

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

PRINTED: 11/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2011
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard Health survey was initiated on 11/15/11 and concluded on 11/17/11 and the Life Safety Code survey was conducted on 11/17/11 with highest scope and severity at an "F". An abbreviated survey was initiated on 11/15/11 and concluded on 11/17/11 investigating KY17258. The Division of Health Care substantiated the allegation and Federal deficiencies were cited.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225	F 225 Investigate/Report Allegations 1. Resident #14 grievance of missing radio has had an investigation completed. Missing item has been reported to OIG/APS per regulation 2. Review of last 30 days of grievance will be completed to ensure thorough investigation and appropriate reporting to state agencies has been completed.	

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

TITLE

(X6) DATE

X John Schmitt

X Executive Director

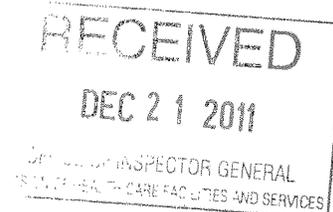
X 12-16-11

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 225	<p>Continued From page 1 prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of grievance forms, and facility policy, it was determined the facility failed to investigate and report an allegation of misappropriation of resident property for one (1) of twenty-four (24) sampled residents (Resident #14). Resident #14 reported a missing stereo on 10/19/11. The facility failed to initiate an investigation and failed to report the missing resident property to the appropriate state agencies.</p> <p>The findings include: Review of the facility's policy Investigation and Reporting of Alleged Violations Involving Abuse, Neglect, Injuries of Unknown Source and Misappropriation of Resident's Property, dated 07/01/2010, revealed it was the policy of the facility to report allegations of misappropriation of resident's property to the administrator immediately and the administrator would report the misappropriation to the state agencies as required by law. The Administrator would then</p>	F 225	<p>Continue from pg 1.</p> <p>3. Director of Clinical education, director of Nursing and Executive Director will in-service current staff on abuse, investigations and reporting process.</p> <p>4. Facility will monitor grievances Monday through Friday at ED stand-up meeting by Executive Director.</p> <p>5. Pattern and trends of grievance will be reviewed at monthly QAA committee for any necessary systematic change by social worker.</p> <p>Completion Date: 12-26-11</p>		



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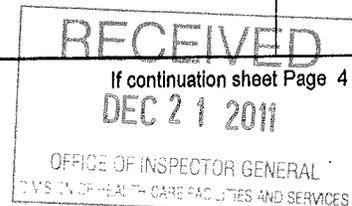
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F 225	<p>Continued From page 2</p> <p>report the results of all investigations to the state agencies. The investigation will include interviews of employees, visitors, residents and volunteers who may have knowledge of the alleged incident. The documentation of the investigation shall be kept in the administrator's office in a secure file. The Verification of Investigation Form shall be completed after the investigation is completed and provided to survey agencies as required by law.</p> <p>Review of the Grievance Form for Resident #14, completed on 10/19/11, revealed the resident reported a missing stereo to the facility. A search of the basement and the resident's room by the facility failed to locate the stereo. The facility purchased a new stereo for the resident. The administrator and social services signed the report as reviewed and resolved on 10/21/11.</p> <p>Review of the clinical record for Resident #14 revealed the facility admitted the resident on 06/15/11 with diagnoses of Aspiration and Dysphagia. The facility completed a quarterly Minimum Data Set (MDS) assessment on 09/07/11 which indicated the resident was capable of making independent daily care decisions.</p> <p>Interview with Resident #14, on 11/16/11 at 10:20 AM, revealed the resident reported a stereo missing to the facility. The resident reported no knowledge of who may have taken the stereo from the room; however, the facility purchased a replacement stereo for the resident.</p> <p>Interview with the Social Services Director, on 11/17/11 at 3:10 PM, revealed she was</p>	F 225		

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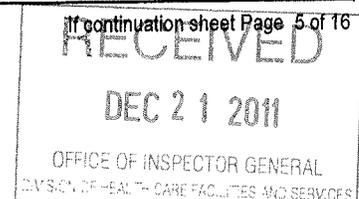
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F 225	Continued From page 3 responsible to investigate the complaint from Resident #14. She stated she talked with housekeeping and nursing and searched the basement without success. She indicated she had no documentation to verify an investigation, including interviews, was completed. She stated she determined the incident was a grievance and filled out a grievance report. She revealed she had recently received in-service training on abuse; however, she had not considered the incident as misappropriation of resident property and did not know if the facility was obligated to notify the state agencies. Interview with the Administrator, on 11/17/11 at 3:30 PM, revealed the facility was unable to verify that Resident #14 owned a stereo therefore, the incident was not considered to be misappropriation of resident's property. He stated he understood the missing stereo incident should have been investigated and reported to the state agencies.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, grievance form reviews and facility policy review, it was determined the facility failed to implement policies and procedures for investigating and reporting misappropriation of resident's property for one (1)	F 226	F 226 Develop/Implement Abuse/Neglect Policies 1. Resident #14 grievance of missing radio has had an investigation completed. Missing item has been reported to OIG/APS per regulation	



