoes located in the floor next to the toilet and a three shelf, plastic storage container, under the sink.</p> <p>A review of the care plans for Resident #10 dated 02/20/13 revealed there was no behavior care plan implemented.</p> <p>An interview with the Social Services Director (SSD), on 07/03/13 at 1:30 PM, revealed Resident #10 was very set in his/her ways and did not like for anyone to come in his/her room and bother his/her things nor make suggestions to get rid of some items to make the room less cluttered. The SSD further revealed the resident</p>	F 279	<p>07/03/2013 for Resident # 10. The care plan team met with Resident #10 and his/her responsible party on 08/01/2013, to discuss the care plan revision.</p> <p>Criteria #2: An audit of resident care plans was completed on 07/31/2013 by members of the care plan team to determine that all resident behaviors were properly addressed on their care plan.</p> <p>Criteria #3: The care plan team received in-service education on development of the care plan on 7/25/13 as provided by the corporate nurse consultant. Housekeeping and nursing staff members received in-service education on reporting of 'hoarding' and/or other potentially hazardous behaviors on 08/05/2013 as provided by the facility administrator. Any reports of 'hoarding' and/or other potentially hazardous behaviors shall be discussed in the next morning meeting with the care plan team so that a plan of care addressing the situation can be developed and implemented timely.</p> <p>Criteria #4: The CQI tool for monitoring of behavior care plan</p>		

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F 279	Continued From page 2 would sometimes let staff and family go through some items and allow them to be sent home with the family but then the family will bring them back per his/her request so the room never gets cleaned out for long. Further interview revealed there should have been a care plan developed to address Resident 310's hoarding like behavior.	F 279	development shall be utilized monthly X 2 months and then quarterly, as per established CQI calendar, under the supervision of the Administrator. Criteria #5: Target Date	08/09/2013	
F 371 SS=F	An interview with the Director of Nursing (DON), on 07/03/13 at 1:45 PM, revealed a care plan should have been developed for Resident #10's hoarding like behavior. 483.35(f) 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 facility policy review it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observations of the kitchen, revealed a rust-colored, build-up of substances on the inside of the the exhaust hood that was mounted above the stove and around the flooring and baseboard, near the entrance to the walk-in refrigerator. In addition, staff members were observed entering the kitchen and service areas	F 371	F 371 Food Procure, Store/Prepare/Service – Sanitary The facility must store, prepare, distribute and serve food under sanitary conditions. Criteria #1: The rust colored substance on the exhaust hood and refrigerator floor was removed/covered by the maintenance department on 07/19/2013 A hair net box holder was installed by the back kitchen entrance on 7/3/13 by the maintenance department for easy access to hair nets by personnel using that entrance. All personnel entering through the back entrance to the kitchen are utilizing hair nets upon entering the kitchen. Criteria #2: All residents have the potential to be affected by this alleged deficient practice. Criteria #3: Dietary staff members		

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F 371	<p>Continued From page 3 without applying a hair net or hair restraints.</p> <p>A review of the facility's census and condition, dated 07/01/13, revealed there were 62 residents in the facility and all the residents utilized the kitchen facilities.</p> <p>A review of the facility "Food Code 2009," and policy for "Hair Restraints", revealed "employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep hair from contacting exposed food, clean equipment, utensils, and linens and unwrapped single-service and single use articles.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. An observation of stove and refrigerators on 07/01/13 at 12:50 PM and 07/03/13 at 1:30 PM, revealed a rust-colored substance that covered the inside of the range hood, that transferred to a glove, when wiped with a gloved hand. <p>An interview with the Dietary Manager, on 07/01/13 at 1:00 PM, revealed she was never told to check for this problem and was not aware the debris could possibly fall down into the food cooking on the stove below. She stated she thought the people responsible for inspecting and conducting maintenance of the hood would have been responsible to take care of the problem.</p> <ol style="list-style-type: none"> 2. An observation of the kitchen, on 07/01/13 at 12:50 PM, on 07/02/13 at 11:35 AM and on 07/03/12 at 07/03/13 at 1:30 PM revealed four staff members, including the Dietary Manager, entered the kitchen and walked past the three 	F 371	<p>received in-service education on 07/25/2013 which included, but was not limited to: (1) reporting rust on any equipment to the maintenance director; and (2) areas of the kitchen that requires utilization of hair nets, as provided by the Dietary Manager and Dietician.</p> <p>Criteria #4: The CQI tools for the monitoring of dietary sanitation shall be utilized weekly X 2 weeks and then monthly in accordance with the established CQI calendar under the supervision of the Dietary Manager and/or RD.</p> <p>Criteria #5: Target Date</p>	08/09/2013	

