

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

PRINTED: 12/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185257	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	RECEIVED DEC 16 2011 09/15/2011	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-GREEN HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 213 INDUSTRIAL ROAD GREENSBURG, KY 40370 Division of Health Care Southern Enforcement Branch
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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	F 000		
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure assistance had been provided for one (1) of twenty-three (23) sampled residents to maintain and/or to achieve the resident's independent functioning, dignity, and well-being in accordance with the resident's needs. An interview conducted with Resident #1 on 09/13/11, at 5:00 PM, revealed the resident was unable to independently access the overbed light cord to turn the light on and off as needed.</p> <p>The findings include: Resident #1 was admitted to the facility on 08/13/08. The resident's medical diagnoses included Recurrent Dislocation Pelvic Region and Thigh Joint, Late Effect of Fracture of Neck of Femur, and Ulcer of Lower Extremity.</p>	F 246	Please See Attached F246	10-30-2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Vicki Trump TITLE: Executive Director (X6) DATE: 12/16/2011

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

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F 246	<p>Continued From page 1</p> <p>A review of Resident #1's Minimum Data Set Quarterly Assessment, dated 08/03/11, revealed facility staff had assessed the resident's cognition to be intact. Facility staff identified no problems with the resident's communication abilities and noted the resident could be understood. In addition, facility staff had not identified any functional limitations in range of motion of the resident's upper extremities.</p> <p>An observation conducted on 09/13/11, at 5:00 PM, of the overbed light cord in Resident #1's room revealed the cord was hanging from the overbed light fixture approximately four to five inches in length above the resident. However, based on observation, the resident was unable to reach the light cord from his/her position while lying in bed.</p> <p>An interview conducted with Resident #1 on 09/13/11, at 5:00 PM, revealed the resident was unable to independently access the overbed light cord. The resident stated he/she was unable to reach the overbed light cord to turn the light on and off because the cord had broken (unable to recall date) and the cord was too short to reach. The resident further revealed he/she had not reported the broken light cord to staff and stated the staff was aware the cord was broken because they came into the room to turn the light off and on for the resident.</p> <p>An additional interview conducted on 09/14/11, at 1:30 PM, with Resident #1 revealed he/she did not like to sleep with the light on at night. The resident stated, "They turn the light off at times; other times they forget."</p>	F 246		

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F 246	Continued From page 2 An interview conducted on 09/14/11, at 10:40 AM, with Certified Nursing Assistant (CNA) #5 revealed she was responsible to report broken overbed light cords to the charge nurse who would then report to the Maintenance Supervisor (MS). CNA #5 further revealed she was unaware Resident #1's overbed light cord was broken. An interview conducted on 09/14/11, at 10:50 AM, with CNA #6 revealed she was responsible to report broken overbed light cords to the MS and was unaware Resident #1's overbed light cord was broken. CNA #6 stated an overbed light cord located within Resident #1's reach would allow the resident to be more independent because the resident would not depend on staff to turn the light on and off. An interview conducted on 09/14/11, at 11:15 AM, with Licensed Practical Nurse (LPN) #2 revealed the MS was responsible to repair broken overbed light cords. LPN #2 was unaware Resident #1's overbed light cord was broken. An interview conducted on 09/14/11, at 11:20 AM, with LPN #3 revealed Resident #1 should have an overbed light cord within his/her reach to turn the light on and off as needed. An interview conducted on 09/15/11, at 3:45 PM, with the Director of Nursing (DON) revealed access to the overbed light cord could promote the resident's functional independence. An interview conducted with the Maintenance Director on 09/15/11, at 1:45 PM, revealed the Maintenance Director made rounds on a monthly	F 246		

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F 246	Continued From page 3 basis to all resident rooms to identify items in need of maintenance/repair. Additional interview revealed the Maintenance Director had not been made aware of the missing light cord in Resident #1's room.	F 246		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide a clean homelike environment. During a three-day period from 09/13/11 to 09/15/11, a urine odor was detected at the Front Entrance Hall, South Dining Room, and the South Hall near room 119. In addition, cobwebs and dust were observed on a window sill in resident room 20. The findings include: A review of the facility policy titled Housekeeper Routine and the Five Step Cleaning Method (undated) revealed resident rooms, including window sills and facility hallways, were to be cleaned daily. Observations conducted upon entry to the facility on 09/13/11, at 11:05 AM Eastern Daylight Savings Time (EDST), revealed a urine odor in	F 252	Please See Attached 252	10-20-2011