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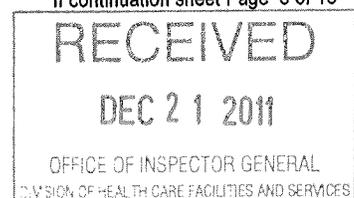
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F 226	<p>Continued From page 4</p> <p>of twenty-four (24) sampled residents (Resident #14). The facility received a report of a missing stereo from Resident #14 and the facility failed to initiate an investigation or report the misappropriation to the state agencies as required by law.</p> <p>The findings include:</p> <p>Review of the facility's policy for Investigation and Reporting of Alleged Violations Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Origin and Misappropriation of Resident's Property, dated 07/01/10, revealed the administrator would direct a thorough investigation of each such alleged violation. The administrator would report the alleged violation to the state agencies as required by law.</p> <p>Review of the facility's Grievance Form revealed the facility received a report of a missing stereo from Resident #14 on 10/19/11. The facility searched the resident's room and the basement with no success. The facility purchased a new stereo for the resident. The administrator and social services reviewed the grievance as resolved and signed off on 10/21/11.</p> <p>Review of the clinical record for Resident #14 revealed the facility admitted the resident on 06/15/11. The resident had diagnoses of Dysphagia and Aspiration. The facility completed a quarterly Minimum Data Set (MDS) assessment for Resident #14 on 06/22/11. The MDS assessment revealed the resident was capable of making daily care decisions independently.</p> <p>Interview with Resident #14, on 11/16/11 at 10:20</p>	F 226	<p>2. Review of last 30 days of grievance will be completed to ensure thorough investigation and appropriate reporting to state agencies has been completed.</p> <p>3. Director of Clinical education, director of Nursing and Executive Director will in-service current staff on abuse, investigations and reporting process.</p> <p>4. Facility will monitor grievances Monday through Friday at ED stand-up meeting by Executive Director.</p> <p>5. Pattern and trends of grievance will be reviewed at monthly QAA committee for any necessary systematic change by social worker.</p> <p>Completion Date: 12-26-11</p>	



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F 226	Continued From page 5 AM, revealed the resident was alert and oriented and remembered the missing stereo complaint. The resident stated the social services staff searched the room and the basement and did not locate the stereo. The resident stated the facility replaced the missing stereo. Interview with the Social Services Director, on 11/17/11 at 3:10 PM, revealed she received a complaint from Resident #14 on 10/19/11 regarding a missing stereo. She indicated she searched the resident's room and the basement, however, she found no stereo. She stated she talked with nursing and housekeeping regarding the stereo. She determined the complaint was a grievance and completed a grievance form. She stated she did not have documentation of an investigation. She revealed she received inservice training on abuse two (2) months ago by the facility educator, however, she was unable to outline the facility policy on reporting misappropriation of resident's property. Interview with the Administrator, on 11/17/11 at 3:30 PM, revealed he knew Resident #14 complained of a missing stereo; however, he was not able to verify the resident had a stereo so the incident was determined to be a grievance and not misappropriation of resident's property. He stated there was no documentation of an investigation into the incident nor was the missing personal property reported to the state agencies. He revealed knowledge of the facility's abuse policy for investigating and reporting misappropriation of resident's property.	F 226		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253	F 253 Housekeeping and Maintenance 1. Room 316 clutter was removed on 11/15/11, Room 304 and room 306 were deep cleaned and 309 door repaired.	



