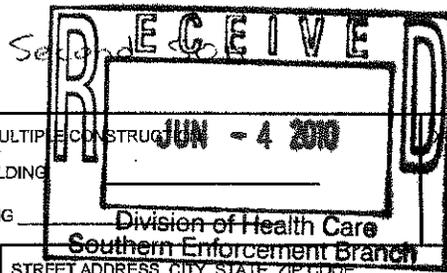


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 06/01/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ Division of Health Care Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED 04/29/2010
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - STANFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484
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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 000	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on April 26-29, 2010. Deficient practice was identified with the highest scope and severity being at an "F" level, with an opportunity to correct.</p>	F 000		
F 248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities for the individual assessed needs of four (4) of thirty-three (33) sampled residents. The facility had identified activities of interest for residents #2, #13, #19, and #20; however, the facility failed to assist the residents to the identified activity.</p> <p>The findings include:</p> <p>1. Observations of resident #19 on April 29, 2010, at 1:30 p.m., revealed the resident was in the beauty salon having his/her hair done. The resident was alert, oriented, appropriately dressed, and conversing with the hairstylist.</p> <p>A review of resident #19's medical record revealed the resident was admitted to the facility on February 5, 2010. The facility completed a significant change Minimum Data Set (MDS) assessment on April 9, 2010, and assessed the</p>	F 248		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator DATE 6/3/2010

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 248	<p>Continued From page 1</p> <p>resident to have short-term memory impairment, but able to recall the current season, the location of the resident's room, staff names/faces, and that he/she was in a nursing facility. Resident #19's cognitive skills for daily decision-making were assessed as "modified independent" and the resident was assessed to have some difficulty in new situations only. The resident was also assessed to be involved in activities from one-third to two-thirds of the time and to enjoy games, music, reading/writing, spiritual/religious activities, and watching TV.</p> <p>An interview with resident #19 conducted on April 29, 2010, at 1:50 p.m., revealed the resident was alert, oriented, and in good spirits. The resident stated there did not seem to be many diversional activities provided by the facility. Resident #19 further stated he/she was unaware of the music presentation that was scheduled in the dining room that day, but that he/she would like to attend.</p> <p>An interview with the Certified Nursing Assistant (CNA) was conducted on April 29, 2010, at 2:00 p.m. According to the CNA, staff transported residents to activities if the resident requested to attend the activity.</p> <p>An interview with the Activities Director (AD) conducted on April 29, 2010, at 2:45 p.m., revealed the AD informed residents verbally of the day's activities. The AD stated he/she had told resident #19 verbally that morning of the music activity scheduled for that afternoon. The AD stated it was his/her responsibility to transport residents to activities and that CNAs would sometimes assist with transport if it was a special activity. The AD stated he/she was the only</p>	F 248			

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F 248	<p>Continued From page 2</p> <p>Activity Department employee, but that sometimes one of the Social Service Workers would help her/him with activities.</p> <p>2. Resident #2 was observed on April 27, 2010, at 8:50 a.m., 10:20 a.m., and 11:35 a.m., to be lying on the bed with the resident's head covered or partially covered with bed linen. Observation revealed the resident's TV was not turned on. On April 27, 2010, at 11:45 a.m. and 6:15 p.m., resident #2 was observed to be sitting on the side of the bed for meal service. Further observations on April 28, 2010, at 9:10 a.m., 10:50 a.m., and 2:00 p.m., revealed resident #2 was lying in bed with the bed linen pulled over the resident's head. The resident did not respond to questions about activity preferences/interests.</p> <p>A review of the medical record revealed resident #2 was admitted to the facility on June 10, 2009, with diagnoses of Schizophrenic disorders, Alzheimer's disease, and Neurotic disorder, anxiety type. A review of the admission comprehensive assessment conducted on June 23, 2009, revealed resident #2 was assessed to have short-term memory deficit, moderately impaired decision-making skills, and limited assistance with mobility. According to the assessment, resident #2 attended activities one-third to two-thirds of the time. A review of the quarterly assessment conducted on February 24, 2010, revealed resident #2 continued to have short-term memory deficit and required assistance with mobility. However, the resident only attended activities less than one-third of the time during the assessment.</p> <p>A review of the comprehensive care plan initiated on June 23, 2009, revealed the facility identified</p>	F 248		

