

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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
--	--

(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 056	<p>Continued From page 19</p> <p>sprinkler coverage, according to NFPA standards. The deficiency had the potential to affect three (3) of nine (9) smoke compartments, residents, staff and visitors. The facility has one hundred twenty five (125) certified beds with a census of ninety six (96) on the day of the survey. The facility failed to install complete sprinkler coverage in all required locations.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation, on 01/15/13 at 2:34 PM, with the Maintenance Director revealed the porch roof located at the rear exit extended out forty eight (48) inches or greater and did not have sprinkler protection installed. <p>Interview, on 01/15/13 at 2:34 PM, with the Maintenance Director revealed he was unaware the porch roof at the rear exit met the requirement for sprinkler protection being installed.</p> <p>Interview, on 01/15/13 at 4:40 PM, with the Administrator revealed he was unaware the porch roof at the rear exit met the requirement for sprinkler protection being installed.</p> <ol style="list-style-type: none"> 2. Observation, on 01/15/13 at 2:20 PM, with the Maintenance Director revealed the sprinkler heads of mixed response ratings located in the Kitchen. <p>Interview, on 01/15/13 at 2:20 PM, with the Maintenance Director revealed some of the</p>	K 056	<p>was completed to make sure there were none with obstructions below the deflector.</p> <ol style="list-style-type: none"> 3. ED in-serviced the maintenance director and assistant to this regulations on 2/05/13. Competency was determined by successful verbalization reviewed by ED. Maintenance Director will do a monthly audit of sprinkler heads to make sure there were no obstructions below the deflector for 6 months. 4. The Maintenance Director will bring audit findings to the QAPI committee. The QAPI committee will review sprinkler audit for compliance for two quarterly QAPI meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits 5. Date of compliance: 2/28/13 	

RECEIVED
FEB 20 2013
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
--	--

(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 056	<p>Continued From page 20</p> <p>sprinkler heads located closest to the cooking equipment had been changed due to one of the sprinkler heads activating due to the heat from cooking. He was not aware sprinkler heads located in the same compartment had to be of the same response.</p> <p>Interview, on 01/15/13 at 4:40 PM, with the Administrator revealed he was unaware of the mixed response sprinkler heads located in the Kitchen.</p> <p>3. Observation, on 01/15/13 at 1:44 PM, with the Maintenance Director revealed sprinkler heads located in the Administrators Office and the 200 Hall Clean Linen Room were blocked by light fixtures being installed within twelve inches of the sprinkler head, extending below the sprinkler deflector.</p> <p>Interview, on 01/15/13 at 1:44 PM, with the Maintenance Director revealed he was unaware the sprinkler heads could have no obstructions below the deflector within twelve inches of the sprinkler head.</p> <p>Interview, on 01/15/13 at 4:40 PM, with the Administrator revealed he was unaware of the requirement.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system</p>	K 056		
-------	---	-------	--	--

RECEIVED
FEB 20 2013
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
--	--

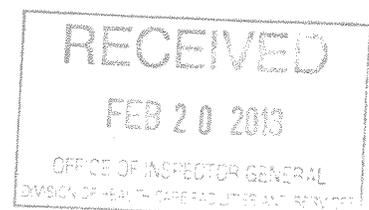
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 21 having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.	K 056		

RECEIVED
FEB 20 2013
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 01/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207		
(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 056	<p>Continued From page 22</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <ol style="list-style-type: none"> (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. <p>Reference: NFPA 13 (1999 edition)</p> <p>5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p> <p>Reference: NFPA 13 (1999 ed.)</p> <p>5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.</p>	K 056			



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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
--	--

(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 056 Continued From page 23
Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)

Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)	Maximum Allowable Distance of Deflector Obstruction (in.)
Less than 1 ft	0
1 ft to less than 1 ft 6 in.	2 1/2
1 ft 6 in. to less than 2 ft	3 1/2
2 ft to less than 2 ft 6 in.	5 1/2
2 ft 6 in. to less than 3 ft	7 1/2
3 ft to less than 3 ft 6 in.	9 1/2
3 ft 6 in. to less than 4 ft	12
4 ft to less than 4 ft 6 in.	14
4 ft 6 in. to less than 5 ft	16 1/2
5 ft and greater	18

For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m.
Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).