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F 253	<p>Continued From page 6</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined the facility failed to maintain sanitary conditions in two (2) resident rooms and maintain a orderly resident room where clutter prevented safe movement of a resident's wheelchair. The facility failed to maintain a homelike environment for residents in the facility. Room 304 had a strong musty odor along with a urine smell coming from the carpet. Room 306 had a strong urine odor coming from the carpet.</p> <p>The findings include:</p> <p>Observations, on 11/15/11 at 1:55 PM, revealed Room 316 floor was cluttered with cartons of soft drinks, plastic bags containing packaged food items partially blocking the entrance to the room. The clutter at the end of bed one (1) prevented wheelchair access to enter or exit Room 316 for the resident in bed two (2).</p> <p>Observations, on 11/15/11 at 1:55 PM, revealed the bathroom door in Room 309 was splintered at the bottom right side of the door.</p>	F 253	<p>2. Maintenance Director and Housekeeping Manager will complete Audit of resident rooms for necessary maintenance/housekeeping opportunities. Opportunities will be corrected as identified based on availability of contractors or supplies.</p> <p>3. Education will be completed by Maintenance Director on proper reporting process for repairs, maintenance and housekeeping issues. Administrative staff (Social Service, Activities, M DS, ADNS, DNS, DCE and FBOC) will complete non-clinical rounds weekly. Rounds will address resident rooms, hallways, resident dignity, shower rooms and common areas. All issue will be brought to daily stand-up daily.</p>

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F 253	Continued From page 7 Interview with the Director of Maintenance, on 11/17/11 at 10:15 AM, revealed he was unaware of the splintered door and had no work order. Observations, on 11/15/11 at 1:55 PM, revealed a musty urine odor in resident room 304. The carpet in the center area of the room had stain discolorations. Room 306 also had an odor of urine coming from the carpet and the carpet was sticky when walked on. Interview with the Director of Housekeeping, on 11/17/11 at 10:15 AM, revealed he confirmed the odor of urine was present in both rooms 304 and 306. Observations of Room 304, on 11/15/11 at 4:00 PM and 11/16/11 at 12:25 PM, revealed a strong musty foul odor coming from the floor especially around bed 1. Observation of Room 306, on 11/15/11 at 4:00 PM and 11/16/11 at 12:25 PM, revealed a strong urine odor from the floor. Observation of Housekeeping Staff on the 200 and 300 wings, on 11/15/11 at 3:30 PM and on 11/16/11 at 9:00 AM and 11:00 AM, revealed housekeepers spraying a pinkish liquid into the air and onto carpets.	F 253	4. Results of weekly non-clinical rounds will be compiled and reviewed at ED stand up meeting weekly for trends and patterns. Result of round will be reported at monthly QAA committee. 5. Results of rounds will be reported at monthly QAA committee. Completion Date: 12-26-11		

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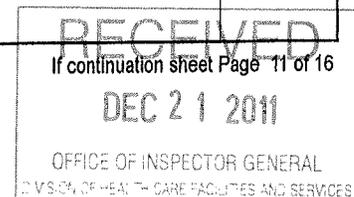
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F 281	<p>Continued From page 9</p> <p>resident on 10/05/11 which revealed the resident had an unhealed abdominal surgical wound with infection, an abscess of the buttock with a drain, a urostomy, TPN and medport. The resident was discharged to an acute care hospital on 10/16/11 and did not return.</p> <p>Review of the initial care plan completed by the facility on 10/05/11 revealed the facility care planned a urinary tract infection, pain and high blood sugar. The facility added the care of the surgical wound, abscess, drains, urostomy and skin issues on 10/11/11, six (6) days after admission. There was no documentation provided to verify the facility addressed the TPN therapy, care of the medport, NPO (nothing by mouth) status or the extensive assistance the resident required for completion of all activities of daily living (ADL).</p> <p>Interview with Licensed Practical Nurse #2, on 11/17/11 at 2:30 PM, revealed the initial care plan was developed by the nurse using the information obtained from the assessment completed on admission. She stated the initial care plan was developed to address the resident's needs until the comprehensive care plan was developed. She indicated the wounds, TPN, ADLs, drains and urostomy should have been care planned on admission 10/05/11.</p> <p>Interview with the Director of Nursing, on 11/17/11 at 3:45 PM, revealed an initial care plan should have been developed based on the Clinical Health Status Form and that the form led the nurse to the care plan. She indicated she was unsure why the care plan did not address the resident's needs.</p>	F 281	<p>4. Director of Nursing will ensure all new admission charts are brought to ESU and audit by IDT. To ensure resident are provide needed services by appropriate staff.</p> <p>5. ADNS will bring noted issues to QA committee and will be track and trended.</p> <p>Completion Date: 12-26-11</p>		

