

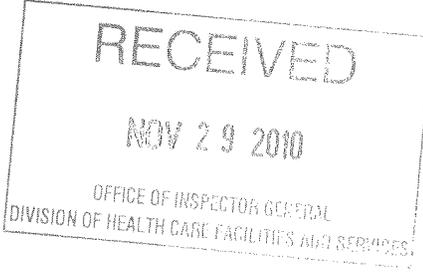
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/16/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/03/2010
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222
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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	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted 11/01/10 through 11/03/10 and found the facility to be in compliance with no deficiencies cited. A Life Safety Code survey was conducted on 11/02/10 and deficiencies were cited with the highest scope and severity of an "F".</p> <p>An abbreviated survey investigating KY00014669, KY00015078, KY00015302, KY00014923 and KY00015091 was initiated on 11/01/10 and concluded on 11/03/10. KY00014669, KY00015078, KY00015302, KY00014923 and KY00015091 were unsubstantiated.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Dir* (X8) DATE *11/29/10*

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

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222
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K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and concluded on 11/02/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was an "F".</p> <p>K 025 SS=E NFPA 101 LIFE SAFETY CODE STANDARD</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, it was determined the facility failed to ensure approved doors were used in smoke barriers, according to NFPA standards. Doors used in smoke barriers must be of an approved type to limit the spread of smoke and fire. The deficiency affected five (5) smoke compartments and eighty-seven (87) residents of the facility.</p> <p>The findings include:</p> <p>Observation on 11/02/10 at 11:52am revealed an unapproved door in the attic area smoke barrier of the East Wing B Hall. The observation was</p>	K 000	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></p> <p>K 025 Appropriate Smoke Barriers</p> <p>This facility will ensure that approved doors are used in smoke barriers, according to NFPA standards.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>No residents were known to be affected by the alleged deficient practice.</p> <p>All doors identified have been replaced with doors which meet the standards as referenced in NFPA 80 (1999 edition)</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p>	
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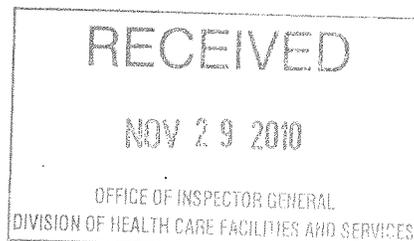
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X8) DATE 11/29/10
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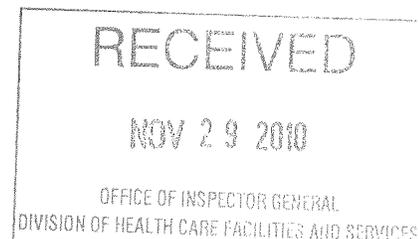
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K 025	Continued From page 1 confirmed with the Director of Maintenance. During the Life Safety Code survey, three (3) additional unapproved doors were found in the attic area smoke barriers of the East Wing Halls A, C, and D. Interview on 11/02/10 at 11:52am, with the Director of Maintenance, revealed he was not aware the doors located in the attic area smoke barriers did not meet code. Reference: NFPA 80 (1999 edition) 11-1 Doors. 11-1.1 General. This chapter shall cover the installation of both horizontal and vertical access doors in fire-rated walls, floors, and floor-ceiling or roof-ceiling assemblies. 11-1.2 Components..An access door shall be an integral unit including the door, frame, hinges, latch, and closing device (where required) bearing a label that reads " Frame and Fire Door Assembly. " Exception: A vertical access door shall be permitted to have hinges that are not part of the labeled assembly, provided the hinges conform to Table 2-4.3.1. 11-1.2.1 Access doors shall be self-closing. 11-1.2.2 Access doors shall be self-latching. Exception: A horizontal access door that does not open downward and that remains in place when an upward force of 1 psf (48 N/m2) is applied over the entire exposed surface of the door shall	K 025	All residents have the potential to be affected. All doors in the attic have been checked to ensure that they meet the standards as referenced in NFPA 80 (1999 edition). Any not meeting the code will be replaced. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Maintenance supervisor will audit doors through preventative maintenance program to ensure proper operation. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Findings of audits will be brought to Quality Assessment & Assurance (QAA) monthly for three months. Action plans will be reviewed for progress or new developments and revised as needed with QAA. Compliance Date: 11/29/10	11/29/10



