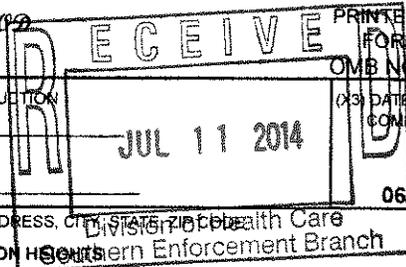


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Amended SOP



PRINTED: 07/10/2014
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 _____	(X3) DATE SURVEY COMPLETED 06/05/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HOSPITAL 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
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS	F 000		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p>	F 441	<p><u>Preparation, submission and implementation of this plan of correction does not constitute an admission of agreement with this facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a mean to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></p> <p>F441 D</p> <p>Resident #7 and Unsampled Resident</p> <p>#1 Resident #1 or Unsampled resident had no adverse outcome related to this deficient practice. 1:1 Education was conducted with LPN #1 on 6/27/14 as relates to guidelines for cleansing the blood glucose meter before and after use for each resident. 1:1 Education was conducted on 6/9/14 with C.N.A. #1 as relates to proper handling of dirty meal trays vs. unserved trays on food cart for residents.</p> <p>#2 All residents have the potential to be affected by the same deficient practice. The Director of Clinical Educator conducted observations beginning 6/25/14 and will be completed by 7/2/14 with current nurses during performance of blood glucose testing for other residents. Nurses performed blood glucose testing with proper cleansing of the glucose monitor with bleach wipes according to facility guidelines. No concerns were identified during this observation.</p> <p>The Director of Clinical Educator and/or designees (Department Managers, Unit Managers) conducted observations during daily meal service on 6/9/14, 6/11/14, 6/16/14, 6/18/14, and 6/24/14. No concerns were noted with dirty meal trays placed on meal cart with unserved trays to residents.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE July 11, 2014
---	------------------------	----------------------------

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

PRINTED: 07/10/2014
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 _____		(X3) DATE SURVEY COMPLETED 06/05/2014
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	
F 441	<p>Continued From page 1</p> <p>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, record review, and review of facility policies, it was determined the facility failed to maintain an effective infection control program to help prevent the development and transmission of disease for two (2) of twenty-four (24) sampled and two (2) unsampled residents (Resident #7 and unsampled Resident B). Observation of the medication pass on 06/03/14 at 12:05 PM revealed Licensed Practical Nurse #1 failed to sanitize the glucose meter before and after use for Resident B; and before proceeding to use the same glucose meter to test Resident #7's blood glucose level. In addition, observation of the evening meal on 06/03/14 on the 200 Unit revealed a staff member placed a soiled food tray back on the meal cart with three (3) clean resident food trays remaining on the cart that had not been delivered to the residents.</p> <p>The findings include:</p> <p>A review of the facility policy, "Optimum Return Demonstration Cleaning the Glucose Meter," (not dated) revealed the glucose meter exterior was cleaned after each resident use with a 10% bleach wipe. Staff was directed to turn the meter off, wipe the meter's exterior clean with the 10% bleach wipe, and allow to air dry.</p> <p>Review of the Education/In-service Report dated 05/27/13 revealed nurses were to "clean the</p>	F 441	<p>#3 A re-in-service was initiated and completed on 6/9/14 by the Director of Clinical Educator for all current Nurses and CNAs as relates to disinfecting multi use equipment for residents. A re-in-service was initiated and completed on 6/9/14 by the Director of Clinical Educator as relates to Meal Service placing dirty meal trays on tray cart with unserved meal trays. New hires will be educated during orientation process on Disinfecting of multi use equipment, and Meal Service. The Director of Clinical Educator and/or designee will conduct random observations weekly for 4 wks then monthly for 3 months during performance of blood glucose testing and other multi equipment use for proper cleansing following facility guidelines. Daily observations during meal service will be conducted either by the Director of Clinical Educator, Dining Service Hostess, Unit Managers, and /or the Charge Nurses as relates to proper handling of dirty vs. unserved meal trays on food carts. The Director of Nursing/Assistant Director of Nursing and/or designee will conduct random observations during use of multi equipment for proper disinfecting, and observations during meal service for proper handling of dirty meal trays vs. unserved meal trays on food carts.</p> <p>#4 Results of observations will be taken to the monthly Quality Assurance Process Improvement meetings and action plans will be developed as needed.</p> <p>Date of Compliance 7/4/14.</p>		