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F 252	Continued From page 4 the Front Hall of the facility near the entrance, the South Hall dining area, and the South Hall near room 119. Additional observations conducted on 09/13/11, at 2:15 PM (EDST), revealed urine odor in the Front Hall near the entrance and in the South Hall near room 119. Observations conducted on 09/14/11, at 6:30 AM (EDST), revealed urine odor at the South Dining Room and the South Hall near room 119. Observation of resident room 20 conducted on 09/13/11, at 6:30 PM (EDST), revealed a buildup of dust and cobwebs on the window sill. An interview conducted with the Housekeeping Supervisor on 09/15/11, at 10:50 AM (EDST), revealed that housekeepers use a foul odor digester to reduce odors in the facility. Additional interview revealed although the Housekeeping Supervisor had made rounds daily of all areas of the facility, to include resident rooms, the Supervisor had not noticed the urine odors or dust and cobwebs in room 20.	F 252		
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: Based on observation, interview, and record review it was determined the facility failed to provide maintenance services necessary to	F 253	please see attached F 253	10-20-2011

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F 253	<p>Continued From page 5</p> <p>maintain an orderly comfortable interior. Chipped Formica, loose/torn wallpaper, a loose baseboard, a missing heater cover, and missing pull cord on overhead lights were observed during a tour of the environment on 09/15/11.</p> <p>The findings include:</p> <p>A review of the facility maintenance policies titled Inspecting Resident Rooms and General Maintenance or Heating, Cooling, Air Conditioning and Ventilation (undated) revealed light fixtures were to be checked to ensure the fixtures were not loose or dirty, and wallpaper was to be assessed for damage and tears during daily general inspections. According to policy, inspections of the facility's heating and cooling systems were to be performed two times per year and the blower, fan switches, and thermostats were to be assessed two times per year.</p> <p>Environmental observations conducted on 09/15/11, at 1:30 PM (EDST), revealed chipped Formica on the counter surfaces at the South Wing Nurses' Station and torn/loose wallpaper was observed on the wall of the South Wing Dining Room. In addition, a heating/air unit located in the South Dining Room was observed to have an uncovered thermostat/fan switch with exposed electrical wiring. There were loose baseboards near room 24, and overbed lights in resident rooms 5, 13, 25, and 30 failed to have pull cords that would enable residents to turn the light off/on independently.</p> <p>A review of work orders for September 2011 revealed no evidence the items had been identified and/or that a work order had been</p>	F 253			

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F 253	Continued From page 6 submitted for repairs to be made to the items identified during the environmental tour. An interview conducted with the Maintenance Director on 09/15/11, at 1:45 PM, revealed the Maintenance Director conducted rounds and observed all resident rooms monthly to identify items in need of maintenance/repair. Further interview with the Maintenance Director revealed he was not aware of the items identified to be in need of repair and had not received maintenance requests for the items.	F 253		
F 371 SS=D	483.35(f) 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 and interview the facility failed to ensure foods served in the Dietary Department were stored, prepared, and distributed under sanitary conditions. The overhead fan metal/grill in the Dietary Department dish room was observed on 09/15/11 to be soiled with a black greasy coating. The findings include:	F 371	Please See Attached F 371	10/20/2011

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F 371	Continued From page 7 An interview conducted on 09/15/11, at 2:30 (EDST) PM, with the Dietary Manager (DM) revealed the dish room overhead fan was not on a routine cleaning schedule and there was no dietary policy/procedure to ensure the fan's maintenance and cleaning. The DM stated the dietary staff was responsible to ensure the fan was maintained and cleaned. Observation of the facility dish room on 09/15/11, at 2:45 PM (EDST), revealed the overhead fan's grill was soiled with a black, greasy buildup of lint and dust. This soil had the potential to contaminate the clean dishware after the dishes had been washed and sanitized by the dietary staff.	F 371		
F 372 SS=F	Reference: 902 KAR 45:005 Retail Food Code. 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: The facility failed to ensure that garbage and refuse were stored/contained outside the facility in a manner that was inaccessible to rodents and insects. Observations throughout the survey conducted on 09/13-15/11, revealed bags of trash containing soiled resident briefs, boxes and cardboard, used Styrofoam food containers, and garbage/refuse were not stored in a closed, covered container that effectively prevents the harborage and feeding of insects and rodents as required by the Retail Food Code 902 KAR	F 372	Please See Attached F 372	10-20-2011

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F 372	<p>Continued From page 8 45:005.</p> <p>The findings include:</p> <p>An interview conducted with the Facility Administrator on 09/14/11, at 2:30 PM, revealed the facility had no policy/procedure specific to the containment/disposal of trash and garbage. The Administrator stated the facility housekeepers were assigned to take out the trash while the housekeepers were on duty. Housekeeping staff was not on duty after 2:30 PM, at the time of the observation on 09/14/11.</p> <p>Initial tour of the Dietary Department conducted on 09/13/11, at 11:20 AM (EDST), revealed an uncovered portable cart located adjacent to the Dietary Department door containing seven bags of uncovered trash. Insects, flies, and yellow bees were observed to be flying around the bagged trash. The trash contained bags of soiled resident briefs, used Styrofoam food containers, and other garbage and refuse. An interview was conducted with the DM on 09/13/11, at 11:30 AM, and revealed the bagged trash had been collected and placed in the open cart by the housekeepers.</p> <p>An interview was conducted on 09/13/11, at 2:25 PM (EDST), with a housekeeper who stated the open trash cart would be emptied at 6:00 AM, after the housekeepers came on shift. The housekeeper further stated the housekeeping staff did not work after 3:30 PM (EDST), and sometimes the trash would remain stored in the uncovered cart all night.</p> <p>An interview was conducted with an evening shift</p>	F 372			

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F 372	Continued From page 9 State Registered Nursing Assistant (SRNA) on 09/13/11, at 2:25 PM (EDST). The SRNA stated the evening/night shift staff did not empty the trash at night. The SRNA stated the housekeepers emptied the trash carts the next morning after Housekeeping reported for duty at 6:00 AM. Observation of the dumpster area on 09/14/11, at 12:10 PM (EDST), revealed dumpster #1 had two open lids and dumpster #2 had one open lid and trash was not contained appropriately. An interview conducted with the Facility Administrator on 09/14/11, at 2:30 PM (EDST), revealed she was not aware of the recommended system of trash containment.	F 372		
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 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. 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. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431	Please see Attached F 431	10-20-2011

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F 431	<p>Continued From page 10</p> <p>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, interview, and record review, it was determined the facility failed to label, date, and store all drugs and biologicals in accordance with currently accepted professional principles. Observation of a medication pass on 09/13/11, revealed facility staff failed to ensure the medication cart was locked/secured at all times. In addition, observation on 09/15/11, of the medication refrigerator on the South Unit revealed medications that exceeded the recommended expiration dates were available for resident use.</p> <p>The findings include:</p> <p>1. A review of the Medication Administration policy (dated September 2010) revealed the medication cart was to be kept closed and locked when out of sight of the medication nurse.</p>	F 431		
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F 431	<p>Continued From page 11</p> <p>Observation of the medication pass on 09/13/11, at 5:35 PM, revealed RN #1 administered medications to Resident #22. The medication cart was left in the hallway and was observed to be unlocked. The resident's privacy curtain was pulled and the medication cart was not visible to the RN.</p> <p>Further observation revealed RN #1 prepared medications for Resident #23. The RN entered the resident's room at 6:55 PM, and administered the medications to Resident #23. However, the medication cart was observed to be unlocked and not in view of the RN.</p> <p>Interview with RN #1 on 09/13/11, at 6:30 PM, revealed the medication cart was to be kept locked and pulled close to the resident's doorway when medications were administered. The RN stated she did not realize the medication cart had been left unlocked.</p> <p>Interview conducted with the DON on 09/15/11, at 3:30 PM, revealed the medication cart was to be kept locked/secured at all times.</p> <p>2. A review of the Emergency Pharmacy Service and Emergency Kits policy (dated September 2010) revealed the provider pharmacist would supply emergency medications/items according to the provider pharmacy agreement. The policy noted emergency medications and supplies were required to be kept secure and checked periodically for dates and storage in accordance with the State Board of Pharmacy and federal regulation. The policy further noted when facility staff removed any medication from the emergency kit the nurse would document the</p>	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 12</p> <p>medication on the emergency kit log and fax the log to the pharmacist. The faxed log was utilized to inform the pharmacy of items used from the emergency kit and to replace the kit or item. According to the policy, when the new kit arrived, the nurse was required to give the used kit to the pharmacy personnel for return to the pharmacy.</p> <p>Observation conducted on 09/15/11, at 2:00 PM, of the medication refrigerator located on the South Unit revealed an emergency medication kit in the refrigerator. The following medications were observed to be stored in the emergency medication kit:</p> <ul style="list-style-type: none"> -An unopened 10-milliliter multi-dose vial of Novolog 1000U/ml with an expiration date of August 2011; -An unopened 10-milliliter multi-dose vial of Novolin R 100U/10ml with an expiration date of August 2011; --An unopened 5-milliliter vial of Inuvite Adult Multi-Vitamin for injection with an expiration date of February 2010; -Three Phenadoz 25-milligram rectal suppositories with an expiration date of February 2011. <p>Interview conducted with Licensed Practical Nurse (LPN) #1 on 09/15/11, at 2:15 PM, revealed the nurse was responsible to notify the pharmacy when a medication was removed from the emergency kit. LPN #1 stated the pharmacist was responsible to replace the opened kit with a new kit whenever medication was removed. The</p>	F 431			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185257	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/15/2011
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-GREEN HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 213 INDUSTRIAL ROAD GREENSBURG, KY 42743	
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F 431	Continued From page 13 LPN also stated the pharmacy was responsible to check the expiration dates on the medications. An interview conducted with the DON on 09/15/11, at 3:30 PM, revealed the pharmacy was responsible to replace the opened emergency medication kit with a new kit and to check the medications for expiration dates. The DON stated a pharmacy representative had been at the facility the previous week and had checked the medication refrigerators.	F 431		
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: The facility failed to maintain an effective pest control program to adequately eliminate/prevent the harborage of flies and insects. On 09/13-15/11, flies were observed to be in the common areas, resident rooms, the dietary department, and resident dining rooms. The findings include: An interview conducted with the Facility Administrator on 09/14/11, at 2:30 PM (EDST), revealed the facility had no policy/procedure on prevention/control of flies. Observations made during the evening meal on	F 469	Please see attached F 469	10-20-2011

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F 469	<p>Continued From page 14</p> <p>09/13/11, at 7:00 PM, revealed flies were in the resident dining rooms and were flying around the residents and the trays served to the residents.</p> <p>Observation of Resident #2 on 09/14/11, at 10:10 AM (EDST), revealed Resident #2 sitting in the dining room awaiting a meal. The resident was alert to time and place. During the observation two flies were observed to be on the resident's mouth. An interview was conducted with Resident #2 at 10:10 AM (EDST), and revealed the flies were bothersome when he/she ate meals.</p> <p>A group interview was conducted with eight unsampled, alert, and oriented residents on 09/14/11, at 3:30 PM (EDST). The interview revealed flies in the building had been a problem during the summer of 2011.</p> <p>Observation of the tray assembly line during breakfast on 09/14/11, at 9:40 AM (EDST), revealed two flies in the kitchen area on clean utensils and dishware.</p> <p>An interview conducted with the facility Maintenance staff on 09/15/11, at 4:30 PM (EDST), revealed a spring closure had been recommended by an environmental pest control company. Based on interview, the spring closure would ensure the door would close promptly. The Maintenance Director further stated the dietary staff would be unable to prop the door open to receive supplies if the spring closure was applied. The Maintenance Director stated the spring closure had not been applied although the closure was recommended by the pest service representative.</p>	F 469		

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F 469	Continued From page 15	F 469		
F 520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Observations conducted during the breakfast meal on 09/13/11, at 9:40 AM, revealed a fly was</p>	F 520	Please See Attached	10 26 2011

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F 520	<p>Continued From page 16</p> <p>observed to be flying around the kitchen and landed on a hanging serving utensil. Further observations on 08/14/11, at 10:10 AM, revealed two flies were flying around Resident #2's food tray during the breakfast meal.</p> <p>Deficient practice was identified during the previous health survey completed on 08/05/10, related to the facility's ineffective pest control program. According to the facility's plan of correction dated 09/09/10, the facility would implement a Fly Program and report any concerns to their environmental service provider for further recommendations. In addition, the plan of correction noted the Maintenance Director (MD) would be responsible to monitor the effectiveness of the Fly Program daily and report any concerns immediately to the service provider. These concerns were to be discussed in the monthly Quality Assurance (QA) meetings to determine the effectiveness of the action plan to the need for other corrective action as indicated.</p> <p>A review of the environmental service provider's report dated 08/16/10, revealed the environmental service provider had made a recommendation for a spring to be installed on the door leading to the outside from the kitchen area to enable the door to shut automatically when entering or exiting near the kitchen door. However, there was no evidence that a spring had been installed on the door as recommended.</p> <p>An interview with the Director of Maintenance (DOM) on 09/15/11, at 2:55 PM, revealed he was aware of the recommendations made by the environmental service provider on 08/16/10, and stated the facility had not discussed the possible</p>	F 520		

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F 520	<p>Continued From page 17</p> <p>causes for the continued observations of flies during the QA meetings or developed further actions to correct the reoccurring pest problem in the facility.</p> <p>An interview with the Administrator on 09/15/11, at 3:25 PM, revealed the Administrator had been at the facility for approximately three months and was not aware of the recommendations from the environmental service provider. The Administrator stated the fly problem had been discussed during the QA meeting and she had not felt the QA program had been effective to control flies in the facility since the problem had been identified.</p>	F 520		

This Plan of Correction is the center's credible allegation of Compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F 246 D

Corrective Actions for Targeted Residents:

Resident # 1 received a longer cord for the over bed light on September 15 2011.

Identification of Other Residents with Potential to Be Affected:

Non-clinical rounds were made by the facility managers on all residents. Any unmet needs were identified and corrected immediately. Facility managers consists of but not limited to: The ED, DNS, ADNS, Director of Education, Activities Director/Assistant, Director of Maintenance, Director of Hsk, MDS Coordinators, Director of Admissions, Dietary Manager and Social Worker.

Staff was reminded, by re-in servicing, to complete maintenance work orders in accordance with facility's guidelines. This was completed the week of September 17, 2011.

Systemic Changes:

Needs of all residents will be observed during Guardian Angels non clinical rounds. These rounds are conducted weekly on all residents. Any unmet needs are corrected immediately or a plan to correct is initiated. The Guardian Angel will document their findings on the revised Non-Clinical Rounds check-list. Facility Managers are the Guardian Angels.

Monitoring:

The non-clinical rounds checklist is reviewed daily in the Daily Stand-up. The Daily Stand-up consists of the facility managers.

Summary of the check list will be reported to the monthly QA Committee for follow up, if needed.

Correction Date: October 20, 2011

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F 252E

Corrective Actions for Targeted Residents:

No individuals were identified to be affected by this alleged deficient practice. Resident Room 20 was deep cleaned.

Identification of Other Residents with Potential to Be Affected:

All residents have a potential to be affected by this practice. Residents rooms and common areas were inspected for dust, cobwebs and odors on September 15, 2011. Any issues were corrected immediately. These inspection were completed by the HSK Director.

Systemic Changes:

Resident Rooms were deep cleaned using the Five Step Cleaning Method. Hsk staff was in serviced on the Five Step Cleaning Method. This in service was completed on September 16, 2011

Monitoring:

ED, DNS, and Director of HSK will complete daily observation rounds of the facility for odors, dust, and cobwebs. Any issues will be corrected immediately. These observations will be conducted with the normal daily rounds.

The ED and Director of HSK makes monthly rounds of the facility. These rounds include but not limited to, checking room for cleanliness, and the facility for any odors.

Summary of these observations will be reported to the monthly QA Committee for follow up, if needed.

Correction Date: October 20, 2011

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F 253 E

Corrective Actions for Targeted Residents:

No individuals were identified to be affected by this alleged deficient practice. The chipped Formica was repaired on September 15, 2011. The loose or torn wallpaper was repaired or replaced on September 15, 2011. The loose base board was repaired on September 15, 2011. The missing pull cords for overhead lights was replaced on September 15, 2011. The missing heater cover was replaced on September 15, 2011.

Identification of Other Residents with Potential to Be Affected:

All residents have a potential to be affected by this practice. The Director of Maintenance completed a facility wide tour to check for loose or torn wallpaper, chipped Formica, loose base boards, missing covers for heaters and missing pull cords for over beds lights. Any issues were corrected immediately. This was completed the week of September 19, 2011.

Systemic Changes:

ED and Director of Maintenance will complete daily observation rounds of the environment. Issues will be corrected immediately or plan to correct will be initiated immediately. Staff were reminded to placed maintenance work orders if they observed any issues with the environment.

Monitoring:

Summary of these observation rounds will be reported to the monthly QA Committee for follow-up, if needed.

Correction Date: October 20, 2011

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F 371 D

Corrective Actions for Targeted Residents:

No individuals were identified to be affected by this alleged deficient practice.

Identification of Other Residents with Potential to Be Affected:

All residents have a potential to be affected by this practice.

Systemic Changes:

The wall fan was removed from the dish room.

Monitoring:

The ED and DSM will complete an ED dietary checklist weekly through December 31, 2011 and then monthly thereafter during meal service.

Sanitation QI audit will be completed by the Dietitian Consultant quarterly.

All checklist/audits will be reviewed for trends with results and action plans reported in quarterly QA&A minutes.

Correction Date: October 20, 2011

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F 372 F

Corrective Actions for Targeted Residents:

No individuals were identified to be affected by this alleged deficient practice.

Identification of Other Residents with Potential to Be Affected:

All residents have a potential to be affected by this practice.

Systemic Changes:

Garbage will be removed from the facility using "barrels" on wheels.

No garbage will be "stored" outside using portable dumpsters.

Staff has been serviced on the new system of garbage containment. All staff is to ensure that the lids are shut on the dumpsters and the gate is closed surrounding the dumpsters. This in service was completed the week of the September 19, 2011.

The dumpster sitting outside the fence will be moved.

Monitoring:

The ED, DNS, Director of Maintenance, Director of Hsk and the DSM will complete daily observation rounds to ensure that the garbage is removed from the facility timely and in the proper container and that at no time is garbage stored outside the facility.

Summary of these observations will be reported to the QA Committee for follow-up if needed.

Correction Date: October 20, 2011

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F 431 D

Corrective Actions for Targeted Residents:

No individuals were identified to be affected by this alleged deficient practice.

Identification of Other Residents with Potential to Be Affected:

All residents have a potential to be affected by this practice.

Med rooms and medication carts were inspected by the DNS/ADNS for any expired medications. Any expired medication found was removed.

Drugs used in the facility are labeled and stored in accordance with professional standards that include expiration dates, temp control, locked compartments with only authorized personnel having access to the keys.

Systemic Changes:

Medications stored in refrigerators will be checked for expiration dates weekly for one month and monthly thereafter by the licensed staff, DNS/ADNS. Any issues will be corrected immediately.

The contracted Pharmacist will perform a check of all stored medication for any expired meds, monthly. Issues will be handled immediately.

EDKs are changed three times a week. New ones delivered and others returned to Pharmacy by Pharmacy representative. Licensed staff will be observed for med pass competency, which includes locking the medication cart. These competency are preformed every six months. The Director of Education completes the competencies.

Monitoring:

A Summary of the Competencies will be reported to the monthly QA for follow up, if needed.

The contracted pharmacist will report her findings to the monthly QA Committee, for follow up, if needed.

Correction Date: October 20, 2011

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F 469 F

Corrective Actions for Targeted Residents:

Resident #2 will be monitoring by nursing staff while she is eating to ensure that no flies are "bothersome" to her.

Identification of Other Residents with Potential to Be Affected:

All residents have a potential to be affected by this practice.

The facility has a contract with Ecolab for fly prevention. Ecolab treated the facility twice in August, twice in September 2011 and monthly since 08-2010 during spring and summer months.

Systemic Changes:

New system for garbage containment, please refer to F Tag 372.

Staff has been directed to use the front doors for entrance and exit to the facility. Fly lights will be installed by the Therapy Door and the Door by room 114, this is the door that the garbage will be taken outside the facility. This was completed the week of September 19, 2011

Monitoring:

All staff will monitor for flies daily and report issues to the Director of Maintenance. This monitoring will be part of their daily duties.