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F 248	<p>Continued From page 3</p> <p>that resident #2 preferred independent leisure activities over group activities. According to the care plan, resident #2 enjoyed sitting in the rehab room talking with staff and residents, and enjoyed watching TV in the resident's room. Care plan interventions included providing a large print activity calendar in the resident's room. There was no evidence the facility had developed/implemented interventions to address independent leisure activities for resident #2.</p> <p>A review of the activity participation logs revealed resident #2 attended seven group activities in February 2010, three group activities in March 2010, and zero group activities during April 2010. Facility staff was unable to provide evidence the resident was provided with any independent activities during February, March, or April 2010.</p> <p>Interview conducted with CNA #1 on April 28, 2010, at 10:50 a.m., revealed resident #2 attended some group activities and would eat most meals in the dining room. However, the resident had not been going out of the room for activities/meals for several months.</p> <p>An interview conducted with CNA #2 on April 29, 2010, at 9:00 a.m., revealed resident #2 began refusing to go to the dining room for meals and to activities approximately three to four months ago. In addition, CNA #2 stated the resident did not want the TV turned on now.</p> <p>An interview conducted with the AD on April 29, 2010, at 3:00 p.m., revealed the AD had assumed the role as the AD in February 2010. The AD stated the AD had functioned as the AD assistant prior to February 2010. The AD stated an activity assessment was conducted for each resident</p>	F 248			

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F 248	<p>Continued From page 4</p> <p>upon admission, when a significant change occurred, and annually. However, the AD stated no activity assessment had been conducted for resident #2. The AD stated resident #2 did attend some group activities "last year," but the resident currently did not want to come out of the resident's room. The AD stated the AD took magazines to the resident's room for the resident to look at. The AD further stated the AD attended care plan meetings; however, resident #2's change in activity participation had not been discussed and no in-room activities had been developed for the resident.</p> <p>3. A review of the medical record revealed resident #13 was admitted to the facility on February 24, 2010, with diagnoses of Advanced Dementia and Cerebrovascular Accident (CVA) with right-sided hemiparesis.</p> <p>Resident #13 was observed on April 27, 2010, at 9:05 a.m., 11:40 a.m., 3:00 p.m., 4:25 p.m., and 6:00 p.m., to be lying in bed or up in a recliner chair in the resident's room. On April 28, 2010, at 9:15 a.m., 10:40 a.m., and 2:00 p.m., resident #13 was again observed lying on the bed. At 3:30 p.m., the resident was observed to be receiving therapy in the Rehab Department while music was playing. The resident was observed to be moving the left foot with the music. Further observations conducted on April 29, 2010, at 9:20 a.m., revealed resident #13 to be in the Therapy Department for therapy services and at 2:10 p.m., the resident was observed to be in bed. There was no observation of a TV on during these observation times. The resident's fingernails were observed to be clean/trimmed with no polish applied.</p>	F 248			

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F 248	<p>Continued From page 5</p> <p>Resident #13 was unable to respond verbally to questions; however, the resident would sometimes nod or smile.</p> <p>A review of the admission comprehensive assessment conducted on March 9, 2010, revealed resident #13 was assessed to have short/long-term memory deficits, severely impaired decision-making skills, to require total assistance with mobility, and to attend less than one-third of activity programs. A review of the comprehensive care plan revealed the resident was identified to have limited group activity involvement related to a CVA diagnosis, communication deficit, dementia, and weakness. A review of the care plan revealed the facility would provide the following activities for resident #13: listening to music, watching other residents in the hallway, socialization in rehab, church, jazz/blues music, and to have the resident's nails painted "from time to time."</p> <p>A review of the activity assessment (no date) revealed the assessment was incomplete and areas related to the resident's functional status, reading ability, and current/past activity interests were blank.</p> <p>A review of the activity progress notes dated March 3, 2010, March 22, 2010, and April 21, 2010, revealed the resident enjoyed music and a TV was left on in the resident's room for sensory stimulation. A review of the activity participation logs revealed resident #13 attended six group activities during March 2010 and two group activities during April 2010.</p> <p>An interview conducted with CNA #3 on April 29, 2010, at 9:15 a.m., revealed resident #13 was</p>	F 248		

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F 248	<p>Continued From page 6</p> <p>taken to church related activities on Tuesday, Thursday, and on Sunday. CNA #3 stated the CNA had not observed any in-room activities being provided for the resident.</p> <p>A review of the April 2010 activity calendar revealed group activities related to singing/church were scheduled on April 27, 2010, at 2:00 p.m., and on April 28, 2010, at 10:00 a.m. and 2:00 p.m. However, resident #13 was not observed to be present during these activities.</p> <p>An interview conducted with the AD on April 29, 2010, at 3:00 p.m., revealed the activity assessment had not been completed due to the resident's inability to communicate verbally. The AD stated the AD had not "had time" to call or meet with the resident's family to obtain the information. The AD stated the resident's nails had not been painted due to the AD not having time. The AD further stated resident #13 had not attended the scheduled group activities due to not being transported to the activity.</p> <p>4. A review of the annual comprehensive assessment conducted on April 21, 2010, revealed resident #20 was assessed to have short-term memory deficits, moderately impaired decision-making skills, to require total staff assistance with mobility, and to attend activity programs one-third to two-thirds of the time. A review of the comprehensive care plan dated April 21, 2010, revealed the facility identified the resident to enjoy both group and independent leisure activities. Interventions included out-of room activities, such as bingo; and music related activities; church related activities; and in-room activities of watching/listening to the TV and visiting with family/staff.</p>	F 248			