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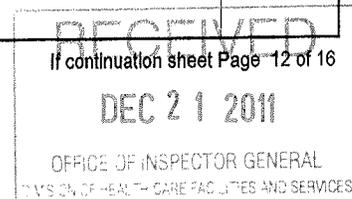
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F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies, it was determined the facility failed to ensure sanitary food handling of steam table pans on two (2) of two (2) dining rooms. In addition, a staff member handled a resident's food item with her bare hands.</p> <p>The findings include: Observations of the lunch meal service, on 11/16/11 at 12:15 PM, revealed a brown substance on the brackets that hold the steam table pans. The underneath side of two (2) pans in the West/East Dining Room were coated with a dark brown sticky substance. One of the pans had a white substance on the inside of the pan. In the North Dining room there was a brown substance on the outside of one (1) of the steam table pans. In addition, CNA #6 was observed placing jelly on a resident's toast and then handing the toast to the resident with her bare hands.</p>	F 371	<p>F 371 Food Procure, store/prepare/serve</p> <ol style="list-style-type: none"> 1. Pan area on steam table was cleaned and CNA #6 was in-serviced. 2. Dietary equipment will be audited for proper cleanliness by Dietary Manager. Observation of 3 meals weekly for 4 weeks to identify other potential area of opportunity will be completed by Dietician. 3. Education will be completed with Dietary department of cleanliness of procedures for dietary equipment by Dietary Manager. Staff will also be educated on proper handling of food during meal service by Director of Clinical educations. 4. Observation of 3 meals per week for 4 weeks for proper food handling by Register Dietician. Kitchen sanitation will be completed weekly for 4 weeks to ensure equipment cleanliness by Dietary manager. 	



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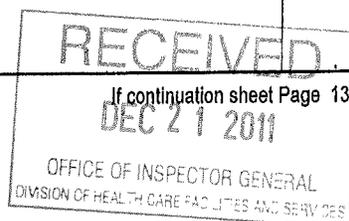
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 11 Interview with CNA #6, on 11/17/11 at 8:00 AM, revealed she was unaware that the use of hand sanitizer did not allow one to handle a resident's food with bare hands. Interview with the Dietary Director, on 11/17/11 at 10:45 AM, revealed the steam tables were cleaned after each meal and weekly. The director could not explain why the water pans were not included in that cleaning process.	F 371	5. Meal observation and Kitchen observations will be trended for patterns for 4 weeks and reported to QAA for 3 months by Dietary manager and Dietician. Completion date: 12-26-11	
F 441 SS=E	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, 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.	F 441	F 441 Infection control, prevent spread, Linens 1. Room 301 Oxygen tubing was change on 11-18-11, Room 305 oxygen tubing was change on 11-18-11. Resident #7 oxygen tubing was changed 11-18-11. Resident #19, resident #10 Foley Catheter was change 11-18-11. Unsampled resident B oxygen tubing was changed 11-18-11. 2. Assistant Director of Nursing to audit of current resident with respiratory equipment and Foley catheters to identify potential infection control issues.	



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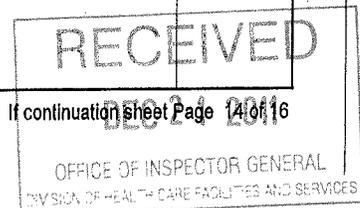
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F 441	Continued From page 12 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to maintain an Infection Control Program designed to provide a sanitary environment and help prevent the development and transmission of disease and infection related to indwelling catheter tubing and oxygen equipment. Two (2) of twenty-four (24) sampled residents, Resident #10 and Resident #29, had their indwelling catheter tubing touch the floor. One (1) of two (2) unsampled residents, Resident B, had oxygen tubing in contact with the floor and two (2) rooms out of eighteen (18) rooms observed during the tour of the facility had oxygen equipment improperly stored. The findings include: Record review of the facility policy on Catheter Care, Indwelling Catheter (Procedure 245) did not include in the procedure for the correct placement of the catheter bag or the tubing. The last step noted in the procedure was to position the	F 441	3. Education to current employees on infection control practices by Housekeeping manager, Dietary manager and Director of Clinical Education. 4. Infection control audits will be completed utilizing the infection control audit sheets. Audits will be completed by Director of Clinical Education and will be completed weekly for 4 weeks then Monthly. 5. Director of Clinical Education will present outcomes with trends and patterns of infection control audits to month QAA committee. Completion Date: 12-26-11		



