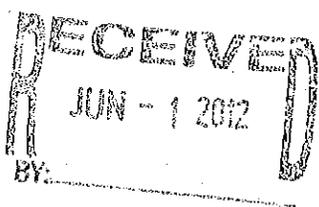
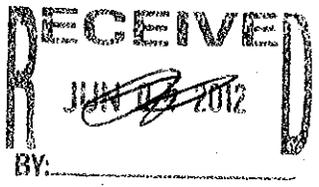


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FORM APPROVED
OMB NO. 0938-0391

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

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 05/12/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - VANCEBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 68 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
F 000	INITIAL COMMENTS	F 000		
F 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to assess one (1) of nineteen (19) sampled residents, Resident #9's, Velcro seat belt as a restraint as per the facility's policy titled, "Restraint Evaluation and Utilization Guideline", dated January 2011. In addition the facility failed to obtain a Physician's order for the Velcro seat belt before it was brought to the facility's attention about the lap buddy ordered 11/15/11 and the Velcro seat belt the resident was observed to be wearing during the survey process.</p> <p>The findings include: Review of the facility's policy entitled, "Restraint Evaluation and Utilization Guideline", dated January 2011, revealed a restraint is any manual method or physical/mechanical device, material</p>	F 221	 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Melissa Barkley</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>6/1/12</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 68 EASTHAM STREET VANCEBURG, KY 41179	
(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 221	<p>Continued From page 1</p> <p>or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom or movement or normal access to one's own body.</p> <p>Review of Resident #9's clinical record revealed the facility admitted Resident #9 on 01/20/09 with diagnoses which included Dementia with Lewy Bodies, Cerebrovascular Disease, Depression, Diabetes II and Psychosis. Further review of the clinical record revealed a Physician's order for a "lap buddy", a positioning/restraint device that fits on a wheelchair, written on 11/16/11.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/12/12, revealed the facility assessed the resident to rarely/never make self understood and to rarely/never understand others. Further review of the MDS revealed Resident #9's Cognitive Skills for Daily Decision Making score was a three (3), which indicated the resident was "severely impaired". Review of MDS revealed Resident #9 required maximum assist of two (2) staff members for all activities of daily living (ADL's). Further review of the MDS revealed the resident was assessed as not using any restraints.</p> <p>Observations of Resident #9, on 05/08/12 at 5:10 PM and 5:55 PM; on 05/09/12 at 9:20 AM, 10:00 AM, 10:30 AM, 1:30 PM and 3:10 PM; on 05/10/12 at 9:15 AM, revealed the resident was sitting in a wheel chair with a Velcro seat belt around the resident's waist.</p> <p>Interview with MDS Nurse #8, on 05/12/12 at 1:05 PM, revealed that positioning devices such as a lap buddy or a Velcro seat belt that a resident</p>	F 221	<ol style="list-style-type: none"> 1. Resident #9 was reassessed by the Interdisciplinary Team and screened by therapy services for positioning. A restraint re-evaluation was completed on 5/17/12 and based on the assessment it was determined the resident did not benefit from the use of this type of device. The Velcro belt was removed and care plan updated to reflect the Velcro belt was discontinued. 2. All residents have the potential to be affected by this deficient practice. The DNS/ADNS/Designee will conduct a restraint reassessment for residents with positioning, enabling, and/or seating devices by 6/15/12. Therapy will conduct re-screens on residents utilizing seating, enabling and/or position devices by 6/20/12. The restraint assessments and therapy screens will be reviewed by the Interdisciplinary Team to assure appropriate use of the device by 6/20/12. The Interdisciplinary Team includes the following: 1. Director of Nursing Services, 2. Assistant Director of Nursing Services, 3. Social Services, 4. Activity Director, 5. Physical Therapy, 6. Occupational Therapy, 7. Minimum Data Set nurse and 8. Dietary Manager. 	

