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OMB NO. 0938-0391

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

OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2010
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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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	INITIAL COMMENTS A Nursing Home Initiative standard health survey was conducted 04/25/10 at 3:00pm through 04/28/10. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. An abbreviated survey investigating KY00014316 was initiated on 04/25/10 and concluded on 04/28/10. KY00014316 was unsubstantiated.	F 000	<u>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.</u>	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Through observation, interview and record review it was determined the facility failed to provide effective Maintenance services to repair overhead lights, a bathroom sink that was not secured to the wall and a shattered window in the solarium area. The findings include: Observations were made on initial tour on 04/27/10 at 10:22am, 11:05am, 2:10pm, 2:25pm and 2:35pm of strings missing from over head lights above resident beds in rooms 101B, 107, 109, 139, 215, 216, 217, 219, 226B, 238B, 307, 309, 310, 315, 328, 335, 400, 411A and 415A and all were missing strings from the overhead lights. The women's bathroom sink in the main entrance	F 253	<u>Corrective Actions for Targeted Residents:</u> All resident rooms that were identified as not having strings on their over bed lights were corrected. The sink in the women's public restroom has been repaired. Facility found a vendor that will replace the cracked window. In the meantime, the window has been covered and the area around the window has been closed. <u>Identification of Other Residents with Potential to Be Affected:</u> All residents have a potential to be effected by this practice.	June 4, 2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *x [Signature]* TITLE *Executive Director* (X6) DATE *5/19/10*

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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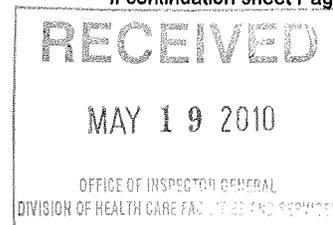
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F 253	<p>Continued From page 1</p> <p>hallway was observed not secured to the wall and very shakey when maneuvered. On 04/26/10 at 11:31am it was observed that a window in the Solarium sitting area was shattered about five (5) feet high above a double seated chair. The window was shattered about five feet by two feet in length and width. The Solarium sitting area was open for use for resident, family or staff.</p> <p>Interview on 04/27/10 at 2:25pm with Resident #25 revealed that he/she would like to have a string attached to the over head light so that he/she could turn the light off and on and not have to struggle while in bed to turn the light on or off.</p> <p>Interview on 04/28/10 at 8:20am. with the Maintenance Director revealed that he did not realize so many residents had no strings to the overhead lights in their rooms. He assesses resident rooms daily but did not know any strings were broken from overhead lights, though his daily schedule of room checks states to assess lighting in resident rooms. The light bulbs were assessed weekly. He also stated that he was not aware of the shattered glass in the solarium and did not know how long it had been broken. The bathrooms were checked on the days allotted on the schedule sheet.</p> <p>Interview on 04/28/10 at 9:05am with the Executive Director revealed that the window was shattered in the solarium and that he could not guarantee that any resident would not get hurt from the shattered glass if it were to get hit again. He also stated that the window had been broken for a month. The Executive Director revealed that he was not aware of strings missing from 19 resident overhead lights. Felt that it was a</p>	F 253 <i>Cont.</i>	<p>Systemic Changes: Associates were in serviced on how to enter maintenance requests in the maintenance computer log. The over bed lights missing strings has been added to the Non-clinical rounds form that is completed weekly by the Department managers. Maintenance will conduct monthly audits to monitor the sinks and the solarium windows to ensure no safety issues.</p> <p>Monitoring: Results from the Non-clinical rounds and audits will be reviewed daily (M-F) during the AM start-up meeting led by the Administrator or his designee. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.</p>	
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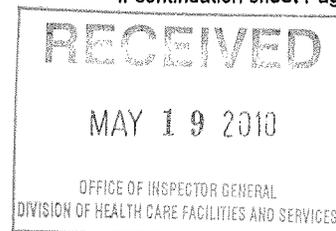
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F 253	Continued From page 2 problem if residents did not have access to light and expected residents to have access to lights above the head of the bed. Review of the maintenance schedule for the month of April 2010 revealed that Maintenance was to assess specific resident rooms daily. Maintenance checks each resident room for lighting, wall and wall coverings, floors, ceiling, sinks, toilets, furniture, HVAC system, exhaust and door frames.	F 253		
F 279 SS=D	No manufacturer label could be provided upon request for the solarium window. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F 279 D <u>Corrective Actions for Targeted Residents:</u> A comprehensive plan of care for discharge planning was formulated by the interdisciplinary team for Resident #16. <u>Identification of Other Residents with Potential to Be Affected:</u> Discharge plans of care were audited and reviewed for active residents to identify other residents having the potential to be affected. <u>Systemic Changes:</u> Comprehensive care plan training was conducted with the interdisciplinary team that included developing care plans for discharge planning. <u>Monitoring:</u> The Social Services Director will audit 10 random records per month for 3 months, then quarterly to ensure a care plan for discharge planning is present. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.	June 4, 2010



