

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

PRINTED: 07/30/2014
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 07/10/2014
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	INITIAL COMMENTS AMENDED A Recertification/Abbreviated Survey (KY #21914 and KY #21916) was conducted on 07/07/14 through 07/10/14 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 being a "D". KY#21914 was unsubstantiated with an unrelated deficiency and KY#21916 was unsubstantiated with no deficiencies.	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 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, and record review, it was determined the facility failed to provide or arrange services by qualified persons in accordance with each resident's written plan of care for two (2) of fifteen (15) sampled residents (Resident #2 and #13) and one (1) unsampled resident (Resident B). The facility failed to change an Alleevyn dressing to an opened scratched scabbed area on Resident #13's right elbow every three (3) days, apply heel boots to Resident #2's feet, and ensure Resident B's call light was within reach.	F 282	F 282 Comprehensive Care Plans The services provided or arranged by the facility shall be provided by qualified persons in accordance with each resident's written plan of care: Criteria #1 – Resident #B has his/her call light easily accessible when in room as determined by documented staff observations on 7/11/14, 7/13/14, and 7/16/2014 Resident # 2's heel boots are being applied in accordance with MD orders. Resident #2's care plan has been updated to include floating his/her heels while in bed if resident removed those, due to his/her frequent removal of them. His/her heels are being elevated on pillows or via heel lift boots when in bed as determined by		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Toni D. Humes TITLE: Administrator (X6) DATE: 7/30/14

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 282	<p>Continued From page 1 The findings include:</p> <p>Interview, on 07/10/14 at 2:20 PM with Corporate Nurse Consultant (CNC), revealed the facility did not have a policy to address following the care plan. The CNC stated staff know to follow the care plan.</p> <p>1. Record review revealed the facility admitted Resident #13 on 05/12/14 with diagnoses which included Diabetes Mellitus, Anemia, Schizophrenia, Hypercholesteremia, Thrombocytopenia, Coronary Artery Disease, and Tardive Dyskinesia. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 06/09/14, revealed the facility assessed the resident's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of four (4) which indicated the resident was not interviewable.</p> <p>Review of the Comprehensive Plan of Care, last revised 07/06/14, revealed the resident was at risk for pressure ulcers related to decreased mobility, poor safety awareness, and incontinence. An intervention, dated 07/06/14, revealed staff should apply an Allevyn dressing to open scratched scabbed area on the right elbow and change every three (3) days and as necessary. Check every shift for signs and symptoms of infection.</p> <p>Observation of Resident #13, on 07/10/14 at 8:25 AM, 8:45 AM and 10:00 AM revealed the resident was sitting in a wheelchair with a dressing on the right elbow dated "7/6" which was four (4) day prior.</p> <p>Review of the July 2014 Treatment Administration</p>	F 282	<p>documented staff observations on 7/11/14, 7/13/14, 7/16/14 and 7/18/2014. Resident # 13's treatment is being provided in accordance with MD orders as determined by administrative nurse observation and TAR reviews on 7/13 and 7/16/2014, the order was discontinued on 7/18/2014.</p> <p>Criteria #2 – An audit of all resident rooms was completed on 7/11/2014 by the Administrator to determine that all call lights were easily accessible to residents. An audit of resident ancillary orders was completed on 7/18/14 by Administrative nurses to determine that physician orders for items including but not limited to: heel boots and HOB elevation were being followed. Treatment observations were performed on 7/11/14, 7/13/14, 7/16/14 and 7/18/14) by the ADON and her designees to determine that treatments were being completed as per MD order(s).</p> <p>Criteria #3 – Nursing staff members received in-service education on the requirements of F 282, including, but not limited to: (1) keeping resident call lights easily accessible to residents; and (2) applying skin care devices such as heel boots in accordance with the care plan and MD orders as provided</p>	