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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 221	<p>Continued From page 2</p> <p>could not release on command, was a restraint and should have been coded as such.</p> <p>Interview, on 05/11/12 2:20 PM, with Licensed Practical Nurse (LPN) #2, revealed Resident #9 was able to release the seat belt on command. Further interview revealed she was not able to remember how long Resident #9 had been wearing the seat belt instead of the ordered lap buddy. However, observation at this date/time with LPN #2, revealed Resident #9 was unable to release the seat belt in spite of verbal cuing from LPN #2.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 05/12/12 at 12:40 PM, revealed she did not consider Resident #9's seat belt to be a positioning device to keep him/her from falling out of the wheelchair, instead of a restraint and because Resident #9 could release the belt on command. Further interview revealed she was unaware Resident #9 was wearing a seat belt instead of the lap buddy that had been ordered on 11/15/11 or when/why the resident started wearing a seat belt. Observations on this date/time revealed Resident #9 was unable to release the seat belt even with verbal cueing from the ADON and the ADON placing the resident's hands on the clasp of the belt.</p> <p>Interview with the Director of Nursing Services (DNS), on 05/12/12 at 3:40 PM, revealed her definition of a restraint was anything that restricts freedom of movement or access to one's body by either chemical or physical means. Further interview revealed she did not think that Resident #9's Velcro seat belt restricted his/her movement because if the resident leaned far enough</p>	F 221	<p>3. The DNS/ADNS/Charge nurse will monitor daily and upon condition changes to ensure residents with devices have a physician order to reflect the type of device used. The DNS/ADNS/Designee will conduct quarterly assessments to monitor residents with positioning/enabling, and /or seating devices utilizing the Restraint Assessment forms for continued use of the device and/or needed changes to the current device utilized. The DNS/ADNS/Designee will re-educate all nursing staff (Nurses/C.N.A.s) on the clinical guideline for Restraint use to include Quarterly Assessments/documentation requirements by 6/20/12.</p> <p>4. Residents will be assessed by the Interdisciplinary team for the need of restraint use upon admission and as needed with change of conditions. Residents will be audited monthly for one month for restraint use to include physician orders, then quarterly by the DNS/ADNS/Designee. Results of the audits will be taken to the monthly Quality Assurance Committee meetings X3 months to discuss findings and develop action plans as indicated.</p>	6/20/12

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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 221	Continued From page 3 forward, the Velcro belt would release. She further stated she considered the seat belt to be an "enabler" and not a restraint because it allowed the resident to maintain a "good, erect position" while in the wheelchair. Further interview revealed she stood by the decision to not code the Velcro seat belt as a restraint completed on the facility's assessment date.	F 221		
F 279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and procedures, it was</p>	F 279		

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F 279	<p>Continued From page 4</p> <p>determined the facility failed to 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 for five (5) of nineteen (19) residents (Residents #3, #8, #11, #14, and #19). The facility failed to develop Resident #3's care plan for falls; Resident #11's care plan for dental care; Resident #14's care plan for communication, falls, dehydration/fluid maintenance and psychotropic drug use; and Resident #19's care plan for urinary incontinence.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled, "Long-Term Care Resident Care Procedures," dated 2006, states the approaches direct caregivers to list instructions unique for each resident is included to remind caregivers to individualize care. The resident's preferences, choices and customary routine should be considered when documenting care plan approaches. Observation, monitoring and reporting of appropriate conditions may be included in this section, according to facility procedure.</p> <p>1. Review of the clinical record for Resident #11, revealed the facility admitted Resident #11 on 05/27/11 with the admitting diagnoses to include: Psychosis, Depression, Constipation, GERD, Electrolyte Imbalance, Anxiety, COPD, Atrial Fibrillation, Hypertension, Hyperlipidemia, and Hyperplasia Prostate.</p> <p>Review of Resident #11's Minimum Data Set</p>	F 279		