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F 248	Continued From page 7 Resident #20 was observed on April 29, 2010, at 9:10 a.m., 9:50 a.m., 11:55 a.m., and 1:35 p.m., to be sitting in a reclined geri-chair with the resident's eyes closed in the resident's room. A review of the April 2010 activity calendar revealed Bible study was scheduled on April 29, 2010, at 10:00 a.m., and singing was scheduled at 2:00 p.m. Observations conducted during these activities revealed resident #20 was not present. An interview conducted with CNA #4 on April 29, 2010, at 1:30 p.m., revealed the Fairfield Church was resident #20's favorite church group and the church group had conducted Bible study activity on April 29, 2010, at 10:00 a.m. CNA #4 stated the CNA had not transported resident #20 to the activity due to "either neglected or was giving a bath." An interview conducted with the AD on April 29, 2010, at 3:00 p.m., revealed the AD had asked the CNA to transport the resident to the church/singing activities scheduled on April 29, 2010, because the AD was in a care plan meeting and was not available to transport the resident to the activities on April 29, 2010.	F 248			
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250			

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F 250	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to provide medically related social services to assist one (1) of thirty-three (33) sampled residents to attain the highest practicable physical, mental, and psychosocial well-being. Resident #18 was utilizing cellophane tape to hold the glass lens in a broken glasses frame. There was no evidence the facility had attempted to assist the resident to obtain new, unbroken glasses.</p> <p>The findings include:</p> <p>A review of the medical record for resident #18 revealed the resident was admitted to the facility on April 1, 2010, discharged to the hospital on April 8, 2010, and readmitted to the facility on April 12, 2010, with diagnoses that included Alzheimer's Dementia, Atrial Fibrillation, Hypertension, and Anemia. A comprehensive admission Minimum Data Set (MDS) assessment completed by the facility on April 23, 2010, revealed resident #18's vision was impaired, that the resident was unable to read regular print and the resident had decreased peripheral vision. Resident #18 was assessed to have short-term memory problems, with moderately impaired cognitive skills for daily decision-making. The resident was further assessed to be able to make him/herself understood and to usually understand others. Further review of the Resident Assessment Protocols (RAPs) revealed the resident had expressed a desire for new eyeglasses, that the frames were "weak," and the right lens was taped in the frame.</p> <p>Observations of resident #18 on April 29, 2010, at</p>	F 250		

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F 250	<p>Continued From page 9</p> <p>12 noon, revealed the resident was sitting in the dining area. Resident #18 was alert, fully dressed/groomed, and wearing glasses that had a broken right frame in the center of the top of the lens holder. Further observation revealed the right lens to be taped around the circumference of the right frame to hold the lens in place.</p> <p>An interview with the Social Worker (SW) conducted on April 29, 2010, at 1:30 p.m., revealed the SW had completed an initial assessment interview during the admission process for resident #18. The SW stated the resident was in bed and was not wearing glasses at the time of the interview. The SW stated the SW was unaware resident #18's glasses frames were broken. The SW further stated that he/she had assisted the resident in a bead stringing activity one day and the resident continually stated, "I can't see, I can't see." According to the SW, the resident was not wearing glasses that day either. The SW stated he/she was unaware the resident's glasses were broken until April 29, 2010, when the MDS nurse notified Social Services.</p> <p>An interview with the MDS Coordinator conducted on April 29, 2010, at 1:35 p.m., revealed the MDS Coordinator was aware of resident #18's broken glasses frames on April 22, 2010, but did not inform Social Services until April 29, 2010. The Coordinator further stated the resident stated the broken glasses didn't bother her/him.</p> <p>An interview with resident #18 was conducted on April 29, 2010, at 1:40 p.m. Resident #18 stated that he/she had fallen at home and broken her/his glasses prior to coming into the facility. The resident further stated that he/she could see, but</p>	F 250			

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F 250	Continued From page 10 the glasses bothered the resident being broken and the resident did not know what he/she could do about them.	F 250			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to meet professional standards of quality during medication administration for two (2) of thirty-three (33) sampled residents. Facility staff failed to follow appropriate technique and standards of practice to ensure residents #24 and #25 received the correct dosage of medications during the medication administration observation conducted on April 27, 2010. The findings include: 1. A review of the medical record revealed resident #24 had a physician's order to receive Benefiber four grams three times a day. The prescription label on the container of Benefiber directed the facility staff to administer two teaspoons of the medication. During observation of the medication administration pass conducted on April 27, 2010, at 12:00 p.m., Licensed Practical Nurse (LPN) #1 was observed to remove a container of Benefiber powder from the medication cart. LPN #1 was observed to remove a portion of the powder from the container with a plastic disposable spoon at	F 281			