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

PRINTED: 07/10/2014
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 _____		(X3) DATE SURVEY COMPLETED 06/05/2014
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	
F 441	<p>Continued From page 2</p> <p>accu-check monitors with Clorox wipes and let dry one (1) minute."</p> <p>1. Observation of the medication pass on 06/03/14 at 11:55 AM revealed Licensed Practical Nurse (LPN) #1 performed a blood glucose test on Resident B with the glucose monitor without cleaning the machine first. After the blood glucose test was completed, LPN #1 cleaned the glucose meter with an alcohol swab (instead of a 10% bleach wipe). LPN #1 then took the same glucose meter and performed a blood glucose test at 12:05 PM for Resident #7 without cleaning the meter with a 10% bleach solution.</p> <p>Interview with LPN #1 on 06/03/14 at 12:10 PM revealed the bleach wipes were in a large container and would not easily fit in the medication cart. LPN #1 said the pharmacist did not want the bleach wipes left on top of the medication cart to ensure residents did not have access to the bleach wipes for their safety and therefore LPN #1 had not left the bleach wipes on the medication cart. LPN #1 said she thought it was acceptable to cleanse the blood glucose meter with either bleach or alcohol.</p> <p>Interview with RN #1 on 06/04/14 at 10:05 AM revealed the blood glucose meters were to be cleaned with bleach. According to RN #1, the facility trained all the nurses on an annual basis to cleanse the blood glucose meters with bleach before and after each use. RN #1 said she did not monitor nurses to ensure they cleanse the blood glucose meters according to facility policy, but the staff development nurse did observe staff performing blood glucose testing during medication passes. RN #1 said she did not know of any problems with blood glucose monitoring.</p>	F 441			

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

PRINTED: 07/10/2014
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 _____		(X3) DATE SURVEY COMPLETED 06/05/2014
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	
F 441	Continued From page 3 Interview with the Staff Development Coordinator on 06/04/14 at 10:20 AM revealed all nurses were trained to clean glucose monitors before and after use with a 10% bleach wipe and to let the meter air dry prior to the next use. The Staff Development Coordinator said the facility observed a medication pass twice a year to ensure staff administered medications by the correct route, for infection control purposes, and to ensure blood glucose testing was performed in accordance with the recommendations. The Staff Development Coordinator stated the facility had not observed any concerns related to staff failure to properly sanitize the equipment during the medication pass, and that in May 2013 the facility had provided an in-service on the correct method to sanitize the blood glucose monitoring equipment. Interview with the Director of Nursing (DON) on 06/04/14 at 11:15 AM revealed nurses should clean the blood glucose meters with a 10% bleach wipe before and after use. The DON said the bleach wipes could be placed on top of the medication carts as long as the nurses were in view of the medication carts. The DON stated the Staff Development Nurse observed staff administering medications to resident, including blood glucose testing, and had not identified any concerns. 2. Review of the facility's policy for Nursing Responsibilities at Meal Service (no date) revealed soiled tabieware cannot be placed on food carts with undelivered meals. Observation of the evening meal on the 200 Unit at 5:55 PM on 06/03/14 revealed Certified	F 441			

