

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

PRINTED: 03/18/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2010
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - VANCEBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 88 EASTHAM STREET VANCEBURG, KY 41179
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>A Recertification/Abbreviated Survey was conducted 03/03/2010 - 03/05/2010. A Life Safety Code Survey was conducted 03/04/10. Deficiencies were cited, with the highest scope and severity of a "F". ARO numbers KY00014358 and KY00014417 were substantiated with no deficient practice identified. ARO number KY00014483 was unsubstantiated.</p> <p>F 156 SS=B 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p>	F 000		
F 156 SS=B		F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Judy Carroll</i>	TITLE <i>ED</i>	(X6) DATE <i>4/9/10</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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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - VANCEBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 88 EASTHAM STREET VANCEBURG, KY 41179		
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F 158	<p>Continued From page 1</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements</p>	F 158			

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - VANCEBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 68 EASTHAM STREET VANCEBURG, KY 41179		
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F 156	<p>Continued From page 2</p> <p>specified in subpart 1 of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to prominently display written information about how to apply for and use Medicare and Medicaid benefits. Observation during the tour revealed the information was not displayed in an areas where residents frequently visited.</p> <p>The findings include: Observations during the initial tour on 03/05/10 revealed no evidence the facility had posted</p>	F 156	<p>F156-B</p> <p>This was fixed immediately after being pointed by OIG inspector. Framed documents containing required contact info were placed on wall in hallway leading from lobby to residential area. This area very public as it is only means of entering residential area.</p> <p>Will be monitored during non-clinical rounds by DNS and ED.</p>	3/14/10

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F 158	Continued From page 3 information on how residents could apply for and use Medicare and Medicaid benefits. Interview with the Administrator revealed this information was located in the Admissions Office. She stated the information was not posted in resident areas and the family usually took care of applying for Medicaid and Medicare benefits for the residents. The Administrator stated the facility had pamphlets in the lobby, however, when she checked the pamphlets were all gone. She stated she was unaware the pamphlets had not been replenished.	F 158		
F 441 SS=F	483.85 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	F 441		

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F 441	<p>Continued From page 4</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide a safe, sanitary environment to prevent the development and transmission of diseases. In addition, the facility failed to have an effective infection control program in order to investigate, control, and prevent infections in the facility.</p> <p>The findings include:</p> <p>1. Review of the Infection Control Log, revealed there were nine (9) Urinary Tract Infections (UTIs) on the 100 hall, three (3) UTIs on the two hundred hall, and four (4) UTIs on the 300 hall for the month of January 2010. Further review of the Log, revealed there were seven (7) UTI' on the 100 hall, three (3) UTIs on the 200 hall, and three (3) UTIs on the 300 hall for the month of February 2010.</p> <p>Interview on 03/05/10 at 3:15 PM with the Infection Control Nurse/ Registered Nurse (RN) #1 revealed she tracked and trended infections in</p>	F 441	<p>1.) Residents identified with infection (UTIs) for January & February will be reviewed and re-assessed for trends to include root cause of infections. Review to be completed by DNS or ADNS or charge nurse by April 10, 2010.</p> <p>Interventions will be implemented to prevent further UTIs as needed.</p> <p>2.) the center will review & revise the Infection Control Program to ensure thorough investigation of the root cause of each infection. Will be reviewed by DNS or ADNS and will be completed by 4/10/2010. Preventive measures will be implemented to control & prevent infections for other residents identified at risk for potential UTIs or potential infections.</p> <p>3.) Infection Control Program will include investigation of causes, controlling & analyzing each infection & preventive measure implemented to prevent further infections. In-services will be provided on 4/2/2010 to include potential causes of infections or UTIs, such as: hand washing or peri care upon identification of infections as they occur. Additional in-services will be conducted based on the tracking/trending of infections.</p> <p>This process will be monitored by the DNS, ADNS, or Charge Nurse during daily rounding. Will verify Preventive measures are being followed, observe peri-care and hand washing monthly of at least 3 care givers, and question care givers as to proper procedures.</p> <p>The infection control nurse will investigate each infection monthly to assure training/education is provided based on trends/analysis. In addition, annual competencies will be completed for Certified Nursing Assistants on Infection Control Measures to prevent infections. Observation will be conducted by the DNS, ADNS, or designee during daily routine care to assure preventative measures are implemented to prevent infections. Re-inservice will be conducted for Nurses & Med Techs on infection control techniques for administering medications and hand hygiene during medication pass. In addition, annual competencies will be completed with observation of Med Pass Techniques and administration for nurses & med techs.</p> <p>4.) The facility will monitor and evaluate the effectiveness of the Infection Control Program quarterly or more often as needed during the QA&A meeting. Action plans will be developed as needed.</p>	4/12/10	

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F 441	<p>Continued From page 5</p> <p>the facility. She stated the last Peri-Care audit was completed in November 2009. RN #1 stated the last infection control inservice was completed on 02/15/10, related to handwashing and contact/standard precautions. Further interview, revealed there had been no recent inservices or audits related to peri-care, although there were several UTIs for January and February 2010, especially on the 100 hall.</p> <p>Interview on 03/05/10 at 3:30 PM with the Director of Nursing (DON), revealed there was a once a year competency for peri-care for the Certified Nursing Assistants (CNAs) during the third quarter. In addition, Quality Assurance reviewed the infections each month in committee and looked for opportunities for improvement. Continued interview, revealed a peri-care inservice and/or audit should have been completed due to the numerous UTIs in January and February 2010.</p> <p>2. Observation of medication pass on 03/04/10 at 12:00 PM, revealed Licensed Practical Nurse (LPN) #1 donned gloves and administered medication and water through Resident #3's Gastric tube. The LPN, then removed the soiled gloves, donned new gloves and administered Tobradex Ointment to both of the resident's eyes. The LPN then proceeded to administer Deep Sea Nasal Spray to the resident's nares with the soiled gloves. There was no evidence the LPN washed her hands after administering the Gastric tube medications and water or prior to administering the resident's eye medication. Also, there was no evidence the LPN washed her hands and changed gloves after administering the eye medication prior to administering the Nasal Spray.</p>	F 441		

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F 441	Continued From page 6 Interview on 03/04/10 at 12:00 PM with LPN #1 revealed she should have washed her hands and then donned new gloves after administering the Gastric Tube medications and prior to administering the eye medication. Further interview revealed she should have again washed her hands and donned new gloves after administering the eye medication and prior to administering the Nasal Spray to prevent cross contamination.	F 441			

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K 000	INITIAL COMMENTS	K 000		
K 025 SS=F	<p>A life safety code survey was initiated and concluded on March 4, 2010 for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility not in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at an " F "</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the fire/smoke resistance rating of the fire/smoke barrier walls in the attic area.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on March 4, 2010 at 11:30 AM., with the Director of Maintenance, observation of the attic above the cross corridor doors in the 100 corridor was noted to have an unapproved make shift door in the</p>	K 025		

RECEIVED
MAR 27 2010
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Andy Caswell, Executive Director* TITLE _____ (X6) DATE *3/29/10*

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 025	<p>Continued From page 1</p> <p>fire/smoke barrier wall. An interview with the Director revealed he/she was going to go through the building and seal these types of unapproved doors and provide a proper access to the attic from the floor below. The Director stated he/she was going to repair any penetrations or holes found in these fire/smoke barrier walls. During the survey the TV cable was observed to be running through an unapproved door in the attic above the 300 corridor. A large section of sheetrock was also noted to be missing from the front hall fire/smoke barrier where heat and air lines were recently installed.</p> <p>Reference: NFPA 101 2000 edition</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for 	K 025	<p>K025-F</p> <p>Attic doors will be sealed by Maintenance Director. Holes &/or penetrations will also be sealed by Maintenance Director. TV cable will be properly sheathed and area abutting will be sealed with an approved material.</p> <p>This will be monitored by Maintenance Director quarterly as routine inspection and after any work in attic is completed by contractor as a follow up to assure doors still in compliance.</p>	4/10/2010

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K 025 K 072 SS=E	Continued From page 2 the specific purpose. NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridors were maintained free from obstructions to full instant use in the case of fire and/or other emergencies. The findings include: During the Life Safety Code tour on March 4, 2010 at 9:45 AM., with the Director of Maintenance, a "Geri" chair, two (2) patient lifts and two (2) linen carts were noted not to be in use and unattended in the 200 wing corridor. An interview with a staff member revealed these items were routinely left at one side of the corridor for two (2) hours. The 300 wing corridor was also noted during the survey to contain these types of items. The Life Safety Code has specific requirements for storage spaces. Corridors are intended for means of egress, internal traffic and emergency use, not storage spaces. These items would also limit the use of the hand rails by occupants of the building when needed.	K 025 K 072	K072-B 1.) Facility wide in-service/education on proper storage of lifts when not in use. Facility side in-service on proper storage of linen carts clean/dirty when not in use. 2.) Lifts will be store in soiled utility rooms when not in use. Geri chairs will be stored in room of resident that uses or in soiled work room. Linen carts will be stored in linen closets (clean) or shower rooms (dirty). A general facility in-service/education will be completed on reasons for proper storage of linen carts, lifts, geri chairs & soiled linen carts.	4/16/10	