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F 281	<p>Continued From page 11</p> <p>two different times and place the medication into a plastic cup. LPN #1 was then observed to mix the medication with water and administer the medication to resident #24 via gastrostomy tube. Disposable medication cups with graduated markings to indicate exact dosage of medications were observed on top of the medication cart.</p> <p>An interview conducted with LPN #1 on April 27, 2010, at 12:30 p.m., revealed LPN #1 did not routinely pour a powder medication into the measured medication cup prior to administering these medications to the residents. LPN #1 stated the LPN had not considered pouring the medication into the measured medication cups to ensure the correct dosage of medication was administered to the resident.</p> <p>An interview conducted with the DON on April 27, 2010, at 2:00 p.m., revealed powdered medications should be measured in the plastic medication cups prior to administration to ensure the correct dosage is administered to the residents.</p> <p>A review of the facility's policy/procedure related to medication administration revealed facility staff was required to check each prescription label with the medication administration record prior to removing the medication from the medication cart and after pouring the medication to ensure the accurate dosage is administered.</p> <p>2. A review of the medical record revealed resident #25 had a physician's order to receive Potassium Chloride (KCL) ten milliequivalents (meq) routinely once a day and for Miralax 17 grams to be administered in eight ounces of water or juice once a day.</p>	F 281			

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F 281	Continued From page 12 During observation of the medication administration pass conducted on April 27, 2010, at 9:10 a.m., LPN #2 was observed to place KCL ten meq (one tablet) in a plastic medication cup containing water to dissolve the medication. The LPN was observed to administer the medication orally to resident #25 and discard the medication cup into the trash can. A moderate amount of the liquid was observed to be left in the medication cup when the LPN placed the cup into the trash can. In addition, LPN #2 was observed to pour Miralax 17 grams into a cup containing four ounces of water. A review of the physician's orders revealed the Miralax was to be mixed with eight ounces of fluid. An interview conducted with LPN #2 on April 27, 2010, at 11:30 a.m., revealed the LPN had not been directed to rinse the medication cup to ensure the resident received the correct dosage of medication. LPN #2 stated the LPN was aware of the prescribed amount of water required to be mixed with the Miralax, but the LPN did not provide the correct amount of water for resident #25. An interview conducted with the DON on April 27, 2010, at 2:00 p.m., revealed the nurses had received training related to administering the correct dosage of medication. However, the DON stated the nurses had not been trained/directed to rinse the medication cup to ensure the resident received all the medication.	F 281			
F 371 SS=E	483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371			

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F 371	<p>Continued From page 13</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions. Buildup of a tan, brown sticky substance was observed on the steam table counter.</p> <p>The findings include:</p> <p>Observations during the tray line service on April 28, 2010, at 11:30 a.m., and during the sanitation audit on April 29, 2010, at 9:10 a.m., revealed buildup of a sticky, tan substance on the steam table counter.</p> <p>An interview with the Dietary Manager on April 29, 2010, at 9:00 a.m., revealed that a shelf was glued to the side of the steam table and had come loose, leaving the glue residue behind.</p> <p>An interview with the Maintenance Supervisor (MS) on April 29, 2010, at 10:30 a.m., revealed that the shelf in the kitchen had come loose from the side of the steam table, leaving a glue residue behind. The Maintenance Supervisor stated that the shelf had not been replaced yet.</p>	F 371		

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F 372 SS=F	<p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY</p> <p>The facility must dispose of garbage and refuse properly.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure garbage and refuse was disposed of properly. Observations of the dumpster revealed an uncovered Rubbermaid cart filled with pink insulation, broken ceiling tiles, and water. Additionally, the dumpster area had debris/refuse on the ground around the dumpster.</p> <p>The findings include:</p> <p>During the sanitation audit on April 29, 2010, at 9:10 a.m., an uncovered Rubbermaid cart filled with pink insulation, broken ceiling tiles, and water was observed to be in the dumpster area. Further observation of the dumpster area revealed four milk cartons, one yogurt container, three gloves, and one lotion bottle lying on the ground beside the dumpster. The dumpster lid was noted to be closed and only one-half full of refuse.</p> <p>An interview with the Maintenance Supervisor (MS) on April 29, 2010, at 10:30 a.m., revealed the dumpster was emptied on Monday, Tuesday, and Wednesday. The MS stated he/she did not realize the garbage was on the ground beside the dumpster. The MS stated the ceiling tiles and insulation were in an uncovered garbage can beside the dumpster. The MS said water had filled the can with the ceiling tiles and insulation</p>	F 372			

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F 372	Continued From page 15 during the winter, and the water had frozen in the can.	F 372			
F 387 SS=D	<p>483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that two (2) of thirty-three (33) residents were seen by a physician at least once every thirty (30) days for the first ninety (90) days after admission and at least once every sixty (60) days thereafter. A review of the medical records for residents #10 and #20 revealed there was no evidence the residents' physician had visited within the required timeframes.</p> <p>The findings include:</p> <p>1. A review of the medical record for resident #10 revealed the resident was admitted to the facility on February 5, 2010. Resident #10 was discharged to an acute care facility on February 10, 2010, and readmitted to the facility on February 19, 2010. There was no evidence resident #10's physician conducted a visit and wrote progress notes until April 16, 2010.</p> <p>An interview with the Assistant Director of Nursing</p>	F 387			