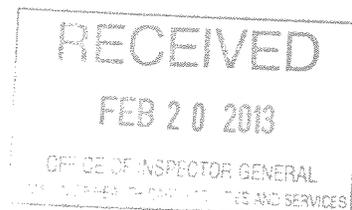
Reference: NFPA 13 (1999 edition)

5-13.8.1. Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width.
Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.

Reference: NFPA 101 (2000 edition)

19.1.6.2 Health care occupancies shall be limited to the types

K 056



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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
--	--

(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 056	Continued From page 24 of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception:* Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system	K 056		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation, sprinkler testing record review, and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect nine (9) of nine (9)	K 062	K062 1. The gauges on the sprinkler riser were inspected and calibrated or replaced on 1/22/13. The shelf in the 400 hall medical supply closet was removed 1/28/13.	

RECEIVED
FEB 20 2013
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
--	--

(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 25</p> <p>smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty five (125) beds with a census of ninety six (96) on the day of the survey. The facility failed to complete the required testing for the sprinkler system, and ensure the sprinkler heads were not blocked by storing items within eighteen (18) inches of the sprinkler head.</p> <p>The findings Include:</p> <p>Sprinkler Testing Record Review, on 01/15/13 at 10:30 AM, with the Maintenance Director revealed the facility did not have documentation that the gauges on the sprinkler riser had not been calibrated or replaced within the last five years.</p> <p>Interview, on 01/15/13 at 10:30 AM, with the Maintenance Director revealed he was not aware of the requirement.</p> <p>Interview, on 01/40/13 at 4:40 PM, with the Administrator revealed he was not aware of the requirement.</p> <p>Observation, on 01/15/13 at 11:51 PM, with the Maintenance Director revealed the facility had items stored within eighteen inches of a sprinkler head located in the 400 Hall Medical Supply Closet.</p> <p>Interview, on 01/15/13 at 11:51 PM, with the Maintenance Director revealed he was aware of the requirement, but not aware the storage had</p>	K 062	<p>2. All sprinkler risers will be inspected by Sprinkler Company. All closets were checked for items to be stored within 18 inches of sprinkler heads. Shelves re removed from all areas of concern.</p> <p>3. ED in-serviced the maintenance director, maintenance assistant, DON, medical supply clerk and laundry/housekeeping supervisor to this regulation on 2/05/13. Competency was determined by successful verbalization reviewed by ED. The CSC in-serviced the DCE to his regulation on 2/06/13. Competency was determined by successful verbalization reviewed by CSC. Routine monthly sprinkler checks will include the gauges on the sprinkler riser and Sprinkler Company has been made aware and this has been placed in our routine maintenance program for reminders.</p>	
-------	---	-------	--	--

RECEIVED
FEB 20 2013
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

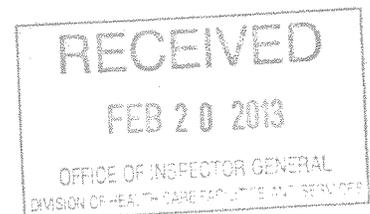
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
---	--

(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 26 been placed too close to the sprinkler head. Interview, on 01/15/13 at 11:51 PM, with the Administrator revealed he was aware of the requirement. Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development: 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated	K 062	4. The Maintenance Director will bring routine monthly sprinkler check findings to the QAPI committee. The QAPI will review the sprinkler inspection for calibration or replacement of sprinkler risers and means of tracking sprinkler routine maintenance for two quarterly QAPI meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits 5. Date of compliance: 2/28/13	



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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
--	--

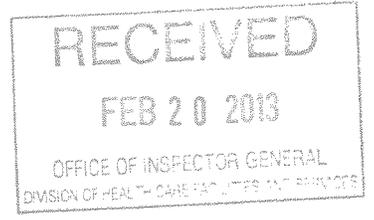
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 062 Continued From page 27
in Figure 7-2.3.2.4 when all of the following conditions are satisfied:
(1) Wet pipe system
(2) Light hazard or ordinary hazard occupancy
(3) 20-ft (6.1-m) maximum ceiling height
The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.

Reference: NFPA 25 (1998 Edition).