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

PRINTED: 07/10/2014
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 _____		(X3) DATE SURVEY COMPLETED 06/05/2014
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	
F 441	Continued From page 4 Nursing Assistant (CNA) #1 placed a soiled food tray back onto the clean cart containing three undelivered resident meal trays. Interview with CNA #1 at 6:00 PM on 06/03/14 revealed the staff does not put soiled trays back onto the food cart until all the clean trays have been served. The CNA further stated soiled food trays usually remained in the resident's room until all the clean trays were served to the residents. Interview with the Dietary Manager at 6:20 PM revealed staff was aware dirty meal trays were not to be placed back on the food cart with clean meal trays remaining on the cart. Interview with the Unit Manager on the 200 Unit at 6:30 PM revealed the CNAs had all been trained to not place soiled food trays back onto a food cart with undelivered (clean) resident trays remaining on the food cart. The Unit Manager stated she did not know why the CNA placed the dirty tray back onto the clean food cart.	F 441			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514	F514D Medical Records 1. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #1: Allergy listed as NSAID - Physician ordered Celebrex 200mg. Daily PRN on 4/28/14. This medication was not given at any time since date of order. Therefore, this medication has been discontinued on 6/3/14. Resident #13: Allergies currently listed as Codeine and Lisinopril. Resident Allergy listing has been updated to reflect current allergies to Codeine, Lisinopril, Meclizine and Ultram and verified by physician. No medications were listed that relates to the above allergies.		

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

PRINTED: 07/10/2014
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 _____		(X3) DATE SURVEY COMPLETED 06/05/2014
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	
F 514	Continued From page 5 and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility policy, it was determined the facility failed to ensure clinical records were complete, accurate, and maintained in accordance with accepted professional standards and practices for two (2) of fourteen (14) sampled residents (Residents #1 and #13). Review of the medical record for Resident #13 revealed physician notes dated 10/10/13, 10/29/13, 12/05/13, and 01/07/14 which revealed the resident was allergic to Codeine (Opiate), Ultram/Tramadol (Atypical Opioid), Lisinopril (Angiotensin-Converting Enzyme inhibitor), and Meclizine (antihistamine). However, continued review of the medical record revealed staff had documented the resident had allergies to only two medications, Codeine and Lisinopril. Review of documentation revealed facility staff had not administered any of the medications to Resident #13 identified as medications that Resident #13 experienced allergic reactions to. In addition, a review of the medical record of Resident #1 revealed on 04/28/14, Resident #1's physician prescribed 20 milligrams of Celebrex (NSAID), to be administered once daily, and as needed (PRN) for the resident. Review of Resident #1's Medication Administration Record (MAR) revealed staff had transcribed the physician's order for the Celebrex to the MAR. Review of the MAR for April, May, and June 2014 revealed facility staff had not administered the Celebrex to the resident.	F 514	2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by this deficient practice; Medical Record audits were initiated on 6/16/14 and completed on 6/17/14 of current residents for current allergy listing. Resident's allergy listings will be updated ongoing to reflect current allergies according to physician documentation. Based on this audit there were 24 residents noted with changes to allergy listing with revisions to reflect current allergy listing. 3. Address what measures will be put into place or systemic changes made to ensure deficient practice will not recur; An In service was initiated on 6/10/14 by the Director of Clinical Education on procedures for documentation of allergies and completed on 6/13/14. The Director of Clinical Education will educate all new hires during orientation on above changes. Upon admission/readmission the resident's allergy listing will be entered by the nurse electronically under the allergy tab in the medical record. The resident's allergies will automatically display onto the electronic medication administration record in red. Changes that occur to the resident's allergy listing will be noted and documented by the physician/NP and a physician order will be written and noted. Allergy listing changes will be noted in medical record under the allergy tab. New Admissions/Re-admissions medical record will be reviewed by the Charge Nurse/Unit Manager for current allergies and noted in the medical record under the allergy tab.		