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F 387	Continued From page 16 (ADON) conducted on April 29, 2010, at 1:00 p.m., revealed the facility did not have a specific policy regarding physician visits. According to the ADON, the resident's physician attended a medical meeting in March 2010 and did not come to the facility for rounds. The ADON further stated the facility Medical Records employee was responsible to ensure timely physician visits and to ensure the facility followed the regulatory timetable. An interview with the Medical Records employee (MRE) conducted on April 29, 2010, at 1:05 p.m., revealed the facility did not notify physicians of required physician visits and that the MRE depended on the physician's office staff to ensure timely physician visits. The MRE further stated he/she had not paid attention to the required timeframes for physician visits. 2. A review of the physician progress notes for resident #20 revealed the physician visited the facility on January 13, 2010, and noted the resident's medical condition was stable. Further review of the physician progress notes revealed the next progress note was dated April 16, 2010, and the physician noted the resident's condition was slowly deteriorating due to the resident's chronic problems. An interview conducted with the DON on April 29, 2010, at 3:15 p.m., revealed the facility could not provide evidence the physician had conducted a visit for resident #20 between January 13, 2010 and April 16, 2010.	F 387			
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465			

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F 465	<p>Continued From page 17</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. A bedside table had sharp edges in need of repair, exit door 5 had broken plastic with sharp edges, the grab bar in the 200 A Hall central bath was detached from the wall, baseboards in the hallway and a resident room were pulling away from the wall, and plaster was marred/missing in a resident room.</p> <p>The findings include:</p> <p>Observation of the facility during the environmental tour on April 26-29, 2010, revealed the following items in need of repair:</p> <ul style="list-style-type: none"> - Resident room 106 had a bedside dresser top that was splintered/marred, leaving sharp edges in need of repair. - Exit door 5 had broken plastic around the glass panes that had sharp edges, leaving a potential for accidents. - The grab bar beside the commode in the 200 A Hall central bath was not anchored to the wall, leaving a potential for accidents. - Baseboards in the 100 Hall across from the medication room and in resident room 108 under 	F 465			

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F 465	Continued From page 18 the air conditioner were pulling away from the wall and in need of repair. - Resident room 130 had plaster on the wall that was marred/missing and in need of repair. Interview with the Maintenance Supervisor (MS) on April 29, 2010, at 10:00 a.m., revealed that staff was required to report maintenance care needs by using the care tracker computer system. The MS looked at the care tracker every morning, reviewed the needed repairs, prioritized them by resident safety/needs, and began the needed repairs. The MS stated that the care tracker generated a preventative maintenance program daily so that all areas of the facility were maintained on a monthly basis.	F 465		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain an effective pest control program to ensure the facility was free of pests. Gnats were observed throughout the facility during the survey on April 26-29, 2010. The findings include: A group interview with residents #19, #27, #28, #29, #30, #31, #32, and #33 on April 27, 2010, at	F 469		

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F 469	<p>Continued From page 19</p> <p>10:30 a.m., revealed that gnats were noted throughout the building. The residents stated that gnats were in the residents' rooms, bathrooms, and in common areas such as the dining rooms, hallways, and the activity room. Resident #27 stated that the gnats would land on residents' food/coffee mugs during the meal services.</p> <p>An interview with resident #26, who resides in room 212, on April 27, 2010, at 9:00 a.m., revealed gnats were present in the resident's room. Resident #26 stated that the resident's roommate stored dirty clothes (soiled with urine and feces) in the room and the clothes drew gnats into the residents' room.</p> <p>Observations on April 27, 2010, revealed gnats in room 103, room 112, room 205, room 211, and in the 200 hallway by rooms 204, 205, and 224. Gnats were also observed in the main dining room at the evening meal on April 27, 2010, at 5:40 p.m. In addition, gnats were observed in the central bath on the 200 hallway A side on April 28, 2010, at 9:00 a.m., and in room 108 at 2:30 p.m.</p> <p>An interview with the Maintenance Supervisor (MS) on April 29, 2010, at 10:30 a.m., revealed a local pest company sprayed monthly for insects including gnats. According to the MS, the pest control company instructed the facility to pour bleach down drains, and spray for gnats when they were present; however, the facility continued to have a problem with the gnats.</p> <p>An interview with the Administrator on April 28, 2010, at 5:30 p.m., revealed the facility was aware of the gnats in the building. The Administrator had discussed with the pest control</p>	F 469			

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F 469	Continued From page 20 company strategies to rid the facility of the gnats, which included pouring bleach down drains, removing food items from resident rooms, and spraying for the gnats when spotted in the facility; however, the gnats continued to be present in the building. A review of the pest control contract on April 29, 2010, at 2:00 p.m., revealed the facility had a contract which included spraying for gnats on a monthly basis.	F 469			

#1) Residents # 2, 13, 19 & 20 were reassessed for their activity preference and care plan updated accordingly. Staff will assist residents to activities of choice, as they desire.