10-2.2* Obstruction Prevention.
Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and

K 062



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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
--	--

(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 28 by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather)</p>	K 062		
-------	---	-------	--	--

RECEIVED
FEB 20 2013
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

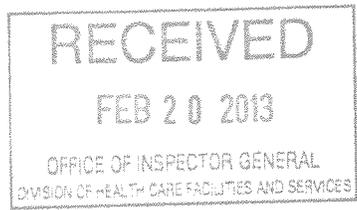
PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
--	--

(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 29 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10	K 062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that fire extinguishers were maintained in accordance with	K 064		



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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - ST MATTHEWS

STREET ADDRESS, CITY, STATE, ZIP CODE

**227 BROWNS LANE
LOUISVILLE, KY 40207**

(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 064 Continued From page 30
NFPA standards. The deficiency had the potential to affect smokers, staff, and visitors. The facility is certified for one hundred twenty five (125) beds with a census of ninety six (96) on the day of the survey. The facility failed to ensure the designated smoking areas had a fire extinguisher.

The findings include:

Observation, on 01/15/13 at 3:39 PM, with the Administrator revealed there was no fire extinguisher located in the designated smoking areas.

Interview, on 01/15/13 at 3:39 PM, with the Administrator revealed he was not aware that a fire extinguisher was required to be located in the smoking areas.

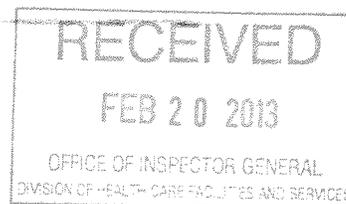
Reference: NFPA 10 1999

4-3.2* Procedures.
Periodic inspection of fire extinguishers shall include a check of at least the following items:
(a) Location in designated place
(b) No obstruction to access or visibility
(c) Operating instructions on nameplate legible and facing outward
(d)* Safety seals and tamper indicators not broken or missing
(e) Fullness determined by weighing or "hefting"
(f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle

K 064

K064

1. A fire extinguisher was purchased and placed in the resident/family designated smoking area on 2/06/2013.
2. All residents have the potential to be affected. ED in-serviced Maintenance director and assistant to this regulation on 2/05/13. Competency was determined by successful verbalization reviewed by ED.
3. Fire extinguisher in designated smoking area will be placed on routine monthly maintenance checks. Routine monthly maintenance checks to be completed by the Maintenance Director each month.
4. The Maintenance Director will report fire extinguisher findings from the routine monthly maintenance checks to the QAPI committee for two quarterly QAPI meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits
5. Date of compliance: 2/28/13



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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
--	--

(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 064	Continued From page 31 (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place 4-3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 4-3.2 (a), (b), (h), and (i), immediate corrective action shall be taken.	K 064		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	K066 1. A metal container with a self closing lid was purchased on 2/18/13 and placed in designated smoking area by 2/27/13. 2. There is only one designated smoking area. 3. ED in-serviced Maintenance director and assistant to this regulation on 2/05/13. Competency was determined by successful verbalization reviewed by ED. Metal container with a self closing lid will be placed on	

RECEIVED
FEB 20 2013
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

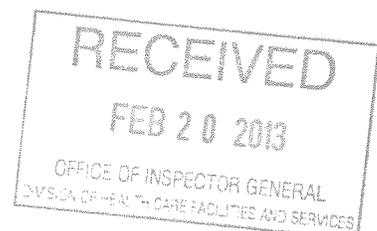
PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
--	--

(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 066	Continued From page 32 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff and visitors. The facility has one hundred twenty five (125) certified beds with a census of ninety six (96) on the day of the survey. The facility failed to ensure the smoking areas had a metal container with a self-closing lid to dump ashtrays. The findings include: Observation, on 01/15/13 at 4:39 PM, with the Administrator revealed the facility failed to provide a metal container with a self-closing lid to dump the ashtrays, located in the designated smoking areas. Interview, on 01/15/13 at 4:39 PM, with the Administrator revealed he was not aware of the requirement for metal containers with a self-closing lid for dumping ashtrays. Reference: NFPA Standard 101 (2000 Edition). 19.7.4 Smoking (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066	routine monthly maintenance checks to be completed by the Maintenance Director each month. 4. The Maintenance Director will report metal container with a self closing lid findings from the routine monthly maintenance checks to the QAPI committee for two quarterly QAPI meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits 5. Date of compliance: 2/28/13	
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in	K 070		



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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
--	--

(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 070

Continued From page 33
non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8

This STANDARD is not met as evidenced by:
Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty five (125) beds with a census of ninety six (96) on the day of the survey.