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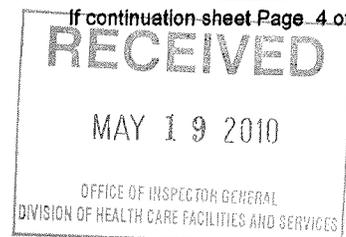
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F 279	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to develop a comprehensive care plan for discharge planning to include measurable objectives and timetables to meet a resident's discharge needs as identified in the comprehensive assessment for one (1) out of 24 (twenty-four) sampled residents. The Resident Assessment Protocols (RAPS) indicated that Resident #16 was admitted to the facility for short-term rehabilitation; however, no individualized care plan was formulated.</p> <p>The findings include:</p> <p>Record review on 04/27/10 at 4:00pm revealed Resident #16 was admitted on 01/15/10 with End Stage Renal Disease, Hypertension, Vascular Disease, and Bilateral below the Knee Amputations. Review of the resident's Minimum Data Set (MDS) dated 01/28/10 and 03/26/10 revealed the resident was independent in decision making.</p> <p>Interview with Resident #16 and family in the resident's room on 04/27/10 at 2:00pm revealed the resident had been admitted to the facility for rehabilitation after a leg amputation. Once he/she completed rehabilitation and a prosthesis fitting, he/she planned on going home with a sister to live.</p> <p>Record review of Resident #16's chart on 04/27/10 at 4:00pm revealed the facility did not complete a Comprehensive Discharge Plan of Care; however, the resident's RAP dated 01/25/10 stated the resident's goal for discharge</p>	F 279		
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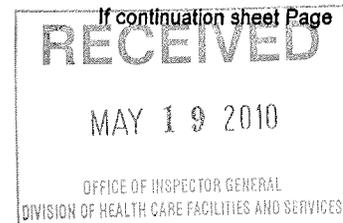
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F 279	Continued From page 4 was to return home, and live with family with the assistance of Home Health. Interview on 04/28/10 at 10:00am with the Minimum Data Set (MDS) Nurse revealed she had only been doing her job for six (6) weeks. She stated that a Discharge Planning Care Plan should have been implemented because discharge to home was a significant goal for this resident. Interview with the Designated Social Worker on 04/28/10 at 9:00am revealed he had specifically worked with the family on discharge planning but had failed to assist in the development of a discharge plan of care in conjunction with the MDS nurse. He stated a discharge care plan should have been initiated on the resident.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The facility was unable to provide a policy on Care Planning. The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to follow interventions for the arterio/venous (AV) shunt assessment for one (1) out of twenty four (24) sampled residents (Resident #18). Facility staff failed to document in the nursing notes as specified in the plan of care.	F 282	F 282 D <u>Corrective Actions for Targeted Residents:</u> Resident #18's AV shunt was assessed and the assessment documented. <u>Identification of Other Residents with Potential to Be Affected:</u> Documentation for active residents with AV shunts were audited for evidence of assessment of their AV shunt. <u>Systemic Changes:</u> Licensed Nurses were educated on assessment of an AV shunt and daily documentation via the Treatment record. <u>Monitoring:</u> The DNS or Designee will audit documentation of residents with AV shunts weekly for 4 weeks, then monthly for 3 months and then quarterly. Findings will be reported monthly to the facility QAA committee for review for 4 months and then quarterly thereafter.	June 4, 2010