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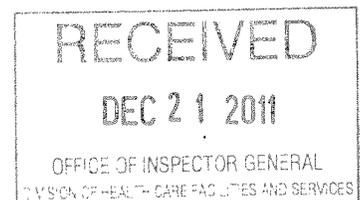
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F 441	Continued From page 13 resident comfortably with the call light within reach. Record review of the facility policy Departmental (Respiratory Therapy) Prevention of Infection (Revised April 2007) stated nebulizer masks were to be stored in a plastic bag with the date and the resident's name between uses. In addition, it stated oxygen tubing was to be kept in a plastic bag when not in use. Observation, on 11/15/11 at 8:15 AM, during the tour of the facility revealed in Room 301 on the Bed two (2) side, oxygen tubing uncovered sitting on top of a pair of shoes in the seat of a wheelchair. In Room 305 on the Bed one (1) side the oxygen tubing was coiled up on top of the oxygen concentrator, uncovered, with no date or label. Additionally, a mini-nebulizer mask was observed sitting on the bedside table uncovered. Observation, on 11/16/11 at 11:00 AM, of Resident #19 revealed his/her indwelling catheter tubing touching the floor while sitting near the nurses station for a singing activity. Additional observation at 11:47 AM revealed the indwelling catheter tubing touching the floor in the dining room during the resident's noon meal. Observations of Resident #10, on 11/15/11 at 11:45 AM, 1:00 PM, 2:00 PM, 5:15 PM, and on 11/16/11 at 7:35 AM and 8:40 AM, revealed staff had positioned the indwelling catheter drainage tubing so the tubing was in direct contact with the floor. Observation of Unsampled Resident B, on 11/15/11 at 8:45 AM, 1:00 PM, and on 11/16/11 at	F 441	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Date of Compliance: December 26, 2011 _____ Joshua L. Schindler- LNHA ____ Date		



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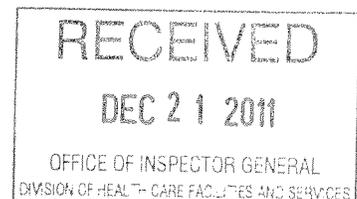
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F 441	<p>Continued From page 14</p> <p>7:40 AM and 4:00 PM, revealed facility staff had the resident's oxygen tubing draped over the end of the bed to a oxygen concentrator with the oxygen tubing in direct contact with the floor.</p> <p>Interview, on 11/17/11 at 4:45 PM, with Certified Nursing Assistant (CNA) #7 revealed oxygen tubing was to be stored in bags when not in use. Also, indwelling catheter tubing was to be secured to the resident's chair so as not to touch the floor. She stated she had been in-serviced on these infection control issues and they were monitored by the Supervisors.</p> <p>Interview, on 11/17/11 at 4:50 PM, with Registered Nurse (RN) #3 revealed oxygen tubing was to be stored in a plastic bag, dated and replaced every seven (7) days. Additionally she stated indwelling catheter tubing was never to touch the floor. "It contaminates" the tubing for it to touch the floor and puts the resident at risk for infection.</p> <p>Interview, on 11/17/11 at 4:52 PM, with CNA #4 revealed oxygen equipment was to be stored in a plastic bag when not in use. She also stated the indwelling catheter tubing was not to be on the floor because it created a potential for infection to the resident. She revealed she had been in-serviced on infection control issues related to oxygen equipment and indwelling catheter tubing. Both the nurses and CNA's monitor this issue.</p> <p>Interview, on 11/17/11 at 4:58 PM, with the Director of Nursing revealed oxygen tubing was to be stored in a bag and dated. The indwelling catheter tubing was not to touch the floor and a risk to the resident for infection was present if the</p>	F 441		



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F 441	Continued From page 15 tubing was dragging on the floor. She revealed she was responsible to monitor for infection control issues, as were all of the staff.	F 441			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION - CARE FACILITIES AND SERVICES A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
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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 V (000)</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors, installed in 2009.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Two (2) existing Type II generators, fuel source was diesel. Installation of a new 350 KW Type II generator was in progress on the day of the survey.</p> <p>A standard Life Safety Code survey was conducted on 11/16/11. Golden Livingcenter - St. Matthews was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one-hundred and twenty-five (125) beds and the census was one-hundred and seventeen (117) on the day of the survey.</p>	K 000	<p>GOLDEN LIVING CENTER @ ST. MATTHEWS</p> <p>PLAN OF CORRECTION FOR SURVEY EDNING 11/16/11</p> <p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Goldenliving @ St. Matthews does not admit the deficiencies listed on the HCFA 2567 exist nor does the facility admit to any statements, findings, facts or conclusions that form the basis of the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the alleged deficiency.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

X [Signature]

X Exclusion Needs X

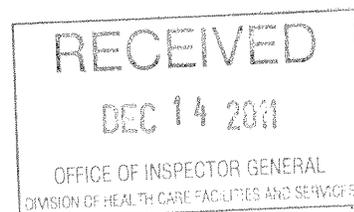
12-9-11

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

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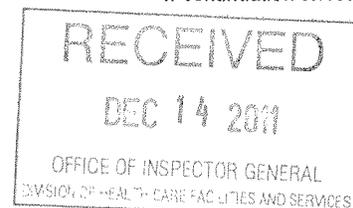
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K 000	Continued From page 1 The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000	K018 NFPA (Corridor doors to rooms 100, 101, 120 and 132 did not latch when tested).	
K 018 SS=E	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 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, according to NFPA	K 018	1. No specific Resident identified. Rooms 100,101, 120 and 132 doors are now latching. 2. All residents have the potential to be affected 3. Facility has completed audit of all doors to assure they are latching. 4. Facility Maintenance Director will complete quarterly audits. All issues will be reported and tracked in QA. Completion Date: 12-26-2011	