#2) Activity Director will complete audit on current residents to ensure activity assessment reflects resident's current activity preferences. Activity Director will assist residents, with little or no activity participation, in developing independent leisure activities of their choice. Resident care plan will reflect changes to their activity preferences. Staff will assist resident to and from activities to include leisure activities.

#3) DNS / DCE will re-in-service nursing on 5/27/2010 on assisting resident to and from activities of choice and providing assistance with in room leisure activities. Nurses and CNAs will assist Activities Director in transporting residents to residents' activities of choice. Large print activity calendar will continue to be posted in resident's room for staff and residents knowledge. Resident's activity preferences will be noted on residents care sheet for staff communication to provide assistance with resident's daily activities. The Activity Director and Nursing Staff will be responsible for assisting residents to daily activities as needed.

#4) Activity Director will monitor resident's activity participation daily and document on monthly participation log to include residents with independent leisure activities. Trends noted with the monitoring of activities will be discussed during quarterly QAA meeting monthly X 3 months. Action plan will be developed as needed.

Date of completion is 6/5/2010.

F - 250

#1) Resident # 18 has received new eyeglasses. Social Service has reassessed resident and documented effectiveness of resident vision with the new glasses. Care plan has been updated to reflect new eyeglasses.

#2) Social Service will complete audit of residents to ensure medically related social services has been provided. Residents identified during audit will have a reassessment completed to reflect resident's specific needs. Documentation will reflect current resident status and needed interventions will be provided by social services.

#3) Director of Social Services / DCE will re-in-service Nursing Staff 5/27/2010 on reporting any medically related resident needs to social services. This will be monitored by social services during facilities daily start-up meeting. Resident's identified with medically related social service needs will have documentation completed to include needed interventions.

#4) Trends identified, with the monitoring of medically related social service needs, will be discussed during quarterly QAA meeting for 2 quarters. Action plan will be developed as needed.

Date of completion is 6/5/2010.

F - 281

#1) Resident # 24 and 25 had no negative outcomes related to staff failure to follow appropriate techniques during medication pass. Resident's # 24 & # 25 Responsible Party/Person have been notified of resident's receiving medication through inappropriate techniques. Medical Director notified and no new orders received. Nurses were educated immediately on correct medication administration for Residents #24, and 25.

#2) Medication pass observation of two nurses on each shift completed by Director of Clinical Education on 5/14/10. No other residents were affected during this audit.

#3) Director of Clinical Education will complete in-service to Nurses and Medication Techs 5/27/2010 on proper medication pass technique/procedure to include using appropriate measuring and administration of medication. Remaining staff will have medication competency completed by 6/5/10. Newly hired nurses will have medication observation competency completed prior to administering medication to residents.

#4) Director of Clinical Education will complete medication pass observation with 2 nurses monthly to monitor and ensure compliance. Any issues noted will be brought to QA&A monthly X 3 months for discussion and action plan developed as needed.

Date of completion is 6/5/2010

F - 371

#1) Dietary Service Manager will complete an audit of equipment and work areas to determine sanitation compliance.

#2) Steam table has been repaired and cleaned. Kitchen has been cleaned and the facility completes sanitation rounds.

#3) Dietary Service Manager will include in the daily start up of the kitchen a procedure to monitor/audit the status of equipment and work area repairs as it relates to sanitation.

#4) Dietary Service Manager and Maintenance Director will educate the dining service department 5/27/2010 on the proper procedure to report any needed equipment and/or work area repairs. Trends identified, with the monitoring of area, will be discussed during quarterly QAA meeting for 2 quarters. Action plan will be developed as needed.

Date of completion is 6/5/2010.

F - 372

#1) Identified cart has been emptied and removed from the dumpster area and the dumpster area has been cleaned.

#2) Waste Management has been contacted and the facility added another day of refuse pick-up to facilities schedule.

#3) Dietary Service Manager, Director of Clinical Education, and Maintenance Director will educate Nursing, Social Services, Activities, Dietary, Housekeeping/Laundry, and facility Administration 5/27/2010 on the proper procedure and responsibilities for removing trash from the facility and placing correctly into the waste management dumpster.

#4) Maintenance Director / will complete walk through of dumpster area 5 times a week to ensure compliance. Trends identified, with the monitoring of dumpster area, will be discussed during quarterly QAA meeting. Action plan will be developed as needed.

Date of completion is 6/5/2010.

F - 387

#1) Residents #10 and 20 will be seen by MD on 5/19/10. Progress note will reflect Resident's current condition.