The findings include:

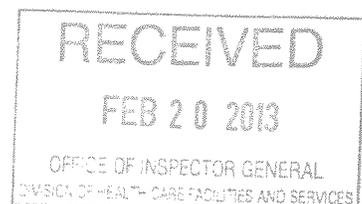
Observation, on 01/15/13 at 2:16 PM, with the Maintenance Director revealed a portable space heater located in the Dietary Managers Office. The facility did not have a policy for portable heaters or documentation that the heaters did not exceed 212 degrees.

Interview, on 01/15/13 at 2:16 PM, with the Maintenance Director revealed they were not aware the heaters could not exceed 212°F in non-sleeping, staff, and employee areas, they thought this requirement was only for patient care areas.

Interview, on 01/15/13 at 4:40 PM, with the Administrator revealed he was aware the heaters could not exceed 212°F in non-sleeping, staff,

K 070 K070

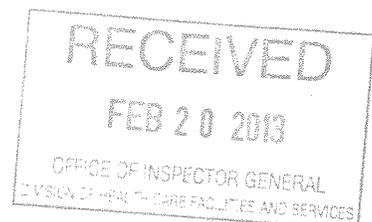
1. The heater was removed from the dietary manager's office on 1/18/13.
2. All offices were checked for heaters and removed.
3. The ED in-serviced Maintenance Director and assistant to this regulation on 2/05/13. The department heads were in-serviced to this regulation on 2/19/13. Competency was determined by successful verbalization reviewed by ED. The housekeeping staff will monitor for heaters when cleaning the offices. The housekeeping staff will notify the ED of any concerns identified to be corrected immediately.
4. The ED will bring any concerns identified to the QAPI committee quarterly for two quarters. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits
5. Date of compliance: 2/28/13



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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207	
(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 070	Continued From page 34 and employee areas.	K 070		
K 072 SS=D	<p>Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies.</p> <p>Exception: Portable space-heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect two (2) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty five (125) beds with a census of ninety six (96) on the day of the survey. The facility failed to ensure the means of egress was free of all obstructions or impediments.</p>	K 072	<p>K072</p> <ol style="list-style-type: none"> The 2 lifts in the 400 hall were removed on 1/18/13 and taken to the permanent storage site of Therapy department storage area. The chair in the 400 hall was removed on 1/18/13 and taken to the 500 hall storage area, the permanent storage site. The linen cart on 100 hall was removed on 1/18/13 and taken to the soiled utility room, the permanent storage site. The lift on 100 hall was removed from blocking the egress and taken to the North Hall Education room, the permanent storage site. The center was audited for items blocking egress and any found were removed. 	



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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
--	--

(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 Continued From page 35
The findings include:

Observations, on 01/15/13 between 9:00 AM and 4:30 PM, with the Maintenance Director revealed the storage of two (2) lifts and a chair located in the 400 Hall. Further observation revealed the storage of a linen cart and a lift located in the 100 Hall.

Interview, on 01/15/13 between 9:00 AM and 4:30 PM, with the Maintenance Director revealed the items were routinely stored in these areas.

Interview, on 01/15/13 at 4:40 PM, with the Administrator revealed the items were routinely stored in these areas.

Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.

K 073 SS=F
NFPA 101 LIFE SAFETY CODE STANDARD

No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, residents, staff and

K 072 3. ED in-serviced Maintenance Director, assistant, DON to this regulation on 2/05/13. The CSC in-serviced the DCE on 2/06/13 to this regulation. DCE will in-service all nursing staff on storage areas and to not store items in the exit path. Linen carts to be stored in soiled utility rooms. The west hall should store in the Solarium. The 500 hall should use the storage area. The North hall should use the education room. The 400 hall should use the Therapy department storage area. The Maintenance Director will do monthly audits to check for items stored in exit paths for 6 months.

K 073 4. The Maintenance Director will bring audit results to the QAPI committee for two quarterly meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits

5. Date of compliance: 2/28/13

RECEIVED
FEB 20 2013
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

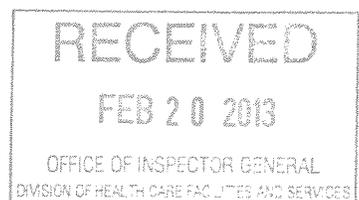
PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
--	--