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F 279	<p>Continued From page 5</p> <p>(MDS), dated 08/03/11, revealed dental care was triggered on the Care Area Assessment (CAA) Summary. The MDS identified dental care as triggered and addressed in the care plan.</p> <p>Review of Resident #11's CAA, dated 08/03/11, revealed dental care was triggered for Resident #11 as having no natural teeth or tooth fragment(s) (edentulous). Further review of the CAA, revealed the analysis of findings indicated a cognitive deficit as a contributing factor for oral/dental problems as well as functional impairment related to decreased mobility and lack of motivation or knowledge regarding adequate oral hygiene or dental care.</p> <p>Review of Resident #11's Comprehensive Plan of Care (CPC), revealed Resident #11 did not have a written plan of care for dental care.</p> <p>Interview with the Registered Nurse Assessment Coordinator (RNAC) #10, on 05/11/12 at 2:30 PM, revealed the dental care care plan had not been developed. Further interview revealed, after reviewing the MDS and CAAs, she validated the dental care plan should have been developed and place on the CPC. Continued interview revealed, the RNAC searched through the facility's computer system to verify the dental care plan may not have been printed, however, she confirmed the dental care plan was not developed.</p> <p>2. Review of the clinical record for Resident #8, revealed the facility admitted Resident #8 on 08/18/10 with the admitting diagnoses to include: Kidney Disease, Anxiety, Congestive Heart Failure, Diabetes with Peripheral Vascular</p>	F 279	<p>1. Residents #3, #8, #11, and #14 care plans were reviewed and revised by the Interdisciplinary Team according to the residents' needs to include current status/condition on 5/31/12. Resident #19 was discharged from facility 1/12/12 prior to survey. Resident #3 had care plan revision to reflect Falls, Resident #8 had care plan revisions to reflect urinary incontinence, Resident #11 had care plan revisions to reflect dental care, Resident #14 had care plan revision to reflect communication, falls, dehydration/fluid maintenance, and psychotropic drug use. The Interdisciplinary Team includes: 1. Director of Nursing Services, 2. Assistant Director of Nursing Services, 3. Dietary Manager, 4. Therapy Department, 5. Social Services, 6. Activities, 7. Minimum Data Set Nurse (Registered Nurse Assessment Coordinator.)</p>	

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F 279	<p>Continued From page 6</p> <p>Disease, Depression and Dyspepsia with other stomach disorders.</p> <p>Review of Resident #8's Annual MDS, dated 08/16/11, revealed urinary incontinence was triggered on the Care Area Assessment (CAA) Summary. The MDS identified urinary incontinence triggered and was addressed in the care plan.</p> <p>Review of Resident #8's CAA, dated 08/16/11, revealed urinary incontinence was triggered for Resident #8 with causative factors to include: psychological or psychiatric problems, pain and restricted mobility. Further review revealed Resident #8's diagnoses of Diabetes and Depression coupled with anticholinergic and antidepressant medication he/she was taking were also causative factors. Further review of the CAA revealed the urinary incontinence functional status would be addressed in the Comprehensive Plan of Care (CPC).</p> <p>Review of Resident #8's CPC, revealed no documented evidence the facility developed a plan of care for Resident #8 for urinary incontinence.</p> <p>Interview with RNAC #10, on 05/11/12 at 2:30 PM, revealed the urinary incontinence care plan had not been developed. Further interview revealed, after reviewing the MDS and the CAA's, she agreed the urinary incontinence care plan should have been developed and placed on the CPC.</p> <p>3. Review of medical record for Resident #14 revealed the facility admitted the resident on 03/26/12, with diagnoses which included Tib/Fib</p>	F 279	<p>2. All residents have the potential to be affected. Residents currently residing in the facility will have their care plan reviewed/ revised according to current needs to reflect current status/condition by 6/20/12 by the Interdisciplinary Team utilizing the CAA (Care Area Assessment) to ensure accuracy of the care plans. Care Plan development will be conducted using the CAA. Additionally, revisions will be made to the resident's care plan as conditions change and reflect the resident's most current condition.</p> <p>3. Care plans will be reviewed by the Interdisciplinary Team at least on a quarterly basis and/or with significant changes. Interdisciplinary Team includes: 1. Director of Nursing Services, 2. Assistant Director of Nursing Services, 3. Dietary Manager, 4. Therapy Department, 5. Social Services, 6. Activities, 7. Minimum Data Set Nurse (Registered Nurse Assessment Coordinator). The IDT will be re-educated by the DNS/ADNS/Designee on the Care Area Assessments protocol in conjunction with development of comprehensive care plans to reflect the resident's current condition/needs by 6/20/12.</p>	