#2) Medical records will be reviewed on current in-house residents to identify last MD visit.

Residents identified as needing current MD visit will have MD visit completed by June 5, 2010

#3) DNS/ADNS/MR will provide a calendar of scheduled MD visits for current residents. MDs will be contacted by certified letter one week prior to scheduled visit as a reminder of required visit. MD visit will be documented in the medical record by nursing staff. MD visit will occur every 30 days for the first 90 days after admission and every 60 days thereafter. Current residents will have an MD visit every 60 days and will include 10 day extension past scheduled visit. Facility's medical director will be responsible to perform the scheduled visit if resident's attending MD is unable to do so.

#4) DNS/ADNS/MR will monitor calendar to ensure scheduled MD visits have been completed. Any concerns will be brought to QA&A committee for discussion with medical director and action plan will be developed as needed.

Date of completion is 6/5/2010.

F – 465

#1) Facility has addressed the following identified concerns:

- RM – 106 the bedside dresser top edges have been restored.
- Exit door has been repaired.
- Grab bar in 200 Hallway shower room has been anchored properly.
- Baseboard on 100 Hallway (across from Med Room) & in RM 108 has been secured.
- Room 130 the plaster on the wall has been revamped.

#2) Maintenance Director / Director of Clinical Education will re-in-service Nursing, Social Services, Activities, Dietary, Housekeeping/Laundry, and facility Administration 5/27/2010 on the proper procedure for reporting maintenance issues in need of repair.

#3) Maintenance Director / will complete walk through of each department 5 times a week to ensure all areas of concerns are addressed and brought into compliance.

#4) Trends identified, with the monitoring of maintenance repairs, will be discussed during quarterly QAA meeting. Action plan will be developed as needed.

Date of completion is 6/5/2010.

F – 469

#1) The Maintenance Director contacted Terminix and requested an additional service visit. The Maintenance Director will meet with the Terminix technician to receive education and suggestions to alleviate facilities pest control issues.

#2) Maintenance Director / Director of Clinical Education will re-in-service Nursing, Social Services, Activities, Dietary, Housekeeping/Laundry, and facility Administration 5/27/2010 on the proper procedure for reporting pest control problems to include facilities pest control logs.

#3) Maintenance Director will complete walk through of each department 5 times a week to ensure all pest control matters are addressed timely and in compliance.

#4) Trends identified, with the monitoring of pest control issues, will be discussed during quarterly QAA meeting. Action plan will be developed as needed.

Date of completion is 6/5/2010.

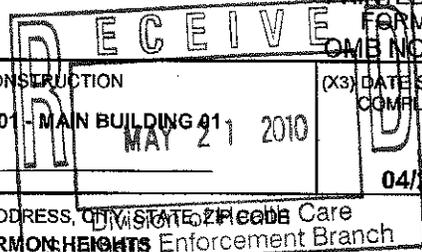
Golden Living Center – Stanford

Disclaimer

Preparation, submission and implementation of the 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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 41 2010 B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2010
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - STANFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS	K 000		
	<p>A life safety code survey was initiated and concluded on April 27, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition for existing construction.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>			
K 012 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure a combustible canopy at the front of the facility was sprinkler-protected as required.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on April 12, 2010, at 11:15 a.m., with the Director of Maintenance, a combustible canopy approximately 30 feet by 10 feet in size, located at the front of the facility was noted not to be sprinkler-protected. Combustible canopies exceeding four feet in width must be sprinkler-protected. Interview revealed the Director of Maintenance was not aware of this requirement.</p> <p>Reference: NFPA 13 (1999 Edition).</p>	K 012	See attached plan of correction	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 5/20/2010
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - STANFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 012	Continued From page 1 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustibile construction.	K 012			
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire/smoke resistance rating of the corridor ceiling area. The facility failed to maintain fire/smoke barrier walls in the attic area. The deficient practices would affect five (5) of five (5) smoke compartments in the existing building, ninety-six (96) residents, staff, and other occupants of the building in a fire situation. The facility has the capacity for 128 beds with a census of 116 on the day of survey. The findings include: During the Life Safety Code survey on April 28, 2010, at 8:55 a.m., with the Director of	K 025	<i>See attached plan of correction</i>		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - STANFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	<p>Continued From page 2</p> <p>Maintenance, a wooden pull-down set of stairs located in the corridor ceiling next to resident room 110 was noted not to meet the one-half hour fire-rated construction as required for a smoke barrier. The stairs are used to access the attic area for maintenance issues. An interview revealed the Director of Maintenance was not aware the stairs in the corridor ceiling were required to maintain a one-half hour fire resistance rating. During the survey the same type of stairs were noted at two other corridor locations in the facility.</p> <p>At 9:30 a.m. on April 28, 2010, during the Life Safety Code survey, an unapproved makeshift door was observed in the fire/smoke barrier wall in the attic above the cross corridor doors located next to resident room 222. This type of access door is required to be of an approved design and rating. An interview revealed the Director of Maintenance was unaware the door needed to be of an approved design and rating. During the survey three other fire/smoke barrier walls in the attic area were noted to be of an unapproved design and rating.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial</p>	K 025		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - STANFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 025	<p>Continued From page 3</p> <p>space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.</p> <p>8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following. (a) * Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies.</p> <p>Reference: NFPA 80 (1999 Edition).</p> <p>11-1.2 Components. An access door shall be an integral unit including the door, frame, hinges, latch, and closing device (where required) bearing a label that reads " Frame and Fire Door Assembly. " Exception: A vertical access door shall be permitted to have hinges that are not part of the labeled assembly, provided the hinges conform to Table 2-4.3.1.</p> <p>11-1.2.1 Access doors shall be self-closing.</p> <p>11-1.2.2 Access doors shall be self-latching. Exception: A horizontal access door that does not open downward and that remains in place when an upward force of 1 psf (48 N/m²) is applied over the entire exposed surface of the door shall not be required to be self-latching.</p> <p>11-1.2.3 Self-closing access doors that are intended to be</p>	K 025			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - STANFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484	
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K 025	Continued From page 4 used to allow a person to enter the concealed space behind the door completely shall be operable from the inside without the use of a key or tool. 11-1.2.4 Access doors shall be installed in accordance with their listing. 11-2.2 Vertical Access Doors. 11-2.2.1 Vertical access doors shall have a fire protection rating of 3/4 hour, 1 hour, or 1 1/2 hours. (See Appendix F.)	K 025		