(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 073	<p>Continued From page 36 visitors. The facility has one hundred twenty five (125) certified beds with a census of ninety six (96) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/15/13 at 11:16 AM, with the Maintenance Director revealed the facility did not have a flame retardant policy or documentation that newly introduced personal decorations for residents have been treated with a flame retardant.</p> <p>Interview, on 01/15/13 at 11:16 AM, with the Maintenance Director revealed they were not aware decorations were required to be treated with a fire retardant and documentation was to be kept on the items that had been treated.</p> <p>Interview, on 01/15/13 at 4:40 PM, with the Administrator revealed he was not aware decorations were required to be treated with flame retardant and the items were required to be documented.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour</p>	K 073 K073	<ol style="list-style-type: none"> 1. A room to room search was completed to look for resident's decorations that need to be treated with fire retardant by 2/22/13. 2. All residents and families were notified of this regulation and asked for permission to treat or to have personal decorations picked up by 2/19/13. Maintenance director documented the items treated. 3. ED in-serviced maintenance director, maintenance assistant, DON to this regulation on 2/05/13. Competency was determined by successful verbalization reviewed by ED. The CSC in-serviced the DCE to this regulation on 2/06/13. Competency was determined by successful verbalization reviewed by CSC. Social services, admission coordinator, and housekeeping/laundry supervisor were in-serviced to this regulation on 2/19/13 by the ED. Competency was determined by successful verbalization reviewed by ED. Upon admission the 	
K 076 SS=D		K 076		



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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
---	--

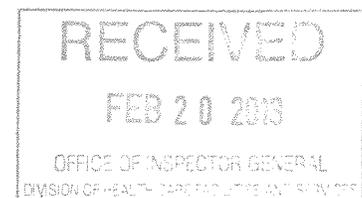
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 076	<p>Continued From page 37 separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored in accordance with NFPA standards. This deficiency had the potential to affect one (1) of nine (9) smoke compartments, residents, staff, and visitors. The facility is certified for one hundred twenty five (125) beds with a census of ninety six (96) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/15/13 at 2:05 PM, with the Maintenance Director revealed the facility failed to provide proper signage stating oxygen was stored inside the oxygen storage room, and the oxygen tanks were not marked full or empty.</p> <p>Interview, on 01/15/13 at 2:05 PM, with the Maintenance Director revealed the facility was remodeling the room and he was not aware signage had been taken down.</p> <p>Interview, on 01/15/13 at 4:40 PM, with the Administrator revealed he was not aware the</p>	K 076	<p>Admission Director will make families and residents aware of this policy during the admission process. Within 3 days of admission, the maintenance director will check resident's room for decorations that may need to be treated and work with social services to either treat the items or remove from the center.</p> <p>4. The Maintenance Director will bring findings to the QAPI committee for two quarterly meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits</p> <p>5. Date of compliance: 2/28/13</p>	

RECEIVED
FEB 20 2013
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

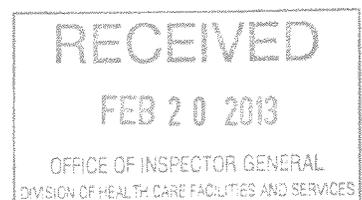
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 01/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207		
(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 076	Continued From page 38 signage had been taken down. Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m ³ (300 ft ³) but less than 85 m ³ (3000 ft ³) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum:	K 076	K076 1. Permanent O2 storage signs were replaced on outside of O2 storage room by 2/27/13. The signs for full and empty were placed 2/20/13. 2. There is only one O2 storage area. 3. ED in-serviced maintenance director, maintenance assistant, and DON to this regulation on 2/05/13. Competency was determined by successful verbalization reviewed by ED 4. The permanent O2 storage signs will be fixed. The Unit Manager will check for the empty and full signs weekly. The ED will bring findings to the QAPI committee for two quarterly meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits 5. Date of compliance: 2/28/13		



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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207	
(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 076 K 144 SS=F	Continued From page 39 CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation, generator testing record review, and interview, it was determined the facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, residents, staff and visitors. The facility has one hundred twenty five (125) certified beds with a census of ninety six (96) on the day of the survey. The findings include: Generator testing record review, on 01/15/13 at 10:40 AM, with the Maintenance Director revealed the facility failed to document the transfer time of the generator to ensure during a power disruption the generator would transfer within ten (10) seconds.	K 076 K 144	1. The generator transfer time was documented during the February generator testing by 2/25/13. 2. RSP will do service on the generator to make sure the battery charger is not hooked up to the generator battery and to hook it up correctly RSP will service all equipment associated with alternative power source by 2/25/13. 3. ED in-serviced Maintenance Director and assistant to this regulation on 2/05/13. Competency was determined by successful verbalization reviewed by ED. ED will audit that transfer time is documented and the battery charger is not hooked up directly to generator battery monthly for 6 months. 4. The ED will bring results of the findings to the QAPI committee for two quarterly meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits 5. Date of correction 2/28/13	