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

PRINTED: 07/10/2014
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(K3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-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)	DATE COMPLETION DATE	
F 514	Continued From page 6 The findings include: Review of facility policy titled SBAR (Situation, Background, Assessment, Response) Nurse/Physician Communication, not dated, revealed the facility would have all information available when reporting, including the resident chart, advance directive, allergies, and medication list. 1. A review of the medical record revealed the facility admitted Resident #13 on 10/08/13. A review of a quarterly Minimum Data Set (MDS) assessment dated 03/14/14, revealed facility staff assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident's cognition was moderately impaired. Review of documentation (not dated) on the allergy notification sticker located on the interior cover of the resident's medical record, on the face sheet of Resident #13's medical record, on the June 2014 Physician Orders, and on the Medication Administration Record (MAR) revealed the resident had allergies to Codeine and Lisinopril. However, review of physician notes dated 10/10/13, 10/29/13, 12/05/13, and 01/07/14 revealed the resident had allergic reactions to Codeine, Ultram, Lisinopril, and Meclizine. In addition, review of documentation from a physician's admission note to the local hospital, dated 11/30/13, revealed the resident had allergies to Codeine, Lisinopril, and Tramadol/Ultram. An interview with Resident #13 on 06/04/14 at 1:34 PM revealed the resident was unsure of what medication allergies he/she had.	F 514	The Charge Nurse/Unit Manager will monitor for changes to allergy listing daily during normal start up with review of physician orders. DNS/ADNS or designee will conduct random audits to validate resident's allergy listing is current and accurate based on physician documentation. 4. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; The results of the audits will be taken to the facility's monthly Quality Assurance Process Improvement meeting and plans will be developed as needed. Date of Compliance July 4, 2014		

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

PRINTED: 07/10/2014
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 _____		(X3) DATE SURVEY COMPLETED 06/05/2014
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	
F 514	<p>Continued From page 7</p> <p>An interview with Licensed Practical Nurse (LPN) #2 on 06/04/14 at 4:51 PM revealed the facility utilized a "point click computer charting system" and stated the "allergy section on the profile listed Codeine and Lisinopril" as Resident #13's medication allergies.</p> <p>Registered Nurse (RN) #4 confirmed in interview conducted on 06/04/14 at 4:55 PM that the allergy sticker in Resident #13's medical record revealed the resident was allergic to only "Codeine and Lisinopril."</p> <p>An interview with the Director of Nursing (DON) on 06/05/14 at 3:50 PM confirmed facility staff had not identified that Resident #13's medication allergies included Ultram and Meclizine and stated, "We missed it."</p> <p>2. Review of Resident #1's medical record revealed the facility admitted Resident #1 on 03/08/13 with diagnoses that included closed fracture of Trochanteric Femur, Intestinal Infection, Anxiety, Depression, Primary Pulmonary Hypertension, Osteoporosis, and Chronic Pain Syndrome. Review of Resident #1's Minimum Data Set (MDS) assessment dated 12/12/13 revealed facility staff assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident's cognition was intact. Continued review of Resident #1's medical record revealed the resident had a documented allergy to Non-steroidal Anti-Inflammatory Drugs (NSAIDs).</p> <p>On 04/28/14, Resident #1's physician prescribed 20 milligrams (mg) of Celebrex (NSAID), to be administered once daily, as needed (PRN). Review of Resident #1's Medication</p>	F 514			