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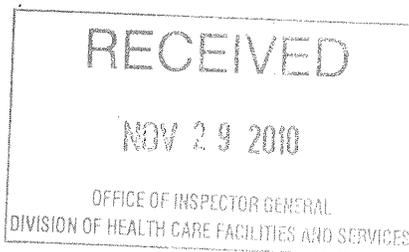
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K 025	Continued From page 2 not be required to be self-latching. 11-1.2.3 Self-closing access doors that are intended to be used to allow a person to enter the concealed space behind the door completely shall be operable from the inside without the use of a key or tool. 11-1.2.4 Access doors shall be installed in accordance with their listing. 11-2.2 Vertical Access Doors. 11-2.2.1 Vertical access doors shall have a fire protection rating of 3/4 hour, 1 hour, or 1 1/2 hours. (See Appendix F.) 11-2.2.2 Vertical access doors shall be used only in walls. 11-2.2.3 Where the authority having jurisdiction determines that a vertical access door is located in proximity to combustibles so that, in a fire condition, the door is likely to transmit sufficient heat to ignite the combustibles, the temperature rise on the unexposed face of the door shall not exceed 250°F (139°C) at the end of a 30-minute exposure to the standard fire test as described in NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Such an access door shall bear a label indicating a maximum temperature rise of 250°F (139°C). 11-2.2.4 Closing by means of gravity using top-hinging vertical access doors shall be permitted to meet the	K 025	K 062 Automatic sprinkler control valve This facility will ensure that our sprinkler system is maintained in reliable operating condition and inspected monthly, according to NFPA standards. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were known to be affected by the alleged deficient practice. Maintenance supervisor will audit sprinkler system through preventative maintenance program to ensure proper operation. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected. Monthly inspection form has been established and will be completed to ensure compliance. All sprinkler inspection forms will be audited by the administrator and	



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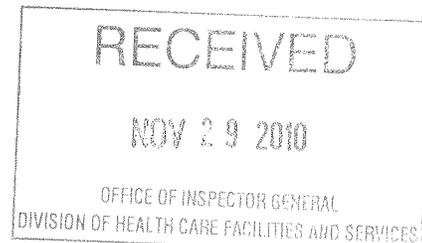
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K 025	Continued From page 3 requirements for self-closing doors. 11-2.2.5 A vertical access door shall bear a label that includes the additional wording " For Vertical Installation. "	K 025 u	checked quarterly to ensure compliance.		
K 062 SS=F	NFPA 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 record review and interview, it was determined the facility failed to ensure sprinkler control valves where inspected monthly, according to NFPA standards. Sprinkler control valves must be inspected monthly to ensure proper operation of the sprinkler system. The deficiency affected eleven (11) smoke compartments and one hundred and thirty nine (139) residents. The findings include: Record review of the sprinkler maintenance on 11/02/10 at 1:53pm, revealed no documentation of the sprinkler control valves being inspected monthly. The observation was confirmed with the Director of Maintenance. Interview on 11/02/10 at 1:53pm, with the Director of Maintenance, revealed he did not check the sprinkler control valves monthly.	K 062	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Audits completed by the administrator on a quarterly basis to ensure compliance. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Findings of audits will be brought to Q.A.A. Action plans will be reviewed for progress or new developments and revised as needed with IDT. Compliance Date: 11/29/10 K 130 Emergency Drill This facility will ensure that an emergency drill is completed on a semi-annual basis. What corrective action(s) will be accomplished for those residents	11/29/10	