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F 282	<p>Continued From page 2</p> <p>Record (TAR) revealed the last time the dressing was changed was on 07/06/14.</p> <p>Interview, on 07/10/14 at 10:05 AM with Charge Nurse (CN)/Registered Nurse (RN) #2 revealed dressing changes were to be completed by the medication nurse. The CN/RN #2 verified the Treatment Administration Record (TAR) and stated the dressing should have been changed every three (3) days and as needed. She examined the dressing on Resident #13's elbow and stated the dressing dated 07/06/14 should have been changed on 07/09/14.</p> <p>Interview, on 07/10/14 at 10:10 AM with the Interim Director of Nursing (DON), revealed the dressing should have been changed on 07/09/14.</p> <p>Interview, on 07/10/14 at 10:13 AM with Licensed Practical Nurse (LPN) #2, revealed the dressing should have been changed on 07/09/14.</p> <p>2. Record review revealed Resident #2 was admitted to the facility on 02/24/1999 with diagnoses which included Psychosis, Hemiplegia, Epilepsy, Chronic Obstructive Pulmonary Disease, Trauma, History of Head Injury, and Asphyxia. Review of the Quarterly MDS assessment, dated 05/14/14, revealed the facility assessed Resident #2's cognition as severely impaired with a BIMS score of three (3) which indicated the resident was not interviewable and he/she was totally dependent on staff for activities of daily living.</p> <p>Review of Resident #2's Comprehensive Care Plan, dated 01/07/14, and the July 2014 Certified Nurse Aide (CNA) Care Plan, revealed an intervention, dated 05/08/14, to ensure heel</p>	F 282	<p>by the DON/ADON on 7/21/2014 & 7/28/2011</p> <p>Licensed nursing staff members received in-service education on following MD orders including, but not limited to: checking the dates on treatment dressings daily to determine compliance with the MD treatment orders.</p> <p>Criteria #4 – The CQI tool for the monitoring of Care Plan Compliance shall be utilized monthly for 2 months and then quarterly as per established CQI calendar under the supervision of the DON. Results of the audits will be reported to the QA Committee by the DON or Designee each month it is completed. If an accepted threshold of compliance is not achieved, the DON or Designee shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. The QA Committee members are comprised of but not limited to; Administrator, DON, Medical Director and Department Managers</p> <p>Criteria #5 – 8/1/14</p> <p>F 323 Free of Accident Hazards/Supervision/Devices</p>	8/1/14

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F 282	<p>Continued From page 3 protectors are in place at all times.</p> <p>Observations on 07/08/14 at 3:35 PM and 3:56 PM, on 07/09/14 at 2:55 PM and on 07/10/14 at 1:20 PM, revealed Resident #2 did not have heel boots on.</p> <p>Interview with the Assistant Director of Nursing (DON), on 07/10/14 at 12:40 PM, revealed Resident #2 was care planned for heel boots and the staff should have ensured the resident had heel boots on at all time.</p> <p>3. Record review revealed Resident B was admitted to facility on 10/27/12 with diagnoses which included Acute Bronchitis, Obstructive Chronic Bronchitis with Exacerbations, Diabetes Mellitus, Cardiac Disease, and Falling. Review of the Quarterly MDS assessment, dated 05/13/14, revealed the facility assessed Resident B's cognition as moderately impaired with a BIMS score of eight (8) and the resident was totally dependent on staff.</p> <p>Review of Resident B's Comprehensive Care Plan, last revised 10/24/13, for at risk for falls, revealed an intervention to ensure call light was within reach, encourage resident to use it for assistance as needed and provide a prompt response to all requests for assistance.</p> <p>Observation on 07/07/14 at 06:25 PM, 7:50 PM, and 8:23 PM revealed Resident B's call light was on the floor under the bed.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 07/07/14 at 8:10 PM, revealed staff conduct rounds every two (2) hours.</p>	F 282	<p>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.</p> <p>Criteria #1: The emergency call light cords for the resident bathrooms for rooms 113 and 114 were lengthened to accommodate resident needs by the maintenance department on 07/10/14. Resident #B has his/her call light easily accessible when in room as determined by documented staff observations on 7/11/14, 7/13/14 and 7/18/14 Resident # 7's safety alarm is being applied and functioning properly as determined by documented staff observations on 7/11/14, 7/13/14, and 7/18/14</p> <p>Criteria #2: An audit of all resident rooms was completed on 7/11/14 by the Administrator to determine that all call lights were easily accessible to residents. An audit of all resident bathroom emergency call light cords was completed on 7/10/14 by the maintenance department. All were noted to be of adequate length. An audit of all resident personal alarms was completed on 7/11/14 by nursing administrative staff to determine that all were properly applied and functioning.</p>		