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

PRINTED: 07/10/2014
FORM APPROVED
OMB NO. 0938-0391

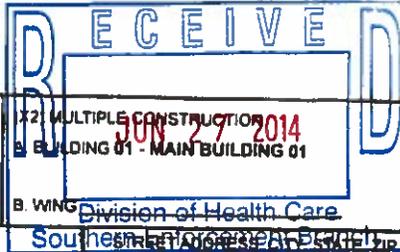
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 514	<p>Continued From page 8</p> <p>Administration Record (MAR) revealed the resident had an allergy to NSAIDs. Continued review of the MAR revealed staff had transcribed the physician's order for Celebrex to be given to the resident, as needed, onto the MAR. Review of the MAR for April, May, and June 2014 revealed facility staff had not administered the Celebrex to the resident.</p> <p>Interview on 06/03/14 at 4:40 PM with Registered Nurse (RN) #3 revealed she had received the physician's order for the Celebrex and had faxed the order to the pharmacy, and the pharmacy called to alert the facility that Resident #1 had been prescribed a medication he/she had a documented allergy to. RN #3 stated she spoke with Resident #1 and the resident's family member and both stated the resident had taken Celebrex in the past and had become nauseous but did not have an allergy to the medication. RN #3 stated she then called Resident #1's primary care provider (PCP) who stated the resident had sensitivity to NSAIDs and not an allergy and could take the Celebrex as ordered. RN #3 stated she called the pharmacy to report that the PCP stated Resident #1 could take the Celebrex as ordered. However, RN #3 stated she had not documented anything related to the conversation with the resident and his/her family member regarding the resident's allergy to NSAIDs, and stated, "I guess I just got busy and forgot to write a note about the allergy change."</p> <p>Interview on 06/03/14 at 4:54 PM with RN #4, the Unit Manager on the rehabilitation unit, revealed that any time a nurse received clarification of an order or received a change to a documented allergy the nurse should write a note for the chart and ensure that a doctor's order was obtained for</p>	F 514			

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

PRINTED: 07/10/2014
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 _____		(X3) DATE SURVEY COMPLETED 06/05/2014
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	
F 514	Continued From page 9 the change. Interview on 06/04/14 at 10:50 AM with the Advanced Registered Nurse Practitioner (ARNP) revealed the ARNP could not recall a conversation she had with RN #3 related to the report that Resident #1 had an allergy to NSAIDs, but stated she didn't feel that it was "a problem" if Resident #1 took the Celebrex in the future. An interview with the Director of Nursing (DON) on 06/05/14 at 3:50 PM revealed the facility reviewed physician orders on a daily basis to ensure medical records were updated. The DON stated staff should have obtained a physician's order to discontinue the identification of NSAIDs as an allergy for Resident #1 if the information was inaccurate.	F 514			

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



PRINTED: 06/19/2014
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 01 - MAIN BUILDING 01 B. WING Division of Health Care Southern Baptist Health System	(X3) DATE SURVEY COMPLETED 06/03/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD		CITY AND STATE ZIP CODE 106 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)

K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1988

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One story, Type 111(200)

SMOKE COMPARTMENTS: Five

FIRE ALARM: Complete automatic fire alarm system

SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system

GENERATOR: Type II natural gas generator

A life safety code survey was initiated and concluded on 06/03/14. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.

Deficiencies were cited with the highest deficiency identified at "E" level.

K 018 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or

K 000

Preparation, submission and implementation of this plan of correction does not constitute an admission of agreement with this facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a mean to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.

K 018

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

1. What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice?

Maintenance department will conduct a facility audit to identify any other doors that may not be working in according to standard and or are in deficient practice.

Maintenance department will correct corridor doors to resident rooms 108 and 112 and any doors that are not closing and or latching to help resist passage of smoke in a fire situation

2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

All resident have the potential to be affected. Facility Maintenance Director will conduct audit to identify any problem areas related to the findings

K 018

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

RuM...