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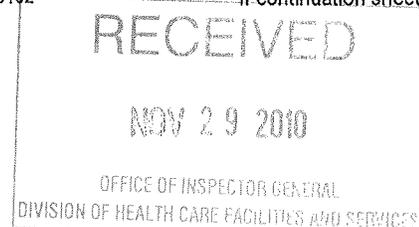
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K 062	Continued From page 4 Reference: NFPA 25 (1998 edition) 9-3.3 Inspection. 9-3.3.1 All valves shall be inspected weekly. Exception No. 1: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Exception No. 2: After any alterations or repairs, an inspection shall be made by the owner to ensure that the system is in service and all valves are in the normal position and properly sealed, locked, or electrically supervised. 9-3.3.2* The valve inspection shall verify that the valves are in the following condition: (a) In the normal open or closed position (b) *Properly sealed, locked, or supervised (c) Accessible (d) Provided with appropriate wrenches (e) Free from external leaks (f) Provided with appropriate identification NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure semi-annual drills were conducted according to	K-062 <i>cu</i>	found to have been affected by the deficient practice? No residents were known to be affected by the alleged deficient practice. One semi-annual drill will be conducted every six months to ensure that our facility is prepared to deal with potential disasters as outlined in our emergency preparedness plan. At least one semi-annual drill shall rehearse mass casualties with emergency services. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected. One semi-annual drill will be conducted every six months to ensure that our facility is prepared to deal with potential disasters as outlined in our emergency preparedness plan. At least one semi-annual drill shall rehearse mass casualties with emergency services. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?	
K 130 SS=F		K 130		



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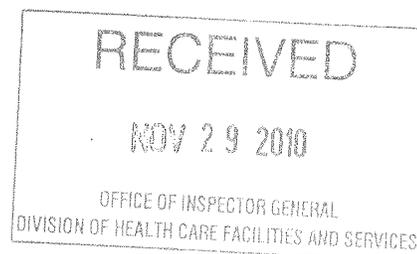
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K 130	Continued From page 5 NFPA standards. Drills utilizing the emergency preparedness plan must be conducted semi-annually. The deficiency affected eleven (11) smoke compartments and one hundred and thirty nine (139) residents. The findings include: Record review of the facility's emergency preparedness plan on 11/02/10 at 2:25pm, with the Director of Maintenance, revealed the facility had failed to conduct any drills utilizing the emergency preparedness plan. The observation was confirmed with the Director of Maintenance. Interview on 11/02/10 at 2:25pm, with the Director of Maintenance, revealed the facility did not conduct drills utilizing the emergency preparedness plan that addressed mass casualty response or disaster receiving stations. NFPA 99 (1999 edition) 11-5.3.9* Drills. Each organizational entity shall implement one or more specific responses of the emergency preparedness plan at least semi-annually. At least one semi-annual drill shall rehearse mass casualty response for health care facilities with emergency services, disaster receiving stations, or both.	K 130	One semi-annual drill will be conducted every six months to ensure that our facility is prepared to deal with potential disasters as outlined in our emergency preparedness plan. At least one semi-annual drill shall rehearse mass casualties with emergency services. Audit will be completed on the findings of the drill, identifying areas for improvement. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Findings of audits will be brought to QAA. Action plans will be developed and reviewed for progress or new developments and revised as needed with IDT input. Additional focus will be placed on areas as needed. Compliance Date: 11/29/10	
K 144 SS=F	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.	K 144		11/29/10



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K 144	Continued From page 6 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure the emergency generator was maintained, according to NFPA standards. Emergency generators must be maintained to ensure its reliability during use. The deficiency affected eleven (11) smoke compartments and one hundred and thirty nine (139) residents. The findings include: Record review of the emergency generator maintenance logs on 11/02/10 at 2:06pm revealed the logs were not completed for the required portions. The only thing completed was the start and stop times for the required thirty (30) minute load test. The observation was confirmed with the Director of Maintenance. Interview on 11/02/10 at 2:06pm, with the Director of Maintenance, revealed he performs the required maintenance for the generator, but he is unsure why the maintenance logs for the emergency generator were not completed. Reference: NFPA 99 (1999 edition) 3-4.4.2 Recordkeeping. A written record of inspection, performance, exercising period, and	K 144	K 144 Generator Inspection This facility will ensure that the emergency generator is maintained to ensure its reliability during use. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were known to be affected by the alleged deficient practice. All forms will be completed to ensure that the emergency generator is maintained to ensure its reliability during use. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All forms will be completed to ensure that the emergency generator is maintained to ensure its reliability during use.	



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K 144	Continued From page 7 repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.	K 144	<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Administrator will audit forms monthly to ensure that they are being completed fully.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Findings of audits will be brought to QAA. Action plans will be developed and reviewed for progress or new developments and revised as needed with IDT input. Additional focus will be placed on areas as needed.</p> <p>Compliance Date: 11/29/10</p>	11/29/10	