K 012 – D

The Maintenance Director immediately, following the survey, contacted the facilities sprinkler contractor for an onsite visit to determine job parameters to bring facility into compliance.

Due to the amount of the expense to get these items completed, a request for a Capital Appropriations Request (CAR) for Capitol Expenditures form has to be submitted to the Division President for approval.

The CAR will be submitted and after approval is granted the work will be completed. Two (2) sprinkler heads will be installed in the combustible canopy located at the front of the facility bringing the facility into compliance.

Date of Compliance 6/13/2010

F 025 – F

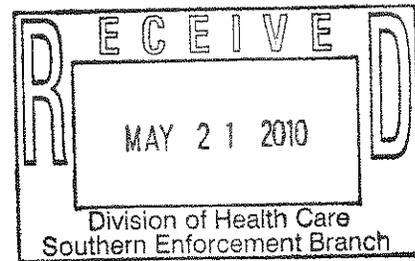
The Maintenance Director immediately, following the survey, contacted the facilities contractor for an onsite visit to determine job parameters to bring facility into compliance.

Due to the amount of the expense to get these items completed, a request for a Capital Appropriations Request (CAR) for Capitol Expenditures form has to be submitted to the Division President for approval.

The CAR will be submitted and after approval is granted the work will be completed. The wooden pull down stairs, outside of room 110, will be renovated to meet the ½ hour fire safety rating. The four (4) doors through the smoke barrier walls in the attic will be sealed and doors/hatches that meet design and rating specs will be installed. This will bring the facility into compliance.

Date of Compliance 6/13/2010

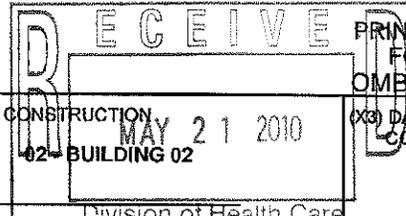
Golden Living Center – Stanford



Disclaimer

Preparation, submission and implementation of the 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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2010
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - STANFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484
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K 000	INITIAL COMMENTS	K 000		
K 012 SS=F	<p>A life safety code survey was initiated and concluded on April 27, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition for new construction.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.2.5.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building sprinkler system was installed throughout the facility according to NFPA standards. This deficient practice would affect three (3) of three (3) smoke compartments in the new building, twenty-four (24) residents, staff, and other occupants of the building in a fire situation. The facility has the capacity for 128 beds with a census of 116 on the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on April 28, 2010, at 10:00 a.m., with the Director of Maintenance, an inspection above the ceiling in, the new building of the facility revealed no sprinkler protection. New facilities are required to be fully sprinkler-protected. An interview revealed</p>	K 012	see attached plan of correction	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE <i>5/20/2010</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 012	Continued From page 1 the Director of Maintenance thought the attic area in the new building should have been sprinkler-protected. Reference: NFPA 101 (2000 Edition). 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered. 9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.	K 012			

K 012 – D

The Maintenance Director immediately, following the survey, contacted the facilities contractor for an onsite visit to determine job parameters to bring facility into compliance.

Construction Company responded with paperwork showing that the newly constructed area did not meet the regulations requiring the attic to be sprinkled. That paperwork is attached.

Date of Compliance 6/13/2010

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