TITLE

Administrator

(X6) DATE

6/27/2014

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

PRINTED: 06/19/2014
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/03/2014
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 018	<p>Continued From page 1</p> <p>hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor doors were maintained according to National Fire Protection Association (NFPA) standards. This deficient practice affected one (1) of five (5) smoke compartments, staff, and approximately fifty-eight (58) residents. The facility has the capacity for 128 beds with a census of 116 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 06/03/14 at 10:45 AM with the Director of Maintenance (DOM), corridor doors to resident rooms 108 and 112 were observed not to close and latch due to</p>	K 018	<p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Maintenance Director will conduct a facility audit to identify any other rooms or common areas that may have deficient practices. Maintenance Director will conduct staff in-services on using Building Engines (system for reporting maintenance concerns). In addition the Maintenance Director will continue to monitor building engines daily. Quarterly walk through by maintenance will continue and be monitored by Executive Director Non-Clinical rounds will be performed by facility Department Heads and reviewed in morning meeting.</p> <p>4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The daily rounds will be reviewed and discussed in morning stand up by IDT and monitored by Executive Director. Executive Director will do and audit of non-clinical rounds weekly for four weeks, then monthly for 3 months. Executive Director will be monitor quarterly environmental rounds by Maintenance Director. Executive Director will bring results to QAPI for 3 months. Quarterly walk through by maintenance will be monitored by Executive Director.</p> <p>Date of compliance 7/4/2014</p>		

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

PRINTED: 06/19/2014
FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/03/2014
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 018	Continued From page 2 the doors sticking in the doorframes when tested. Corridor doors must close and latch to help resist the passage of smoke in a fire situation. An interview on 06/03/14 at 10:45 AM with the DOM revealed he checked doors for proper operation but must have missed these doors. The findings were revealed to the Administrator upon exit. Reference: NFPA 101 (2000 Edition). 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.	K 018	K 027 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1. What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice? Maintenance department will conduct a facility audit to identify any other doors that may not be working in according to standard and or are in deficient practice. Maintenance department will correct corridor fire doors in Zone 3 and 4 and any other fire doors that are not closing to help resist passage of smoke in a fire situation. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All resident have the potential to be affected. Facility Maintenance Director will conduct audit to identify any problem areas related to the findings. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Maintenance Director will conduct a facility audit to identify any other fire doors that may have deficient practices. Maintenance Director will conduct staff in-services on using Building Engines (system for reporting maintenance concerns). In addition the Maintenance Director will continue to monitor building engines daily. Quarterly walk through by maintenance will continue and be monitored by Executive Director Non-Clinical rounds will be preformed by facility Department Heads and reviewed in morning meeting.		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1½-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.8,	K 027			

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

PRINTED: 06/19/2014
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 185 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 027	Continued From page 3 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that cross-corridor fire/smoke barrier doors were maintained according to National Fire Protection Association (NFPA) standards. This deficient practice affected two (2) of five (5) smoke compartments, staff, and approximately nineteen (19) residents. The facility has the capacity for 128 beds with a census of 116 on the day of the survey. The findings include: During the Life Safety Code tour on 06/03/14 at 10:30 AM with the Director of Maintenance (DOM), a set of cross-corridor fire/smoke barrier doors for Zones 3 and 4 were observed not to close all the way when tested. When tested, the bottom of one of the doors would drag on the floor and hold the door approximately three-quarters of the way open. These doors must close all the way to help prevent fire/smoke from spreading to other parts of the building in case of a fire situation. An interview with the DOM on 06/03/14 at 10:30 AM revealed he was aware the door was not working correctly and that funds were not available to have the door fixed or replaced. The findings were revealed to the Administrator upon exit.	K 027	→ How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Executive Director will be monitor quarterly environmental rounds by Maintenance Director, Executive Director will bring results to QAPI for 3 months. Quarterly walk through by maintenance will be monitored by Executive Director. Date of compliance 7/4/2014 K 062 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1. What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice? Maintenance department along with fire and safety vendor will conduct a facility audit to identify that all sprinkler heads meet standards. Quick response and standard response sprinkler should not be grouped together. DOM will ensure that all sprinkler heads are grouped correctly according to standard. Maintenance department and fire and safety vendor will correct quick response and standard response sprinkler heads located in the business lobby. DOM and fire and safety vendor will ensure that sprinklers are all the same type in a compartmented space. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All resident have the potential to be affected. Facility Maintenance Director will conduct audit to identify any problem areas related to the findings.	
K 062	NFPA 101 LIFE SAFETY CODE STANDARD SS=E	K 062		