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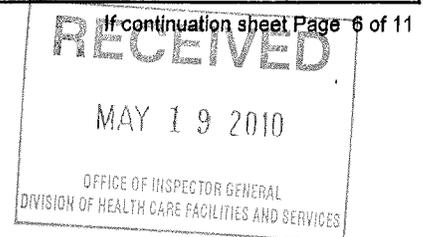
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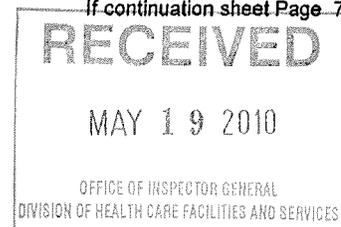
F 282	<p>Continued From page 5</p> <p>The findings include:</p> <p>Review of Resident #18's medical record revealed the resident had a diagnosis of End Stage Renal Disease and an AV shunt. There was no documentation that the bruit and thrill was assessed from 04/09/10 through 04/20/10. A review of the plan of care revealed that on 03/10/10 the plan of care was updated to add: Risk for Complications due to dialysis catheter/fistula. The intervention was to assess the bruit and thrill as per policy due to a fistula in the left arm. The MDS (minimum data set) dated 03/20/10 indicated the resident was assessed as alert and oriented with some short term memory deficit.</p> <p>Interview with Licensed Practical Nurse (LPN) #5 on 04/28/10 at 1:00pm revealed she assessed the site for bleeding and bruising. She checked for a bruit and thrill, but did not document it and understood that she should have.</p> <p>Interview with Registered Nurse #1 on 04/28/10 at 1:10pm revealed the documentation of a shunt check should be documented in the nursing notes.</p> <p>Interview with Resident #18 on 04/28/10 at 1:18pm revealed, the resident did not remember the nurse assessing him/her shunt with a stethoscope.</p> <p>Review of Resident #18's medical record revealed there was no documentation of the AV shunt assessment in the nursing notes.</p> <p>The facility did not produce a policy to address</p>	F 282		
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F 282	Continued From page 6 the AV shunt assessment. An education packet that identified the types of access devices for dialysis was provided; however, it did not include assessing the bruit and thrill of AV shunts.	F 282		
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to prepare and distribute food under sanitary conditions as evidenced by two (2) kitchen employees observed to handle resident's food without proper hand washing or glove change, and one dietary employee observed wearing a hair covering that did not fully restrain hair. The findings include: Review of the facility's policy titled Disposable Gloves (2002) revealed Associates should change gloves after touching items, equipment, utensils, trash can lids or soiled areas, and after doing anything that would contaminate the gloves resulting in possible cross-contamination. Observation of the kitchen's tray line on 04/26/10	F 371	F 371 E <u>Corrective Actions for Targeted Residents:</u> Items identified were corrected. <u>Identification of Other Residents with Potential to Be Affected:</u> All residents have the potential to be affected. <u>Systemic Changes:</u> Dietary staff was educated on hand washing, food handling, cross contamination, and proper hairnet usage. <u>Monitoring:</u> The Registered Dietician will audit the Dietary staff during tray preparation for one meal per week for 4 weeks. Audits will be conducted monthly thereafter. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.	June 4, 2010



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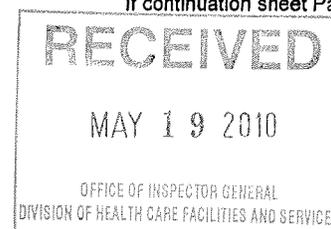
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F 371	<p>Continued From page 7</p> <p>at 11:00am revealed Cook #1 placed hot dog buns on two (2) residents' lunch plates after touching/handling clear plastic food wrap, residents' food trays, and serving utensil handles. Observations revealed hand washing or glove change were not performed after these tasks.</p> <p>Interview on 04/28/10 at 10:15am with Dietary Cook #1 revealed that he should not have touched the hot dog buns with his gloved hands after handling dirty items such as trays, serving utensils and plastic wrap. He stated tongs should be used when handling foods such as hot dog buns. He stated cross contamination could cause residents to become ill.</p> <p>Interview on 04/28/10 at 10:50am with the Dietary Supervisor revealed the dietary staff had been trained many times in the past on cross contamination and infection control. She stated transmission of germs from an employee's hand to a resident's mouth could cause a food-borne illness.</p> <p>Review of the facility policy (2002) titled Cross-Contamination revealed: Dietary associates must follow federal, state and local regulations on the safe handling of foods to avoid cross-contamination. The DSM or trained designee must ensure that food is handled in a safe manner to avoid cross-contamination.</p> <p>Observation of the kitchen's tray line on 04/27/10 at 7:00am revealed Dietary Cook #2 placing a green leafy garnish on the resident's breakfast plates using her bare hands. The garnish did come in contact with the food on the plate.</p> <p>Interview with Dietary Cook #2 on 04/28/10 at</p>	F 371		
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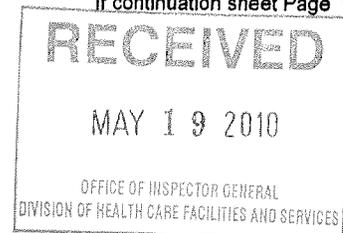
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F 371	Continued From page 8 10:30am revealed she should have used tongs to handle the garnish. She stated she knew better than to touch the garnish with her bare hands. Cross-contamination of food can pass germs on to the residents. Review of the facility's policy titled Associate Hair Guidelines (2002) revealed Associates should wear disposable bouffant caps that cover all hair completely. Observation on 04/25/10 at 3:00pm revealed the Cook Supervisor wearing a hair covering that only covered one half of her head and did not fully restrain her hair. Continued observation of the same employee on 04/26/10 at 11:00am revealed the hair continued unrestrained. Interview with the Cook Supervisor on 04/28/10 at 1:00pm revealed she was unaware that the hair covering did not fully restrain her hair. She stated that the hair covering should fully cover the hair so that hair did not get into the residents' food. Interview with Dietary Cook #2 on 04/28/10 at 10:30am revealed that all kitchen employees are trained to wear hair coverings in order to prevent things like hair and dandruff from falling into the residents' food. Interview with the Dietary Supervisor on 04/28/10 at 10:50am revealed that hair coverings must fully restrain the hair, and are worn by all kitchen employees.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		