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F 282	Continued From page 4 Interview, on 07/07/14 at 8:23 PM with CNA #4, revealed he had no idea where the call light was but with further investigation he found it under the bed. He stated the resident was supposed to have the call light in place so the resident could contact staff. Interview with the Assistant Director of Nursing (ADON), on 07/10/14 at 12:40 PM, revealed the purpose of the care plan to provide staff with the information they needed to provide care to the residents. She stated she expected the staff to follow the care plans. Interview with the CNC, ADON and DON, on 07/10/14 at 11:00 AM, revealed the care plan was a directive as to what care staff should provide to each resident. They stated they expected the staff to follow the care plans.	F 282	<p>Criteria #3: – Nursing staff members received in-service education on the facility's personal alarm policy which includes checking for proper functioning of the alarm each time it is applied, and applying the alarm in accordance with the care plan - as provided by the DON/ADON on 7/10/2014, 7/21/2014 and 7/28/2014.</p> <p>All nursing and housekeeping staff have received in-service education on residents' access to call light cords and to report any problems with call light cords to maintenance for repair (this includes bedside call lights and bathroom call lights), as provided by the DON/ADON on 7/10/2014, 7/21/2014, and 7/28/2014.</p> <p>Criteria #4: The CQI tool for the monitoring of Care Plan Compliance related to the use of safety devices and prevention of accidents/hazards shall be utilized monthly for 2 months and then quarterly as per established CQI calendar under the supervision of the DON. Results of the audits will be reported to the QA Committee by the DON or Designee each month it is completed. If an accepted threshold of compliance is not achieved, the DON or Designee shall immediately develop</p>		
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 and review of facility policy and procedures, it was determined the facility failed to ensure each resident had adequate supervision and assistive devices to prevent accidents for one (1) of fifteen (15)	F 323			

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F 323	<p>Continued From page 5</p> <p>sampled residents (Resident #7) and one (1) unsampled resident (Resident B). Resident B's call light was observed on the floor not in reach of the resident for over two (2) hours and on 05/11/14, a sensor pad alarm was implemented for Resident #7; however, observation on 07/09/14 revealed Resident #7's sensor pad alarm was observed to be off. Additionally, call light cords in two (2) resident bathrooms (Room #113 and #114) were not at an adequate length to ensure resident's would be able to call for assistance if needed.</p> <p>The findings include:</p> <p>Review of the facility's procedure, titled "Resident Safe Environment", last revised 12/07, revealed the call lights should be within reach of residents.</p> <p>1. Observations on 07/08/14 at 10:25 AM and on 07/09/14 at 8:05 AM, 8:50 AM, 9:00 AM and 12:30 PM revealed the bathroom call light cords in Rooms #113 and #114 did not extend any further than 10 (ten) centimeter from the bathroom call light.</p> <p>Interview, on 07/09/14 at 1:05 PM with the Assistant Director of Nursing (ADON) revealed the bathroom call light cords should be within reach and the 10 (ten) centimeter chain would not be of adequate length for all residents at all times.</p> <p>2. Record review revealed the facility admitted Resident B on 10/27/12 with diagnoses which included Acute Bronchitis, Obstructive Chronic Bronchitis with Exacerbations, Diabetes Mellitus, Cardiac Disease, and Falling. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 05/13/14, revealed the facility assessed</p>	F 323	<p>and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting.</p> <p>The maintenance department shall review the maintenance log for needed repairs daily (M-F). The CQI tool for the monitoring of emergency call light cords shall be completed monthly X2, and then every 6 months as per established CQI calendar under the supervision of the administrator. Results of the audits will be reported to the QA Committee by the Maintenance Director or Designee each month it is completed. If an accepted threshold of compliance is not achieved, the DON or Designee shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. The QA Committee is comprised of but not limited to the Administrator, DON, Medical Director, and Department Managers.</p> <p>Criteria #5: 8/1/14</p> <p>F 441 INFECTION CONTROL, PREVENT SPREAD, LINEN The facility shall establish and maintain</p>	8/1/14

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F 323	Continued From page 6 Resident B's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of eight (8) and the resident was totally dependent on staff. Observation, on 07/07/14 at 6:25 PM, 7:50 PM, and 8:23 PM revealed Resident B's call light was on the floor under the bed. Interview, on 07/07/14 at 08:23 PM with Certified Nurse Aide (CNA) #4 revealed the resident's call light should be in reach so the resident could call for assistance if needed. The CNA traced the call light cord to underneath the bed and placed the cord within reach of the resident. 3. Record review revealed the facility admitted Resident #7 on 12/30/09 with diagnoses which included Anxiety Disorder, Alzheimer's, and Generalized Osteoarthritis and backache secondary to Degenerative Joint Disease. Review of the Quarterly MDS assessment, dated 05/05/14, revealed the resident's cognition was severely impaired with a Brief Interview Mental Status (BIMS) coded as ninety-nine (99) which indicated the resident was no interviewable. He/She required one (1) person assist for ambulation and transfers. Review of facility Event Reports, dated 02/01/14, 04/03/14 and 05/11/14, revealed Resident #7 had sustained falls. On 05/11/14, a sensor pad alarm was chosen as the intervention. Review of the Comprehensive Care Plan, initiated 05/11/14, revealed Resident #7 was at risk for falls and an intervention to provide a sensor pad to bed, recliner and wheelchair. Review of the July 2014 SRNA Care Plan Record revealed	F 323	an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Criteria # 1: Resident #2 is provided care in a manner to help prevent the development and transmission of disease and infection as determined by documented care observation performed by administrative nurses on 7/11/2014, 7/13/2014 and 7/18/2014. Criteria # 2: Random resident care observations were done on 7/11/2014, 7/13/2014 and 7/18/2014 by administrative nurses to determine that resident care is being provided in a manner to help prevent the development and transmission of disease and infection. Criteria # 3: SRNA's received in-service education on hand washing and infection control practices when providing care as provided by the DON/ADON on 7/10/2014, 7/21/2014 & 7/28/2014). Criteria # 4: The QA indicator tool for the monitoring of infection control shall be utilized monthly X 2 months and then quarterly as per established QA calendar under the supervision of the Director of Nursing. Results of the		

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F 323	Continued From page 7 Resident #7 was to have a sensor pad alarm to wheelchair, recliner and bed. Observation, on 07/09/14 at 8:32 AM, revealed Resident #7 was in a recliner and the sensor alarm was not blinking. At 8:40 AM, Registered Nurse (RN) #2 and another staff member assisted the resident up out of recliner to check the sense alarm and the alarm did not sound. RN#2 then proceeded to turn on the alarm. Interview with SRNA#3, on 07/09/14 at 9:00 AM, revealed she had provided personal care to Resident #7 and stated that she was unsure if she checked to see if the sensor alarm was functioning properly or if the sensor alarm was on or off. Interview with the Director of Nursing (DON), on 07/09/14 at 3:43 PM, revealed her expectation was when residents were provided care staff should check the functionality of the alarms and ensure alarms were in place.	F 323	audits will be reported to the QA Committee by the Director of Nursing or Designee each month it is completed. If an accepted threshold of compliance is not achieved, the DON or Designee shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. The QA Committee is comprised of but not limited to the Administrator, DON, Medical Director and Department Managers. Criteria # 5: 8/1/2014	8/1/14
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		

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F 441	Continued From page 8 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policy and procedures, it was determined the facility failed to ensure appropriate hand washing and glove application during personal care for one (1) of fifteen (15) sampled residents (Resident #2). State Registered Nurse Aide (SRNA) #4 and SRNA #5 gloved then touched an oxygen concentrator, privacy curtains, tube feeding and IV poles, a rolled up floor mat, bed, and cord to the oxygen concentrator and then touched Resident #2's Texas catheter without changing gloves and	F 441			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 9 washing hands.</p> <p>The findings include:</p> <p>Review of the facility's Infection Control policy, not dated, revealed it was the policy of the facility to provide a safe sanitary and comfortable environment. The facility will investigate, control, and attempt to prevent the development and transmission of infections. "1. This facility's infection control policies and procedures will apply equally to all personnel, residents, visitors, volunteer workers, and the general public alike, regardless of race, color, creed, national origin, religion, age, sex, handicap, and marital or veteran status. 2. The objectives of our infection control policies and procedures are to: a) Investigate, control, and prevent infections in the facility; b) maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public.</p> <p>Review of the facility's policy "Gloves", not dated, revealed gloves shall be worn when handling blood, fluids, secretions, excretions, mucous membranes and/or non-intact skin. 3. The use of gloves will vary according to the procedure involved. The use of disposable gloves is indicated for procedures where blood, body fluids, secretions, excretions, mucous membranes and/or non-intact skin are handled and includes the following circumstances: If handling soiled items that may be contaminated; during all cleaning of blood, body fluids, and decontaminating procedures. Handwashing/hand antisepsis is necessary when gloves are removed.</p> <p>Review of the facility's policy "Handwashing", not</p>	F 441			

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F 441	Continued From page 10 dated, revealed handwashing and hand antiseptis shall be regarded by this facility as the single most important means of preventing the spread of infections. 2) If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations described in items d-j (alternatively wash hands with an antimicrobial soap and water in these clinical situations; d) before having direct contact with residents, i) After contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident, j) after removing gloves, and k) whenever in doubt. 4) The use of gloves does not replace handwashing/hand antiseptis. 6) Change gloves during care if moving from a contaminated-body site to a clean-body site. Record review revealed the facility admitted Resident #2 on 02/24/1999 with diagnoses which included Psychosis, Hemiplegia, Epilepsy, Chronic Obstructive Pulmonary Disease, Trauma, History of Head Injury, and Asphyxia: Review of the Quarterly Minimum Data Set (MDS) assessment, dated 05/14/14, revealed the facility assessed Resident #2's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) and the resident was totally dependent on staff. Observation, on 07/09/14 at 2:55 PM of SRNA #4 and SRNA #5 providing personal care to Resident #2, revealed the SRNAs gloved after coming into the resident's room and then proceeded to touch touch the privacy curtains, an oxygen concentrator, tube feeding and intravenous pole, a rolled up floor mat, bed, and cord to the oxygen concentrator. The SRNAs failed to remove the gloves and wash their hands prior to touching the	F 441			

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F 441	Continued From page 11 resident's Texas urinary catheter. Interview, on 07/09/14 at 3:10 PM with SRNA #4, revealed he touched the draw sheet, bed, oxygen cord, power cord, tube feeding pump and did not take old gloves off or wash hands or put on new gloves. He stated he was taught to change gloves, wash hands and reglove after touching objects and before providing care. Interview, on 07/09/14 at 3:10 PM with SRNA #5, revealed she touched the door, the privacy curtain, the call light, the floor mat, the remote control, the oxygen cord, the pumps and did not change gloves/wash hands and that could cause cross contamination. She stated they should have situated everything then washed hands and put on gloves. Interview, on 07/09/14 at 4:15 PM with the Director of Nursing (DON), revealed she expected staff to change gloves, wash hands and reglove prior to providing care to the resident.	F 441			

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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 000	<p>INITIAL COMMENTS</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 (211).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1965, and upgraded in 2005 with 21 smoke detectors and 0 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 07/08/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for seventy-three (73) beds with a census of fifty-nine (59) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		