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F 279	<p>Continued From page 7</p> <p>fracture, Diabetes, Rheumatoid Arthritis, Hypertension, Depression, Urinary Tract Infection, Lung Cancer with metastasis to brain and bone.</p> <p>Review of the CAA Summary, dated 04/06/12, revealed that Resident #14 triggered Care Areas for Communication, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, nutritional Status, Dehydration/Fluid Maintenance, Pressure Ulcer, Psychotropic Drug Use, and Pain.</p> <p>Review of Comprehensive Care Plan printed on 05/12/12 revealed the facility failed to formulate comprehensive care plan for 4 out of 9 care areas triggered by the CAA which were Communication, Falls, Dehydration/Fluid Maintenance, and Psychotropic Drug Use.</p> <p>Interview with the Director of Nursing (DON), on 05/12/12 at 9:10 AM, revealed that comprehensive care plans should have been formulated for care areas triggered by the CAA.</p> <p>Interview with the MDS Coordinator revealed that all care areas were addressed on the Immediate Plan of Care (IPOC) after the admission assessment was completed but were not addressed when the Comprehensive Care Plans was put in place.</p> <p>4. Review of Resident #3's clinical record revealed the facility admitted the resident, on 12/29/11, with diagnoses which include Closed Fracture of the Spinal Cord and Depression.</p> <p>Review of the Admission Minimum Data Set</p>	F 279	<p>4. The DNS/ADNS/IDT/Designee will monitor need for care plan development/revisions during the clinical start up process daily/weekdays (5 days/week), as well as on daily basis by the assigned charge nurse. Audits will be conducted on 5 residents weekly for 2 weeks, then monthly for 1 month, then quarterly for two quarters. Results of these audits will be taken to the Quality Assurance Meetings X3 months and action plans developed as needed.</p>	6/29/12

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F 279	<p>Continued From page 8</p> <p>(MDS) Assessment, dated 01/02/12, revealed the facility assessed the resident as having a Spinal Cord Injury resulting with quadraplegia and as taking antianxiety and antidepressant medications which triggered the resident's risk for falls.</p> <p>Review of the CAA Summary, dated 01/12/12, revealed Falls/Fracture triggered as a care area and would be addressed in the care plan. Review of the Comprehensive Care Plan, dated 01/12/12, revealed there was no documented evidence a plan of care was developed related to Resident #3 being at risk for falls.</p> <p>Interview, on 05/11/12 at 2:30PM, with RNAC #10, on 05/11/12 at 3:00 PM, revealed the Care Plan for falls was not developed. The process for writing care plans was normally the facility developed the care plan by reviewing the triggers from the MDS Assessment and the Physician's orders.</p> <p>5. Review of Resident #19's closed record revealed the facility admitted the resident on 12/16/11 with a diagnosis of Renal Insufficiency.</p> <p>Review of the Admission MDS Assessment, dated 12/22/11, revealed the facility assessed the resident as needing assist of two (2) staff for toileting.</p> <p>Review of the Plan of Care, dated 12/17/11, revealed there was no documented evidence a plan of care was developed related to Resident #19's urinary incontinence. Review of the CAA Summary, dated 12/28/12, revealed Urinary Incontinence triggered as a care area and would be addressed in the Comprehensive Care Plan.</p>	F 279		