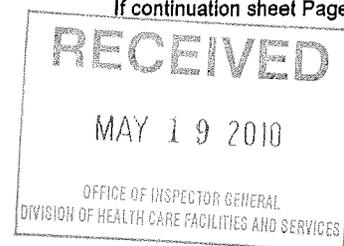
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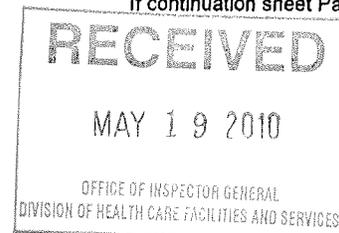
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 9</p> <p>of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to ensure expired medications and biologicals were removed, not available, or accessible for staff use during resident care.</p>	F 431	<p>F 431 D</p> <p><u>Corrective Actions for Targeted Residents:</u> The 100 wing medication room was audited by the Unit Manager to ensure expired medications and biologicals were removed.</p> <p><u>Identification of Other Residents with Potential to Be Affected:</u> Each medication room was audited by the Unit Manager to ensure expired medications and biologicals are not available or accessible for staff use.</p> <p><u>Systemic Changes:</u> Licensed Nurses were educated on drug and biological storage to include checking the expiration dates. Additionally the facility educated the Unit Managers to audit the medication rooms weekly.</p> <p><u>Monitoring:</u> The Unit Manager will conduct an audit weekly of the medication room and review with the Assistant Director of Nursing. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.</p>	June 4, 2010



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

PRINTED: 05/11/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2010
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
(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 431	<p>Continued From page 10</p> <p>The findings include:</p> <p>Observation on 04/27/10 at 8:50am, with Licensed Practical Nurse (LPN) #2, of the 100 Wing Medication Room revealed one (1) Phenergan 25 mg suppository, Lot #8102365, expired 02/10, two (2) Intravenous (IV) start kits, Lot #705048, expired 02/09, Braun Small Bore Extension Set, Lot #60736393, and Lot #60736389, expired on 01/10, and one (1) IV catheter Introcath Safety twenty-four (24) gauge, 3/4 inch, Lot # 4G 07258R01, expired on 07/09.</p> <p>Interview on 04/27/10 at 9:05am with LPN #2 revealed she is responsible to check the expiration date on the medications in the refrigerator during her shift. She indicated expired medications were not to be given to residents. She reported she failed to check for expired medications.</p> <p>Interview on 04/27/10 at 9:30am with the 100 Wing Unit Manager revealed that each nurse is responsible to check the expiration date on the medications and medication room supplies. She indicated expired medications were not to be given to residents, or expired supplies available for resident use. She did not have any explanation as to why expired medications and intravenous supplies remained in the medication room available for use. She indicated she did not have a system in place to ensure the medication room was checked by staff and there was not any one person assigned to a specific task for that purpose.</p>	F 431		



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

OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	DIVISION (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GOLDEN LIVING CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2010
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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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	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.	
K 062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 05/17/10, it was determined the facility failed to ensure sprinkler heads were free of corrosion as required by NFPA 25, 1999 Edition.</p> <p>The findings to include:</p> <p>A tour of the facility conducted 05/17/10 at 10:30 AM, revealed sprinkler heads throughout the facility had a build-up of lint and dust.</p> <p>An interview with the Administrator and Maintenance Director, on 05/17/10 at 10:35 AM, revealed they were unaware of the build-up of lint and dust on the sprinkler heads.</p> <p>Reference to: NFPA 25 1999 Edition.</p>	K 062	<p>K 062 F</p> <p><u>Corrective Actions for Targeted Residents:</u> No individual residents were targeted.</p> <p><u>Identification of Other Residents with Potential to Be Affected:</u> All residents have a potential to be effected.</p> <p><u>Systemic Changes:</u> Living center contracted with local sprinkler company to audit the facility's sprinkler heads related to the cited deficiency. Any areas of concern will be corrected immediately by the contract company.</p> <p><u>Monitoring:</u> Contracted sprinkler company will conduct an audit on their quarterly inspection of 25% of the sprinkler heads. A report will be generated and presented to the QAA committee for review and further recommendations if needed.</p>	06/04/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Brian P. Mueller</i> EDL/HA	TITLE Executive Director	(X8) DATE 5/26/2010
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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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GOLDEN LIVING CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2010
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
(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 062	Continued From page 1 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062			