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

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

7/28/14

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

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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "F" level.	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 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for seventy-three (73) beds and at the time of the survey, the census was fifty-nine (59). The findings include: Observation, on 07/08/14 at 1:15 PM with the Maintenance Supervisor, revealed the lobby side of the fire doors on the 100 hall did not have an exit sign located above the fire doors. Interview, on 07/08/14 at 1:16 PM with the Maintenance Supervisor, revealed he was unaware the exit signs in the facility were required to be on both sides of the fire doors.	K 047	K 047 Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. Criteria 1 – The lobby side of the fire doors on the 100 hall have had an exit sign located above the fire doors. An exit sign pointing toward the front exit at the lobby side of the 200 hall were added on 7/9/2014. Criteria 2 – All four smoke compartments were inspected by the Administrator and Maintenance Supervisor using an auditing tool on 7/9/2014 to determine if any other areas were at risk to affect residents, staff, and visitors. No further areas were identified. Criteria 3 – The Maintenance Supervisor has received in-service education from the Administrator on 7/9/2014 to assure that exit and directional signs are displayed in accordance with section 7.10 with continuous illumination and that exit signs are located on both sides of the fire doors.. Criteria 4 – The QA indicator tool will be utilized by the maintenance supervisor monthly X 2 then quarterly thereafter to identify potential issues with exit or directional signs above fire doors. Findings of the audits will be brought to the QA meeting by the maintenance director or designee each month it is completed. If an accepted threshold of compliance is not achieved, the maintenance director or designee will immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with the updated audit results, at the next monthly meeting. The QA committee includes, but is not limited to, the	

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K 047	Continued From page 2 Observation, on 07/08/14 at 2:30 PM with the Maintenance Supervisor, revealed no exit sign pointing toward the front exit at the lobby side of the fire doors on the 200 hall.	K 047	Administrator, DON, Medical Director, Maintenance Supervisor, and Department Mangers Criteria 5	7/26/2014
K 052 SS=F	Interview, on 07/08/14 at 2:31 PM with the Maintenance Supervisor, revealed he was unaware one (1) side exits was taken away, then a new exit sign was required to direct you through the front. The census of fifty-nine (59) was verified by the Administrator on 07/08/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 07/08/14. Actual NFPA Standard: Reference: NFPA 101.(2000 edition) 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction 7.10.5 Illumination of Signs. 7.10.5.1* General. Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible In both the normal and emergency lighting mode. NFPA 101 LIFE SAFETY CODE STANDARD	K 052	K052 A fire alarm system required for life safety is installed, tested and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72.. Criteria 1 -- The fire alarm charger, battery, discharge, and low voltage tests were conducted and documented by the fire alarm inspecting and testing company used by this facility. On 7/10/2014 no issues were found. Criteria 2 -- The maintenance supervisor and administrator reviewed all other required testing to ensure no other tests were required and not done on 7/10/2014, no other issues were found.. Criteria 3 -- The maintenance supervisor and his assistant have received in-service education by the Administrator on 7/10/2014 on the required annual testing Criteria 4 -- The Maintenance Supervisor will use a QA monitoring tool on a monthly basis X 2, then quarterly thereafter to assure that all required testing are conducted in accordance with NFPA standards. Findings of the audits will be reported to the QA Committee by the Maintenance Supervisor each month it is completed. If an accepted threshold of compliance is not achieved, the DON or Designee shall immediately develop and oversee a corrective plan. The details of the corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. The QA Committee includes, but is not limited to, the Administrator, DON, Medical Director, Maintenance Supervisor, and Department Managers..	

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K 052	Continued From page 4 Maintenance Supervisor, revealed he was unaware the inspection company was to perform a charger test on the fire alarm batteries on an annual basis. Fire alarm inspection review, on 07/08/14 at 11:25 AM with the Maintenance Supervisor, revealed the discharge test was not documented on the fire alarm inspection paperwork. Interview, on 07/08/14 at 11:26 AM with the Maintenance Supervisor, revealed he was unaware the inspection company was to perform a discharge test on the fire alarm batteries on an annual basis. Fire alarm inspection review, on 07/08/14 at 11:30 AM with the Maintenance Supervisor, revealed the load voltage test was not documented on the fire alarm inspection paperwork. Interview, on 07/08/14 at 11:31 AM with the Maintenance Supervisor, revealed he was unaware the inspection company was to perform a load voltage test on the fire alarm batteries on a semi-annual basis. The census of fifty-nine (59) was verified by the Administrator on 07/08/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 07/08/14. Actual NFPA Standard: Reference: NFPA 101 (2000 ed.), 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70,	K 052		

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K 052	Continued From page 5 National Electrical Code, and NFPA 72, National Fire Alarm Code.	K 052			