The Director of Maintenance will review report from Ecolab in the monthly QA Meeting.

Correction Date: October 20, 2011

520 con't

responsibilities will be conducted on October 10, 2011.

Monitoring:

The QA committee will review summaries of observations rounds by the ED, Maintenance Director, Director of

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F 520 D

Corrective Actions for Targeted Residents:

No individuals were identified to be affected by this alleged deficient practice.

Identification of Other Residents with Potential to Be Affected:

All residents have a potential to be affected by this practice.

The facility's Quality Assurance meets at least monthly to review and analyze data from various sources that may help to identify the possibilities of deficient practices. These may include but are not limited to reports from outside contractors, such as the Pest Control Program. The facility's Quality Assurance Committee members: consists of the Executive Director, Director of Nursing Services, Medical Director, Assistant Director of Nursing, Director of Education, Admissions Director, Social Worker, Director of Activities, Resident Assessment Coordinator, Therapy Supervisor, Director of Maintenance, Director of Housekeeping/Laundry, Business Office Manager, Director of Human Resources, Pharmacists Consultant, Dietary Manager, Restorative Supervisor, Wound Prevention Coordinator, Safety Committee Chair.

Reports from outside contractors, such as Pest Control was reviewed by the Executive Director on September 16, 2011. The reports were reviewed for any suggestions that may have not been acted on. Any issues were corrected. The QA Committee meets the last Wednesday of each month.

Systemic Changes:

The Quality Assurance Committee was in serviced on reports/information they are to provide to the Committee. This was completed on September 16, 2011 and September 19, 2011 by the Executive Director. A final review of the Committee's functions and the members

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Received Time: Oct 7, 2011 2:33PM No. 2764
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185257	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/15/2011
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-GREEN HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 213 INDUSTRIAL ROAD GREENSBURG, KY 42743
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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1979

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One story, Type 111(000)

SMOKE COMPARTMENTS: Nine smoke compartments

FIRE ALARM: Complete fire alarm system with heat and smoke detectors.

SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.

GENERATOR: Type II generator. Fuel source is diesel.

A life safety code survey was initiated and concluded on 09/15/11. 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 in substantial compliance with the Requirements for Participation for Medicare and Medicaid.

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

K 025 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

K 000 This Plan of Correction is the center's credible allegation of Compliance.

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K 025

Corrective Actions for Targeted Residents:
No individuals were identified to be affected by this alleged deficient practice.

Identification of Other Residents with Potential to Be Affected:
All residents have a potential to be affected by this practice.

Systemic Changes:
All penetrations of smoke barrier walls have been repaired.

Monitoring:
The Director of Maintenance will conduct an inspection of the smoke barrier walls monthly and after any work conducted by outside vendors. Issues, if any, will be corrected immediately. Outcomes of these inspections will be reported to the Monthly QA Committee for follow up, if needed.

K 025 Correction Date: October 20, 2011

October 20
2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Vicki Trump</i>	TITLE Executive Director	(X6) DATE 10/07/2011
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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 safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025	<p>Continued From page 1</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers with a one-half hour fire resistance rating as required. The facility failed to ensure that penetrations at smoke barrier walls were properly sealed. This deficient practice affected seven (7) of nine (9) smoke compartments, staff, and approximately eighty-five (85) residents. The facility has the capacity for 118 beds with a census of 111 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 09/15/11, at 09:15 AM, with the Director of Maintenance (DOM), the fire/smoke barrier wall in the front hall attic area was observed to have a gap around piping that was penetrating this wall. Fire/smoke barrier walls must be properly maintained to prevent fire and smoke from spreading to other areas of the facility in a fire situation. During the survey four other fire/smoke barrier walls were</p>	K 025		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185257	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/15/2011
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-GREEN HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 213 INDUSTRIAL ROAD GREENSBURG, KY 42743
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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
K 025	<p>Continued From page 2</p> <p>observed to have gaps around conduit and wiring and non-rated insulation filling holes in these walls. An interview with the DOM on 09/15/11, at 09:15 AM, revealed the DOM must have missed these areas in the past while maintaining these walls.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19 3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 	K 025		

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

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