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K 018	<p>Continued From page 2</p> <p>standards. The deficiency had the potential to affect one (2) of seven (7) smoke compartments, approximately fifty (50) residents, staff, and visitors. The facility is licensed for one-hundred and twenty-five (125) beds and the census was one-hundred and seventeen (117) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 11/16/11 between 8:30 AM and 9:15 AM, with the Maintenance Director revealed the resident's corridor doors to rooms 100, 101, 120, and 132 did not latch when tested. Further observation at 9:40 AM revealed the corridor door to resident room 300 was being held open with a trash can.</p> <p>Interviews, on 11/16/11 between 8:30 AM and 9:15 AM, with the Maintenance Director confirmed the observation of the doors not latching and could not resist the passage of smoke in the event of a fire. Further interview at 9:40 AM, revealed the door to room 300 was held open by a trash can because the door would not stay open on its own. The Maintenance Director indicated adjustments needed to be made on the door hardware.</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</p>	K 018		



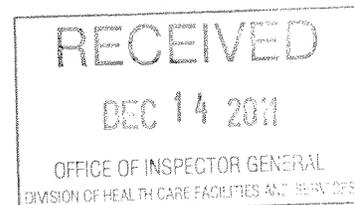
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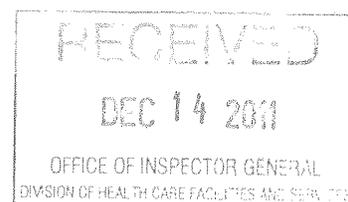
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K 018	<p>Continued From page 3</p> <p>13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire 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> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>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.</p> <p>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</p> <p>19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.</p> <p>A.19.3.6.3.3 Doors should not be blocked open by furniture,</p>	K 018		



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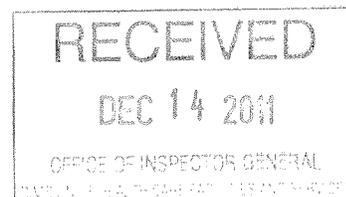
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K 018	Continued From page 4 door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
K 029 SS=D	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 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, according to NFPA Standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, approximately twenty-five (25) residents, staff and visitors. The facility is licensed for one-hundred and twenty-five (125) beds and the census was one-hundred and seventeen (117) on the day of the survey. The findings include:	K 029	K 029 NPFA 101 Life Safety Code Standard (Medical Supply room had one-quarter inch gap in fire doors) 1. No specific Resident identified (Fired rated strip has been installed) 2. All residents have the potential to be affected 3. Facility had placed fired rated strip closing gap to Medical record doors. All other doors have been audited for gaps. 4. Maintenance Director will track and trend in QA.	



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K 029	Continued From page 5 Observation, on 11/16/11 at 9:20 AM, with the Maintenance Director revealed the pair of doors to the Medical Supply Room, had a one-quarter inch gap between the doors and would not resist the passage of smoke in the event of a fire. Interview, on 11/16/11 at 9:20 AM, with the Maintenance Director confirmed the observation of the gap between the pair of doors being too large to resist the passage of smoke in the event of a fire. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms	K 029	Completion Date: 12-26-2011	



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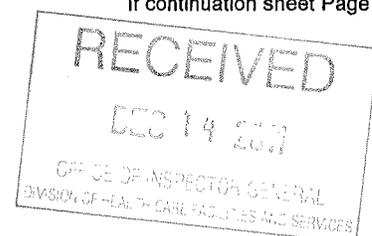
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 11/16/2011
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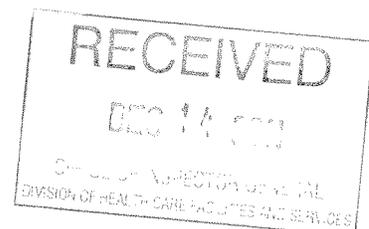
K 029	Continued From page 6 (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible 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 033 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that a stairwell was maintained according to NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments and staff. The facility is licensed for one-hundred and twenty-five (125) beds and the census was one-hundred and seventeen (117) on the day of the survey.	K 033		



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K 033	<p>Continued From page 7</p> <p>The findings include:</p> <p>Observation, on 11/16/11 at 11:00 AM, with the Maintenance Director revealed the ground floor landing of the enclosed stairs to the basement was being used for storage. Items stored in the refuge area of the stairwell were a tool box, a ladder, a wheelchair, and a light fixture. Stairwells are required to be maintained free of items that may interfere from exiting the facility.</p> <p>Interview, on 11/16/11 at 11:00 AM, with the Maintenance Director revealed the stairwell is used by staff only and should not be used to temporarily store items.</p> <p>Reference: NFPA 101 2000 edition</p> <p>7.1.3.2.3* An exit enclosure shall not be used for any purpose that has the potential to interfere with its use as an exit and, if so designated, as an area of refuge. (See also 7.2.2.5.3.)</p> <p>7.2.2.5.3* Usable Space. There shall be no enclosed, usable space within an exit enclosure, including under stairs, nor shall any open space within the enclosure be used for any purpose that has the potential to interfere with egress.</p> <p>Exception: Enclosed, usable space shall be permitted under stairs, provided that the space is separated from the stair enclosure by the same</p>	K 033	<p>K033 NFPA 101 Life Safety Code Standard (debris on the landing to the stair case going down to the basement.)</p> <ol style="list-style-type: none"> 1. No specific Resident identified (All items on the stairwell have been removed. 2. All residents have the potential to be affected 3. Facility will monitor stairwell weekly. 4. Facility Maintenance Director will monitor stairwell weekly. All issues will be tracked through morning meeting and QA process. <p>Completion Date: 12-26-2011</p>	



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K 033 Continued From page 8
fire resistance as the exit enclosure. Entrance to such enclosed usable space shall not be from within the stair enclosure. (See also 7.1.3.2.3.)

K 050 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2

This STANDARD is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, according to NFPA standards. The deficiency had the potential to affect each of the seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for one-hundred and twenty-five (125) beds and the census was one-hundred and seventeen (117) on the day of the survey.

The findings include:
Record review, on 11/16/11 at 1:00 PM, with the Maintenance Director revealed the fire drills were not being conducted quarterly, on each shift at random times. There was no record of fire drills

K 033

K 050

K 050 NFPA 101 Life Safety Code Standard (Fire Drills to be completed Quarterly).

1. No specific Resident identified(Missing fire drill was completed this month)
2. All residents have the potential to be affected
3. Facility Maintenance Director will assure fire drills are completed quarterly.
4. Maintenance Director will track all fire drills monthly and report on during QA monthly.

Completion Date: 12-26-2011



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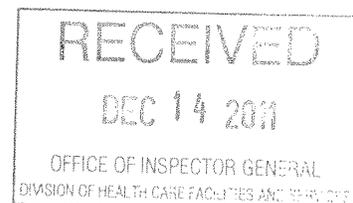
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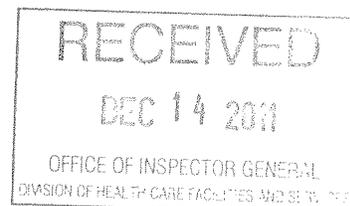
K 050	Continued From page 9 being conducted during the second shift, in the third quarter of this year. Interview, on 11/16/11 at 1:00 PM, with the Maintenance Director revealed the facility had been working two (2), twelve (12) hour shifts up until June 16, 2011. Their work schedule then changed to three (3), eight (8) hour shifts per day. The change in the work schedule contributed to the fire drills not being conducted during the second shift. Further interview, during the exiting conference at 1:45 PM, with the Administrator and the Maintenance Director, confirmed the change in the facility's work schedule contributed to the missing fire drills. Reference: NFPA Standard NFPA 101 19.7.1.2.	K 050		
K 062 SS=D	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 and interview, it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The deficiency had the potential to affect two (2)	K 062		