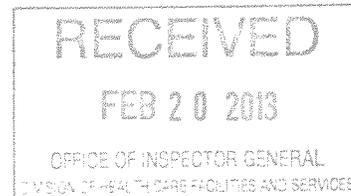
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
--	--

(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 144	<p>Continued From page 40</p> <p>Interview, on 01/15/13 at 10:40 AM, with the Maintenance Director revealed he was not aware the transfer time of the generator had to be documented.</p> <p>Interview, on 01/15/13 at 4:40 PM, with the Administrator revealed he was not aware the transfer time of the generator had to be documented.</p> <p>Observation, on 01/15/13 at 2:40 PM, with the Maintenance Director 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.</p> <p>Interview, on 01/15/13 at 2:40 PM, with the Maintenance Director revealed he was not aware that the battery charger could not be hooked directly to the battery.</p> <p>Interview, on 01/15/13 at 4:40 PM, with the Administrator revealed he was not aware that the battery charger could not be hooked directly to the battery.</p> <p>Reference: NFPA 99 (1999 Edition)</p> <p>Actual NFPA Standard: NFPA 99, 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p>	K 144		



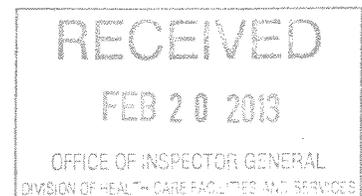
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
--	--

(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 144	<p>Continued From page 41</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1.</p> <p>(b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b). Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position. Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>(b) Inspection and Testing. 1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in</p>	K 144		



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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
---	--

(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 144 Continued From page 42
accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.
2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.
3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.
Actual Standard: NFPA 99, 3- 3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.

Reference: NFPA 110 (1999 Edition).

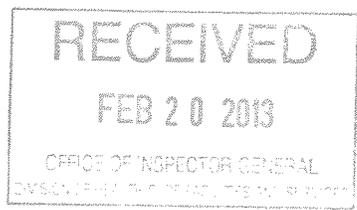
5-12.6
The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers' recommendations and accepted engineering practices.
Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.
NFPA 101 LIFE SAFETY CODE STANDARD
Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

K 144

1. The refrigerator located in the 500 hall was removed from the power strip on 1/18/13. In room 507 the mini nebulizer, oxygen concentrator, lift chair were removed from the power strip on 1/18/13. The mini nebulizer was removed from the 2nd power strip on 1/18/13. The refrigerator was removed from the 3rd power strip and the 3rd power strip was removed from the multi-plug adapter on 1/18/13. In room 504 the refrigerator was removed from the power strip on 1/18/13. In room 406 the oxygen concentrator was removed from the power strip on 1/18/13. The mini nebulizer and bed were removed from the extension cord on 1/18/13. In room 313 the bed was removed from the power strip on 1/18/13. In room 309 the mini nebulizer and refrigerator were removed from the multi-plug adapter on 1/18/13. In room

K 147
SS=E

K 147



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

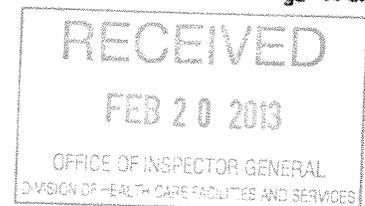
PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
---	--