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F 279	Continued From page 9 Interview, on 05/12/12 at 11:30AM, with RNAC #10 revealed the urinary incontinence care plan had not been developed. Further interview revealed, after reviewing the MDS and the CAA's, she agreed the urinary incontinence care plan should have been developed and placed on the CPC.	F 279		
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system 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</p>	F 431		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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 05/12/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - VANCEBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 68 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
F 431	<p>Continued From page 10</p> <p>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, interview, and review of the facility's policy and procedures, it was determined the facility failed to store all drugs and biologicals in locked compartments and failed to permit only authorized personnel to have access to the key as the keys to the locked refrigerator and narcotic boxes were hanging on the inside of the Center Nursing Station Medication Room.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled, "Medication Administration Controlled Substances", dated 10/07, revealed the director of nursing and the consultant pharmacist monitor for compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized staff members and pharmacy personnel have access to controlled medications.</p> <p>Review of the facility's policy entitled, "Medication Labels", dated 06/2005, revealed medications are labeled in accordance with facility requirements and state and federal laws. Only the dispensing pharmacy or consultant pharmacist modifies or changes prescription labels. Each prescription medication label includes: patient's name, specific directions for use, including route of administration, brand or generic drug product</p>	F 431		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - VANCEBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 58 EASTHAM STREET VANCEBURG, KY 41179
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F 431	<p>Continued From page 11</p> <p>name, strength of medication, injectables to include strength per milliliter (mL), physician's name and date medication is dispensed. Further review of the policy revealed, no medication with a label inserted into the vial or secured only by a rubber band is accepted. Continued review of the policy revealed, floor stock medications are kept in the original manufacturer's container with the expiration date and lot number clearly evident.</p> <p>Review of the facility's policy entitled, "Discharge Medications", dated 06/2005, revealed medications are sent with the patient upon discharge only under conditions that protect the patient and assure compliance with the law. Medications, including controlled medications, are sent with the patient on discharge, based on state regulations and the Physician's order.</p> <p>Observation of the Medication Room of the Center Hall Nursing Station, on 05/11/12 at 9:45 AM, revealed the nurse entered a numerical code into the lock on the door to the medication room and upon entering the refrigerator was not locked; however, the key to unlock the refrigerator and the key to the locked narcotic box was hanging on a hook just inside the door on the wall. Further observation revealed, four (4) vials of Ativan 2 milligram (mg)/milliliter (mL) belonging to a resident that was discharged on 02/07/12. Further observation revealed, an additional seven (7) vials of Ativan 2mg/mL belonging to a current resident; however, record review revealed the medication was discontinued by the Physician on 02/14/12. In addition, these seven (7) vials had an expiration date of 03/2012. Continued observation revealed, eight (8) vials of Ativan 2 mg/mL belonging to a resident that was</p>	F 431		

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F 431	<p>Continued From page 12</p> <p>discharged on 03/03/12. Further observation of the refrigerator revealed an unlabeled box of Allvan 2mg/mL with a lot number of 89-460EV and an expiration date of 11/01/11. Two (2) of the vials within the box were noted to have matching lot numbers; however, two (2) of the vials lot numbers did not match the box lot number. One (1) of the vials had a lot number of 02-332-EV and the other one (1) had the lot number of 03-172-EV. Also, two (2) of the vials had been opened and a partial dose had been administered.</p> <p>Interview with License Practical Nurse (LPN) #8, on 05/11/12 at 10:30 AM, revealed the key had always been on the hook since she could remember. Further interview revealed, the refrigerator should have been locked and should be locked at all times. Continued interview revealed, when a narcotic was discontinued, the nurse receiving the order from the Physician was to alert the Director of Nursing so she could collect the medication from the refrigerator. Further interview revealed, the procedure had not been followed by the nurses.</p> <p>Interview with the Director of Nursing, on 05/11/12 at 10:45 AM; revealed she could not explain as to why the refrigerator was unlocked. Further interview revealed, the refrigerator should be locked at all times. Continued interview revealed, anyone that knew the combination to the medication room would have access to the narcotics in the refrigerator because the key was hanging on the wall inside the medication room. Further interview revealed, the medications belonging to the residents that had been discharged should have been removed from the</p>	F 431	<ol style="list-style-type: none"> 1. No residents were harmed with deficient practice. The expired medication was immediately removed. The numeric code is changed monthly by Maintenance Director. The keys to the narcotic box will be secured in a locked key box to be placed on a wall and only nurses working the floor will have the key. 2. Nurses will be re-educated DNS/ADNS/Designee on medication discontinuation, counting narcotics, expired medication disposal, medication from home, discharge medication destruction or sent home with resident by 6/20/12. 3. Monthly audits of refrigerator medication for expired medications and/or proper storage of medications will be completed monthly by Pharmacy Consultant, and weekly by Director of Nursing Services and/or Assistant Director of Nursing Services. 4. Results of the audit related to medication storage, discharge or discontinuance will proceed to Quality Assurance for problem resolution monthly for 3 months. 	6/20/12

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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 431	<p>Continued From page 13</p> <p>refrigerator and placed in her possession for destruction. She could not explain the differences in the vials with different lot numbers.</p> <p>Interview with the Pharmacy Consultant, on 05/11/12 at 11:05 AM, revealed he could not explain why the medications remained in the locked narcotic box. Further interview revealed, medications should be removed at the time of the discontinuance order. Continued interview revealed, when he came to the facility he reviewed charts and checked the refrigerated medications; however, he did not check the narcotics. Further interview revealed, he and the Director of Nursing usually destroyed the narcotics on a quarterly basis. He further stated, "Honestly, I cannot explain how this happened. It must have been an oversight". Continued interview revealed, the box of Ativan should have had a label on it.</p>	F 431		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - VANCEBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 68 EASTHAM STREET VANCEBURG, KY 41179
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 1978</p> <p>Facility type: SNF/NF</p> <p>Type of structure: One story, Type III (unprotected)</p> <p>Smoke Compartment: Five (5)</p> <p>Fire Alarm: Complete fire alarm with smoke detectors installed in corridor, heat detectors in mechanical rooms, laundry, kitchen, and sprinkler riser room. Upgraded 05/21/08</p> <p>Sprinkler System: Complete sprinkler system (dry). Upgraded in 2008 with new main control valve and in 2008 with new dry valve.</p> <p>Generator: Type 2 generator powered by diesel installed May 2011.</p> <p>A Standard Life Safety Code Survey was conducted on 05/10/12. Golden Living Center Vanceburg was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was ninety two (92). The facility is licensed for ninety four (94) beds.</p>	K 000	 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Melinda Berkeley</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>6/11/12</i>
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A 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 000 K 045 SS=D	<p>Continued From page 1</p> <p>The Highest Scope and Severity deficiency was a "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting, according to National Fire Protection Association (NFPA). The deficiency had the potential to affect one (1) of five (5) smoke compartments.</p> <p>The findings include:</p> <p>Observation, on 05/10/2012 at 11:28 AM, revealed the exterior exit for the Main Hall was equipped with a single bulb for illuminating the public way from the exit. Further observation revealed the single bulb was not working. Exit lighting must be arranged so the failure of a single bulb will not leave the exit in complete darkness. The observation was confirmed with the Maintenance Director.</p> <p>Interview, on 05/10/2012 at 11:28 AM, with the Maintenance Director revealed he was not aware the bulb was not working.</p> <p>Reference: NFPA 101 (2000 edition)</p>	K 000 K 045	<p>The single bulb fixtures located in the exit alcoves shall be replaced with a 2-bulb fixture. The lighting will be monitored on daily rounds by maintenance and/or weekend manager with maintenance being contacted in the need of bulb replacement.</p>	6/20/12

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K 130	<p>Continued From page 3</p> <p>Review of the manufacture instructions supplied with the single station smoke detectors indicated the single station smoke detectors were required to be tested weekly to ensure their reliability.</p> <p>Interview, on 5/10/12 at 10:30 AM, with the Maintenance Director revealed he tested the single station smoke detectors on a monthly basis.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>4.6.12.2* Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed.</p> <p>4.6.12.3 Equipment requiring periodic testing or operation to ensure its maintenance shall be tested or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction.</p>	K 130	<p>As discussed with the Life Safety Inspector during the survey, the single station smoke detectors identified in resident rooms 203, 204, 205, 207, 208, 209, 212, and 213 are not required. These have been removed from the patient rooms.</p>	6/20/12
K 146 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A nursing home or hospice with no life support equipment has an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source. NFPA 99, 3.6.3.1.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was</p>	K 146		

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K 146	<p>Continued From page 4</p> <p>determined the facility failed to ensure the emergency generator was maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, ninety-four (94) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 05/10/2012 at 11:20 AM, revealed the generator's battery charger was hooked directly to the generator battery. Battery chargers cannot be hooked directly to the generator battery due to increase risk of fire. The observation was confirmed with the Maintenance Director.</p> <p>Interview, on 05/10/2012 at 11:23 AM, with the Maintenance Director, revealed the generator was installed new in 2011 by a contractor and he had relied on the contractor to install the generator to code.</p> <p>NFPA 110 (1999 edition)</p> <p>5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturer's recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.</p>	K 146	<p>The generator battery wire will be reconfigured as to not hook directly into the battery, but rather through the starter. This will be monitored visually by maintenance during the weekly generator tests.</p>	6/20/12