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

PRINTED: 06/19/2014
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2014
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 062	<p>Continued From page 4</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 interview the facility failed to ensure that sprinkler heads were maintained as required. This deficient practice affected one (1) of five (5) smoke compartments, staff, and approximately fifty-eight (58) residents. The facility has the capacity for 128 beds with a census of 116 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 06/03/14 at 11:10 AM with the Director of Maintenance (DOM), quick response and standard response rated sprinkler heads were observed in the front business lobby of the facility. Sprinkler heads located in the same compartmented space usually are required to be of the same type. This condition may adversely affect the way the sprinkler system reacts in a fire situation.</p> <p>An interview with the DOM on 06/03/14 at 11:10 AM revealed he was not aware sprinkler heads should have the same rating per compartmented space.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 13 (1999 Edition).</p>	K 062	<p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Maintenance Director will conduct a facility audit to identify any other quick response or standard response sprinkler heads that are located in the same compartmented space. In addition the Maintenance Director will continue to monitor building engines daily. Quarterly walk through by maintenance will continue and be monitored by Executive Director. Fire and Safety vendor will continue to do routine maintenance to the fire system and leave reports for review DOM and Administrator.</p> <p>4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Executive Director will be monitor quarterly environmental rounds by Maintenance Director. Executive Director will bring results to QAPI for 3 months. Quarterly walk through by maintenance will be monitored by Executive Director and Fire and Safety vendor will provide reports from their routine inspections.</p> <p>Date of compliance 7/4/2014</p>	

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

PRINTED: 06/19/2014
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 01 - MAIN BUILDING 01 B WING _____		(X3) DATE SURVEY COMPLETED 06/03/2014
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 062	Continued From page 5 5-3.1.5.2 When existing light hazard systems are converted to use quick-response or residential sprinklers, all sprinklers in a compartmented space shall be changed.	K 062			
K 072 SS=E	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 that corridors were maintained free from obstructions to full instant use in the case of fire or other emergency. This deficient practice affected one (1) of five (5) smoke compartments, staff, and approximately fifty-eight (58) residents. The facility has the capacity for 128 beds with a census of 118 on the day of the survey. The findings include: During the Life Safety Code tour on 06/03/14 at 11:20 AM with the Director of Maintenance (DOM) four patient lifts were observed to not be in use and unattended in Zone 5 of the facility. Two signs on the corridor wall stated "Park Lifts Here." Corridors are intended for means of egress, internal traffic, and emergency use, not storage spaces. The Life Safety Code has	K 072	K 072 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1. What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice? Maintenance/Nursing will remove all signs in the facility that state equipment may be "parked" in the corridors/hallways. Maintenance and Nursing will ensure that all handrails will be accessible for resident use. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All resident have the potential to be affected. Facility Maintenance Director will conduct audit to identify any problem areas related to the findings. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Maintenance Director/Nursing (Unit Managers) will monitor daily usage of equipment to ensure that equipment is not being left unattended on the halls for extensive periods of time. In-service with current staff was initiated on 6/27/2014 by the Director of Clinical Education (DCE) on storage of equipment not in use will be completed 7/2/2014.		

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

PRINTED: 06/19/2014
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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/03/2014
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 072	<p>Continued From page 6</p> <p>specific requirements for storage spaces. These items would also limit the use of the handrails by occupants of the building when needed.</p> <p>An interview on 06/03/14 at 11:20 AM with the DOM revealed these items were routinely left unattended for long periods of time on one side of the corridor. The DOM stated he was not aware items should not be stored in the corridor.</p> <p>The findings were revealed to the Administrator upon exit.</p>	K 072	<p>4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The daily rounds conducted by the Leadership Team will be reviewed and discussed in morning stand up and monitored by Director of Nursing . Executive Director and or designee to ensure that equipment is not being left unattended.</p> <p>Date of compliance 7/4/2014</p>		