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F 371	<p>Continued From page 4</p> <p>compartment sink, tray line, stove and on into the dry storage area, to retrieve a haimet from a large cabinet.</p> <p>An interview with the Dietary Manager, on 07/03/13 at 1:30 PM, revealed she thought the policy was, that it was acceptable to have this practice, as long as they did not actually handle the food or walk directly beside the tray line.</p> <p>An interview with the Administrator, on 07/13/13 at 4:45 PM, revealed the practice of not wearing hair nets, was not acceptable and the rust-colored debris would be rectified.</p>	F 371			

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K 000	<p>INITIAL COMMENTS</p> <p>**AMENDED SOD**</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1965.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1965 and upgraded in 2005, with 21 smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1965 and upgraded in 2009.</p> <p>GENERATOR: Type II generator installed in 2009. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 07-03-13. Green Acres was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Seventy-Three (73) beds with a census of Fifty-Three (53) on the day of the survey.</p>	K 000	<p>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.</p> <p>K056 – If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the installation of sprinkler systems, to provide complete coverage for all portions of the building.</p> <p>Criteria 1 – The three Closets identified during the survey where the sprinkler heads are located closer than four inches to the closet wall have been moved by the facility's contracted sprinkler vendor.</p> <p>Criteria 2 – All closets have been inspected by the facility's maintenance supervisor to identify if other sprinkler heads are located closer than four inches to the wall.</p> <p>Criteria 3 – The Maintenance Supervisor has received in-service education from the Administrator on 7/23/13 to assure that sprinkler heads are not located closer than four inches to the wall.</p> <p>Criteria 4 – The CQI Tool, ES-3 will be utilized by the maintenance supervisor monthly X 2 then quarterly thereafter to identify any sprinkler heads closer than four inches to a wall.</p> <p>Criteria 5</p>	8/9/13

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

Teri D. Dumes

TITLE

Administrator

(X6) DATE

7-24-2013

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

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K 056	Continued From page 2 inches from the wall. The findings include: Observation, on 07/03/13 between 10:42 AM and 1:50 PM with the Maintenance Supervisor, revealed a sprinkler head located in the closets of resident rooms #105, 224, and 234 within one (2) inches of the wall. Interview, on 07/03/13 between 10:42 AM and 1:50 PM with the Maintenance Supervisor, revealed he was unaware of the sprinkler heads being too close to the wall. Reference: NFPA 13 (1999 edition) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.	K 056	K072 - Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. Criteria 1 - The means of egress will be changed on the facility's Evacuation Plan to direct the exit path to the Lobby and the Front Exit Door and to the West Hall and East Hall Exit Door. Criteria 2 - There are no other means of egress affected by this requirement in the facility. Criteria 3 - All staff have received in-service education by the Administrator on 8/9/13 to assure they understand the change in the facility Evacuation Plan. Criteria 4 - The Maintenance Supervisor will use the CQI tool, ES-3 on a monthly basis X 2, then quarterly thereafter to assure that means of egress is arranged in accordance with NFPA standards. Criteria 5	8/9/13
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, forty-two (42)	K 072		

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K 072	Continued From page 3 residents, staff and visitors. The facility is certified for Seventy-Three (73) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure snack machines and ice machines were not stored in the exit corridor. The findings include: Observation, on 07/03/13 at 1:15 PM with the Maintenance Supervisor, revealed a snack machine, a soda machine, and an ice machine were stored in the corridor at the side doors exit. Interview, on 07/03/13 at 1:15 PM with the Maintenance Supervisor, revealed he was unaware the vending machines could not be stored in the egress corridors. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072		