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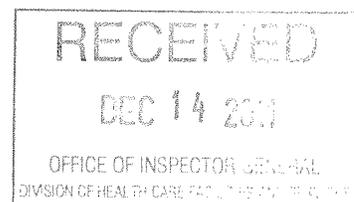
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K 062	<p>Continued From page 10 of the seven (7) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and twenty-five (125) beds and the census was one-hundred and seventeen (117) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/09/11 at 8:35 AM, with the Maintenance Director revealed pillows stored within 18" of a sprinkler head in the linen closet located outside of the laundry room. Further observation at 10:05 AM, with the Maintenance Director revealed a sprinkler head missing an escutcheon plate (trim piece) at the ceiling line, within the soiled utility room located in the 500 Hall.</p> <p>Interviews, on 11/09/11 at 8:35 AM and 10:05 AM, with the Maintenance Director revealed he was not aware of the items being stored within 18" of a sprinkler head in the linen closet, and the escutcheon plate (trim piece) missing on the sprinkler head located in the soiled utility room.</p> <p>Reference:</p> <p>NFPA 13 (1999 Edition)</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing</p>	K 062	<p>K062 NFPA 101 Life Safety Code Standard (Items stored within 18 inches of ceiling and missing coupling to sprinkler head)</p> <ol style="list-style-type: none"> 1. No specific Resident identified(Items remove from ceiling in linen room and couple to sprinkler head replaced). 2. All residents have the potential to be affected 3. Facility Maintenance Director has completed audit of all sprinkler heads and all items in 	



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K 062	Continued From page 11 shall comply With 5-5.5.2. NFPA 25 (1998 Edition) 1-11.1 Maintenance shall be performed to keep the system equipment operable or to make repairs. As-built system installation drawings, original acceptance test records, and device manufacturer ' s maintenance bulletins shall be retained to assist in the proper care of the system and its components.	K 062	regards to 18' to the ceiling. 4. Facility Maintenance director will audit monthly and will follow up daily and track and trend in QA Completion Date: 12-26-2011	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress, according to NFPA standards. The deficiency had the potential to affect one (1) of the seven (7) smoke compartments, and kitchen personnel. The facility is licensed for one-hundred and twenty-five (125) beds and the census was one-hundred and seventeen (117) on the day of the survey. The findings include: Observation, on 11/16/11 at 9:25 AM, with the Maintenance Director revealed an unapproved lock (slide bolt type) was installed on the egress	K 130	K 130 NFPA 101 Life Safety Code Standard (Kitchen door having a slide bolting lock.) 1. No specific Resident identified (Slide bolt lock removed) 2. All residents have the potential to be affected	



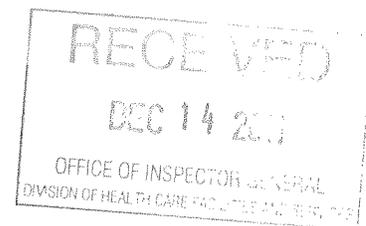
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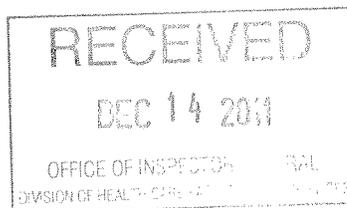
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K 130	<p>Continued From page 12 side of the door to exit the Kitchen.</p> <p>Interview, on 11/16/11 at 9:25 AM, with the Maintenance Director revealed the slide bolt lock could be a deterrent to exiting the Kitchen in the event of an emergency.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>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 according to NFPA standards. The deficiency had the potential to affect four (4) of the seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for one-hundred and twenty-five (125) beds and the census was one-hundred and seventeen (117) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 11/16/11 between 8:40 AM and</p>	K 130	<p>3. Facility Maintenance Director to audit facility for additional sliding bolt locks.</p> <p>4. Facility Maintenance Director will monitor daily and will track and trend in QA</p> <p>Completion Date: 12-26-2011</p> <p>K 147 NFPA 101 Life Safety Code Standard (Electrical wiring and equipment is in accordance with NFPA 70, Nation Electrical Code 9.1.2)</p> <p>1. No specific Resident identified(Surge protectors have been removed from use on all Medical equipment).</p> <p>2. All residents have the potential to be affected</p>	
K 147 SS=E		K 147		



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K 147	<p>Continued From page 13 10:00 AM, with the Maintenance Director revealed:</p> <ol style="list-style-type: none"> In resident room 142, medical equipment (suction pump) was plugged into a power strip. In resident room 100, a refrigerator was plugged into a power strip In resident room 316, a refrigerator was plugged into a power strip In the Employee Refrigeration Room, two (2) refrigerators and a microwave oven were plugged into a power strip. In the MDS office, a refrigerator and a microwave oven were plugged into a power strip. <p>Interviews, on 11/16/11 between 8:40 AM and 10:00 AM, with the Maintenance Director revealed he was unaware of the misuse of power strips within the facility.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p> <p>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.</p>	K 147	<ol style="list-style-type: none"> Facility has placed insert in admission packet regarding use of surge protectors. Maintenance Director has completed audit and has in-serviced Facility Maintenance Director will complete monthly audits and will track and trend in QA. <p>Completion Date: 12-26-11</p> <p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p>	



Date of Compliance:
December 26, 2011