(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 147	<p>Continued From page 43</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of nine (9) smoke compartments, residents, staff, and visitors. The facility is certified for one hundred twenty five (125) beds with a census of ninety six (96) on the day of the survey. The facility failed to ensure the proper use of power strips and extension cords.</p> <p>The findings include:</p> <p>Observations, on 01/15/13 between 9:00 AM and 4:30 PM, with the Maintenance Director revealed:</p> <ol style="list-style-type: none"> 1) A refrigerator was plugged into a power strip located in the 500 Hall Nurse's Station. 2) A mini nebulizer, an oxygen concentrator, and a lift chair were plugged into a power strip. A mini nebulizer was plugged into a 2nd power strip, and a refrigerator was plugged into a 3rd power strip that was plugged into a multi-plug adapter located in room #507. 3) A refrigerator was plugged into a power strip located in room #504. 4) An oxygen concentrator was plugged into a power strip; also a mini nebulizer and a bed were plugged into an extension cord located in room #406. 5) A bed was plugged into a power strip located in room #313. 	K 147	<p>306 the bed and oxygen concentrator were removed from the multi-plug adapter on 1/18/13. In room 305 the television was removed from the extension cord on 1/18/13. In the Social Services office the refrigerator and microwave were removed from the power strip on 1/18/13. In room 204 the bed was removed from the power strip on 1/18/13. In room 200 both beds (2), the oxygen contractor, and the air mattress pump were removed from the multi-plug adapter on 1/18/13. In the copy room, the power strip cord was removed from the wall it was passing through on 1/18/13. In the Administrator's office the refrigerator was removed from the power strip on 1/18/13. In the vending area, the vending machines were removed from the multi-plug adapter on 1/18/13. In the basement, the sump pump was removed from the extension cord on 1/18/13. In Central Supply, both power strips were removed on 1/18/13. In room 109 the mini nebulizer was removed from the power strip on 1/18/13. In room 108 the clock was removed from the extension cord on 1/18/13.</p>	
-------	---	-------	---	--



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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
---	--

(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 147

Continued From page 44

- 6) A mini nebulizer and a refrigerator were plugged into a multi-plug adapter located in room #309.
- 7) A bed and oxygen concentrator was plugged into a multi-plug adapter located in room #306.
- 8) An extension cord was installed to a television located in room #305.
- 9) A refrigerator and microwave was plugged into a power strip located in the Social Services Office.
- 10) A bed was plugged into a power strip located in room #204.
- 11) Two (2) beds, an oxygen concentrator, and an air mattress pump were plugged into a multi-plug adapter located in room #200.
- 12) The cord to a power strip was passing through a wall located in the Copy Room.
- 13) A refrigerator was plugged into a power strip located in the Administrators Office.
- 14) Vending Machines were plugged into a multi-plug adapter located in the vending area.
- 15) A sump pump was plugged into an extension cord located in the basement.
- 16) A power strip was plugged into a power strip located in Central Supply.
- 17) A mini nebulizer was plugged into a power strip located in room #109.
- 18) An extension cord in use to a clock located in room #108.

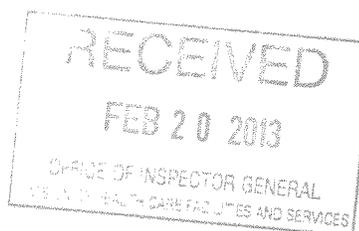
Interview, on 01/15/13 between 9:00 AM and 4:30 PM, with the Maintenance Director revealed they were aware of the proper use of power strips and extension cords but it was hard to monitor.

Interview, on 01/01513 at 4:40 PM, with the Administrator revealed he was aware of the proper use of power strips and extension cords.

K 147

- 2. A room to room search of residents' rooms, offices, storage rooms and basement was completed and all power strips and extension cords were removed.
- 3. ED in-serviced maintenance director, maintenance assistant, DON to this regulation on 2/05/13. Competency was determined by successful

verbalization reviewed by ED. The CSC in-serviced the DCE to this regulation on 2/06/13. Competency was determined by successful verbalization reviewed by ED. The housekeeping/laundry supervisor and department heads were in-serviced to this regulation on 2/19/2013 by the ED. Competency was determined by successful verbalization reviewed by ED. DCE will in-service nursing staff, dietary manager will in-service dietary staff, housekeeping/laundry supervisor will in-service their staff to this regulation. Staff competency will be determined by successful completion of post education test reviewed by the Director of Clinical Education. Maintenance will place at least one or more



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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
--	--

(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 147	<p>Continued From page 45</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	<p>approved 2 to 4 receptacle for each resident's area by 2/27/13. All offices will plug items directly into receptacle or remove items from center. Maintenance will do a monthly check of all resident's rooms for power strips, multi-plug outlets and extension cords for 6 months. A letter will be sent out to families making them aware and requesting them to not bring power strips into center by 2/20/13. Admission director will make residents and families aware upon admission during the admission process with the signing of admission paper work.</p> <p>4. The Maintenance Director will bring audit findings to the QAPI committee for two quarterly meetings to validate that all resident's rooms have had the receptacles replaced; all offices, basement and storage area are free of power strips and extension cords for. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits</p> <p>5. Date of compliance: 2/28/13</p>	
-------	---	-------	--	--

If continuation sheet Page 46 of 46

RECEIVED

FEB 20 2013

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES