

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

PRINTED: 07/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/10/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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F 000 F 246 SS=D	<p>INITIAL COMMENTS</p> <p>A Recertification Survey was initiated on 07/08/14 and concluded on 07/10/14 with deficiencies cited at the highest scope and severity of an "F".</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide a clock for one (1) of twenty (20) sampled residents. Resident #6 was on bed rest and had requested a clock.</p> <p>The findings include: The facility did not provide a policy for accommodations of needs.</p> <p>Interview with Resident #6, on 07/08/14 at 10:55 AM, revealed there had been multiple requests to staff requesting placement of a wall clock in his/her room. The resident stated he/she would like to know what time of the day or night it was. Observation of the resident's room during the interview revealed there was no wall clock.</p>	F 000 F 246	<p>F246</p> <p><u>Corrective Actions for Targeted Residents:</u></p> <p>One individual was affected by the deficient practice. Clock was provided to resident # 6 immediately on 7/08/14 by maintenance director.</p> <p><u>Identification of Other Residents with Potential to Be Affected:</u></p> <p>A limited number of residents have a potential to be affected by this practice. 10 residents will be interview every month for six months regarding staff response to their needs MDS will conduct this interview. Residents will be interview during resident council meeting monthly to access if their needs and request are be attended to timely and appropriately findings will be brought to daily stand up meeting with the IDT team .</p> <p><u>Systemic Changes:</u></p> <p>Follow up with resident #6 was conducted on 7/09/14 resident was happy that he got a clock. Maintenance Director conducted facility round on 7/08/14 no other resident was not found having a clock.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE X Cham TITLE X Administrator (X6) DATE X 8/13/14

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 day 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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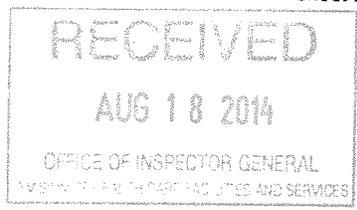
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F 246	<p>Continued From page 1</p> <p>Review of the clinical record for Resident #6 revealed the facility admitted the resident on 06/23/14 with diagnoses of Intervertebral Cervical Disc Disorder with Myelopathy of the Cervical Region, Diabetes Mellitus Type II, Hypertension, Acute Respiratory Failure, Acute Kidney Failure, and Quadriplegia. Review of the Minimum Data Set (MDS) assessment completed by the facility, dated 06/30/14, determined the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact.</p> <p>Interview, on 07/10/14 at 2:30 PM, with Certified Nursing Assistant (CNA) #4 revealed the resident had made several requests to her for a wall clock for the room. The CNA further revealed she had not notified her supervisor regarding Resident #6's request. CNA #4 stated she had removed a broken clock from the wall of Resident #6's room. However, she had not notified maintenance the clock was broken and had not informed anyone of the resident's request for a replacement. She stated she thought the resident's family was responsible for providing a clock for the room.</p>	F 246	<p>Monitoring:</p> <p>Monitoring and inventory of clocks has been incorporated to the non clinical rounds finding are to be reported to the Interdisciplinary team weekly. Maintenance director will conduct monthly audits of clocks for 6 months, finding are to be reported to QAPPI monthly. In-service by the DCE on how to report resident concerns and needs (Grievance process) was started on 7/08/14 for all staff.</p> <p>Correction Date: 8/05/14</p>	
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of non-clinical round forms, it was determined the facility failed to have an effective housekeeping and maintenance program to ensure a safe and</p>	F 253	<p>F 253</p> <p>Corrective Actions for Targeted Residents:</p> <p>No individual was affected by the deficient practice.</p>	



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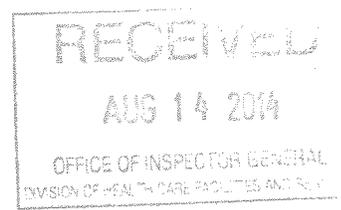
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F 253	<p>Continued From page 2</p> <p>sanitary environment. Observations revealed four (4) of five (5) hallways and common areas had soiled and torn furniture, soiled equipment, torn and hanging wall paper, dead bugs and visible dirt on the floors, dusty ceiling fans, strong odors of urine in the hallway and rooms, torn carpet, missing baseboards, and soiled air conditioner vents, doors, walls, and windows.</p> <p>The findings include:</p> <p>The facility did not provide any maintenance or housekeeping policies regarding how to maintain a clean and safe environment. The facility did provide daily housekeeping cleaning schedule, deep cleaning calendar, floor maintenance assignment, carpet cleaning schedule, daily quality inspections, and daily non-clinical rounds.</p> <p>Observation during entrance of the facility, on 07/10/14 at 8:15 AM, revealed a strong musky odor in the front lobby that increased throughout the facility. The outside welcome mat was covered with dirt and leaves. The inside welcome mat was also dirty with leaves and outside debris on the rug. The windows in the front lobby was coated with heavy dust and dirt. The exterior metal doors had paint missing, chipped paint, black marks across the bottom of the doors, and the door did not close completing leaving an open area for insects to come in.</p> <p>1. Observation of the North Hallway, on 07/08/14 at 11:05 AM, revealed the bathroom trash can in Room 224 had no liner. The trash can contained dark brown liquid and a pair of dirty gloves. In Room 221, the bathroom toilet paper holder was broken. Observation at 11:15 AM, revealed the bathroom in Room 214 had a broken toilet paper</p>	F 253	<p><u>Identification of Other Residents with Potential to Be Affected:</u></p> <p>resident interviewed was conducted by the administrator on 7/25/14 regarding the cleanliness and maintenance of the facility limited number of residents have a potential to be affected by this practice. Resident interview will be conducted during our Monthly resident council regarding the cleanliness and maintenance of the building. finding will be reported to morning stand up on day after resident council issues of concern will be reported to QAPPI monthly for 6 months .</p> <p><u>Systemic Changes:</u></p> <p>Soiled and torn furniture was immediately removed on 7/09/14 by Maintenance and housekeeping directors. Housekeeping supervisor has ordered a special cleaner to aid in maintaining the stains in toilet bowl on 07/15/14. This product will be use on a daily basis by housekeeping to clean and keep these stains from reoccurring. Housekeeping will be responsible for the daily cleaning of resident toilets.</p>	
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F 253	<p>Continued From page 3 holder.</p> <p>Observation, on 07/08/14 at 11:20 AM, revealed a large square area of mismatched carpet on the North Hall in front of the shower room. The edges of the carpet were frayed with many visible loose strings.</p> <p>On 07/09/14 at 10:10 AM, observation of Room 219 revealed the air conditioner (A/C) vents had chipped paint and were soiled with a gray substance.</p> <p>Observation, on 07/09/14 at 12:55 PM, of the North Hall soiled utility room revealed a gray substance on the ceiling vent and there were two (2) soiled gloves lying on the floor.</p> <p>Observation of the North Hall storage room, on 07/09/14 at 12:58 PM, revealed a thick gray substance accumulated on the vents at the bottom of the door. A thick, powdery, black build-up was observed on the base of a mechanical lift that was being stored in the room. There were also multiple broken tiles at the baseboard, under the sink and the wall, including a hole at the base of the wall.</p> <p>Interview, on 07/10/14 at 10:52 AM, with the Maintenance Director revealed he was unaware of the broken tiles and hole in the wall in the North Hall storage room. He stated he did not routinely check the storage area for maintenance issues.</p> <p>Interview with the Housekeeping Supervisor, on 07/10/14 at 10:55 AM, revealed housekeeping was not responsible for cleaning storage areas. He further revealed the floor tech was responsible</p>	F 253	<p>Monitoring:</p> <p>Monitoring of facility furniture has been incorporated to the weekly environmental and maintenance rounds . the outside and inside welcome mat was clean on 07/10/4 by housekeeping , daily cleaning of the front entrance will be done by housekeeping , housekeeping manager is to conduct daily front office rounds .for three months and weekly . for a year. ABM janitorial our contracted housekeeping company, has hired a new site manager who will oversee the golden living facility, site visit are schedule weekly to improve the quality of work with the facility cleaning team.</p> <p>Strong musky odor in facility :Facility has received approval for the replacement of carpet to a new flooring, Schaefer General contracting company has started working on this projected with an anticipated finished month of September 2014. Upon the completion of this project this facility will notice a great improvement in the odor and smell generated by the carpet.. In other to control the odor and smell at this time housekeeping has ordered a new cleaning product on 7/18/14 to be use when extracting or bonneted is done.</p>	

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F 253 Continued From page 4
for monitoring the vents located on the bottom of the doors and dusting them as needed. He acknowledged the door vent was heavily soiled and needed to be cleaned.

Interview, on 07/10/14 at 10:09 AM, with Certified Nursing Assistant (CNA) #3 revealed the third shift CNA's were responsible for weekly cleaning of the resident wheelchairs and mechanical lifts. The CNA stated dirt and debris collected on the lifts from people standing on them. She further stated the base of the lift was "pretty dirty". CNA #3 revealed all CNA's were responsible for wiping down the lift as needed if it became soiled.

Review of the nightly duties checklist revealed lifts and commode chairs were scheduled to be cleaned weekly. Further review of the checklist revealed the CNA's had signed the checklist documenting the assigned tasks were completed.

Interview, on 07/10/14 at 3:50 PM, with the Director of Nursing (DON) revealed third shift nurse aides were responsible for cleaning the resident mechanical lifts and wheelchairs. She further revealed the aides had signed off on the nightly duties worksheet documenting they had completed the assigned tasks. The DON stated the cleaning worksheets are turned in daily to the Unit Manager who was responsible for ensuring the nightly duties were completed. She further stated she routinely performed "spot checks" of resident equipment; however, there was no documentation of her spot checks or findings.

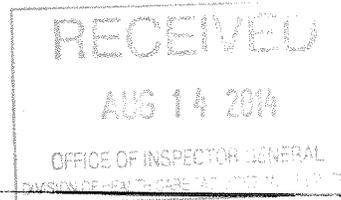
Observation, on 07/10/14 at 8:30 AM, revealed a strong odor of urine in the North Hallway. The A/C vents in room 225 were soiled with a gray substance. There was a baseboard missing in

F 253

carpet will be extracted two times a week by floor technician. All housekeeping routines has been reevaluated and areas of has been given special attention on the daily housekeeping duty list.

On 8/04/14 Facility has purchased a pressure wash machine that will be use for cleaning Window by housekeeping throughout the facility. Housekeeping Manager will monitor window on a daily basis. housekeeping will clean and monitor windows in the facility , floor technician will monitor and clean windows in common area daily. Housekeeping supervisor will add the inspection of the windows to his daily checklist . Maintenance Director will pressure wash out side windows quarterly for year .

Exterior metal door has been painted, On 7/11/14 kick plate was place on bottom of the door to prevent black marks by maintenance director , space between the two double doors has been fixed by maintenance director on 7/11/14 door is closing completely Monitoring of this door will be done during our monthly maintenance round. by Administrator and Maintenance director issues will be reported to QAPPI monthly for six months.



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F 253 Continued From page 5
the bathroom. The inside of the toilet had a dark ring and the elevated toilet seat was splattered with a brown substance. In addition, the door vents to the lower portion of the bathroom door were heavily soiled with a gray substance.

Observation of Room 221, on 07/10/14 at 8:35 AM, revealed a broken floor tile near the window. The A/C unit vents were soiled with a gray substance. There was also a strong odor of urine in the room.

Observation, on 07/09/14 at 12:45 PM, of the North Hall Activity Room revealed two (2) of two (2) A/C air vents were soiled with a grayish-black substance. In the Activity Room (at the end of North Hall) the windows of the exit door was heavily soiled with a grayish substance. The interior windows of the room were soiled with a white sticky substance and the Activity Office's window was splattered with a white substance. The Activity Office door and door facing were scuffed and heavily soiled with a gray/black substance. The door facing also had chipped and splintered wood. In addition, the baseboard at the entrance of the Activity Room was loose and partially pulled away from the wall.

Observation of the Activity Room, on 07/10/14 at 10:40 AM, during environmental tour with the Maintenance Director and Housekeeping Supervisor revealed a chair heavily soiled with a black substance on the seat and back. The chair also had a loose armrest that was freely movable from side to side. In addition, a second chair in the room was missing the entire arm.

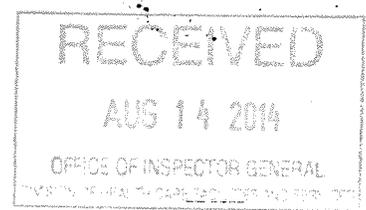
Interview, on 07/10/14 at 10:48 AM, with the Maintenance Director revealed he was

F 253 Room 224 trash can liner was replaced by housekeeping on 7/08/14, facility trash liners in bathroom audits was conducted on 7/08/14 by housekeeping and nursing staff bathrooms without trash can liners were identified and replaced immediately by housekeeping.

Room 221 Bathroom toilet paper holders was fixed on 7/09/14 by maintenance director Upon cleaning of the restrooms, any damaged or broken fixtures will be reported to the housekeeping manager by housekeeping by using our new created maintenance communication forms it will then be reported to the maintenance supervisor and administrator for proper corrective actions to be taken., issues will be reported to QAPPI monthly.

On 7/16/14 Maintenance Director has trimmed the Frayed and loose edges on Large square area of mismatched carpet. carpet is on scheduler to be replace by Schaefer General Contracting Services through out the facility .project is to be completed before September 2014.

Room 219 Air conditioning Units was cleaned and painted by maintenance Director on 7/18/14. facility audits was conducted identified A/C units were fixed and cleaned by housekeeping and maintenance. monitoring of AC units conditions has been added to our daily non clinical rounds issues are to be reported to the IDT team and QAPPI monthly.



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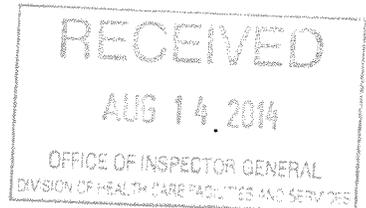
F 253 Continued From page 6 responsible for cleaning the interior of the facility's A/C units. He revealed the A/C vents were last cleaned in May. He stated the A/C vents were soiled and needed to be cleaned. The Maintenance Director revealed he was also responsible for maintaining the outside windows and ensuring they were clean. He stated he conducted weekly rounds of the facility and grounds, but could not provide a record of the audits or findings. The Maintenance Director revealed the facility did not have a system in place for scheduled cleaning of the windows. He stated the outside windows were last cleaned at the beginning of the summer, but was unable to recall the exact date. He revealed he had noticed the soiled, gouged Activity Room door, but had not noticed the missing baseboard at the entrance during his daily rounds. He stated no work order had been submitted reporting the missing baseboard. The Maintenance Director revealed he was not aware of the broken chairs in the Activity Room. He further revealed he had not inspected the furniture in the facility for "some time" because he had not had the time. The Maintenance Director further revealed there were no reports or work orders submitted regarding the loose or missing arms on the two chairs in the activity room. He also stated the chairs were not safe for resident use. The Maintenance Director revealed that he was the only maintenance person for the facility and could not keep up with all of the work required. He stated he had notified the Administrator that he needed additional help with maintenance of the facility. He revealed the Administrator had corporate approval to hire additional maintenance staff; however, this was pending.

Interview, on 07/10/14 at 10:15 AM and 10:34

F 253 North Hall soiled utility floor and vent was cleaned along with all vents on 7/10/14 by housekeeping and maintenance Director. soil utility is on a monthly deep clean schedule to be done by housekeeping floor technician. monitoring of soiled utility room vents to be done on monthly maintenance rounds by maintenance director and report to QAPPI monthly for three months.

On 7/11/14 vent on North hall storage room door was cleaned, gray substances was removed during the cleaning process by housekeeping As part of the housekeeping cleaning schedule the door vent is to be clean weekly by housekeeping continuing monitoring is to be conducted by housekeeping manager weekly.

Mechanical lift was cleaned immediately by housekeeping on 07/09/14 lifts audits was conducted on 7/09/14 and dirty lifts were cleaned immediately by housekeeping. In-service on cleaning mechanical lifts was given to night shift CNA on 07/11/14 by director of clinical education monitoring of lift cleanliness will be the responsibility of unit manager to monitor and follow up will be done weekly and report to the director of nursing, and the IDT team.



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F 253 Continued From page 7
AM, with the Housekeeping Supervisor revealed he conducted daily hands-on inspections of the facility, and monitored the windows weekly. He revealed there was no cleaning schedule for the windows, which were cleaned as needed by housekeeping. He further stated one floor tech was responsible for monitoring the cleanliness of all the common areas, including the windows.

On 07/10/14 at 10:34 AM, interview with the Housekeeping Supervisor revealed the surfaces of the chairs were wiped down and disinfected by housekeeping on an as needed basis. He further revealed the arms of the chairs were wiped down daily. The supervisor revealed he had not noticed the heavily soiled chairs in the activity room during his daily housekeeping inspections. He further revealed there were no checklists that specified the assigned cleaning tasks of the housekeeping staff.

2. Observation of the West Hall, on 07/09/14 at 9:35 AM, revealed the overhead air vents, located at the exit door of the smoking area, were soiled with a grayish black substance. The floor at the exit door had visible dirt piles and dead bugs at the edges and corner of the wall. The dirt and bugs were noted for the three (3) consecutive days during the survey. Observation of the West Hall carpet revealed stains and odors.

Observation of the bathroom in Room 106, on 07/09/14 at 4:20 PM, revealed a brown colored build-up on the floor at the base of the toilet and the baseboards. The vents on the lower portion of the two bathroom doors were heavily soiled with a gray substance.

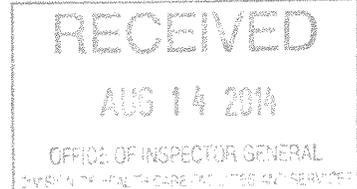
Observation of Room 104, on 07/09/14 at 4:25

F 253 Broken tiles, walls and holes in storage room were fixed by Maintenance director on 08/01/14. monitoring of the North hall storage room has been added to our monthly maintenance rounds finding are to be reported to QAPPI monthly for six months.

Room 225 Air conditioning Units was cleaned and painted by maintenance Director on 7/18/14. facility audits was conducted AC units identified was fixed and cleaned by housekeeping and maintenance. monitoring of AC units conditions has been added to our daily non clinical rounds issues are to be reported to the IDT team and QAPPI monthly .

Room 225 missing Baseboard was replaced by maintenance director on 07/25/14 Monitoring of Baseboards in residents bathroom has be added to non clinical rounds, finding are to be reported to the interdisciplinary team weekly. and to QAPPI monthly for six months.

special cleaner to clean the dark rings in toilet bowl. Housekeeping supervisor has ordered a special cleaner to aid in maintaining these stains on 07/15/14. This product will be use on a daily basis by housekeeping to clean and keep these stains from reoccurring. Housekeeping will be responsible for the daily cleaning of resident toilets. Gray substance on bathroom door was cleaned immediately



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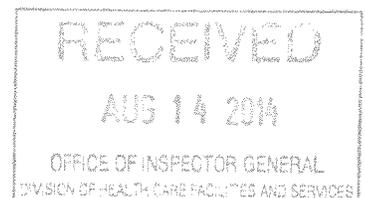
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/10/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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F 253	<p>Continued From page 8</p> <p>PM, revealed a strong odor of urine in the bathroom.</p> <p>Observation of the West Hall and interview, on 07/10/14 at 11:10 AM, during the environmental tour with the Housekeeping Supervisor revealed a strong urine odor in Room 106. He stated housekeeping was responsible for cleaning the residents' bathroom daily. He further stated daily cleaning of the resident rooms included sweeping and mopping the bathroom floors. The Housekeeping Supervisor stated the bathroom floor was visibly dirty and did not appear clean. In addition, he acknowledged the bathroom had a strong offensive odor.</p> <p>Observation, on 07/09/14 at 9:37 AM, of the West Hall weight room revealed the air conditioner (A/C) air vents were soiled with a gray substance, as well as, soiled windows and exit door windows.</p> <p>3. Observation, on 07/09/14 at 12:50 PM, of the East Hall Shower Room revealed the A/C vent and ceiling vent were soiled with a gray substance. In addition, the shower stall tile grout on the walls and floor were discolored with a black and pink substance.</p> <p>Interview, on 07/10/14 at 11:15 AM, with the Housekeeping Supervisor revealed the shower room stalls were cleaned daily. He further revealed the tile grout in the shower rooms were machine cleaned weekly. He stated the tile grout was discolored and needed to be cleaned.</p> <p>Review of the housekeeping project calendar revealed shower rooms were scheduled to be machine scrubbed once a month. Review of the deep clean calendar revealed the shower rooms</p>	F 253	<p>by housekeeping. housekeeping manager will continuing to conduct weekly rounds on bathroom room .</p> <p>Room 221 Air conditioning Units was cleaned and painted by maintenance Director on 7/18/14. facility audits was conducted A/C units identified was fixed and cleaned by housekeeping and maintenance. broken tile near window was replaced by maintenance director on 7/21/14.. monitoring of A/C units conditions has been added to our daily non clinical rounds issues are to be reported to the IDT team and QAPPI monthly for six months .</p> <p>North Hall activities area will be put on a daily cleaning schedule Housekeeping supervisor adjusted the cleaning schedule to ensure proper cleaning and monitoring of the area, this will include the cleaning of the windows on the interior, and the entrance and exit doors by housekeeping and maintenance .</p>	
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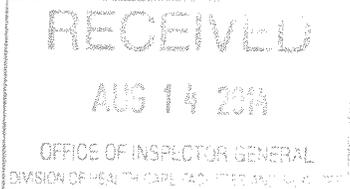
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F 253	<p>Continued From page 9 were also scheduled to be deep cleaned once a month.</p> <p>Observation of the East Hall, on 07/09/14 at 4:10 PM, revealed a soiled, broken baseboard in room 119.</p> <p>Interview, on 07/10/14 at 10:00 AM, with Housekeeper #11 revealed the housekeeping staff were assigned specific hallways for cleaning. The housekeeper revealed she was responsible for sweeping, mopping and dusting her assigned rooms including light fixtures, nightstands, and over bed tables. She also revealed all bathrooms were cleaned daily, which consisted of cleaning the sink and toilet, dusting light fixtures, and mopping the floor. She further stated she was not responsible for the cleaning of the common areas in the facility.</p> <p>4. Observation of the Annex Hall, Room 312, on 07/10/14 at 10:25 AM, during the environmental tour with the Maintenance Director and Housekeeping Supervisor revealed a missing baseboard. In addition, the paint on the door to Room 326 was scuffed and chipped off. At the end of the Annex Hall, outside the maintenance department office, the exit doors were observed to be very scuffed with black marks all across the doors. The glass windows of the doors were very dirty where you could not see through them well. There were paper debris and dirt on the floor, spider webs in the corners, and rusty metal strips holding the ceiling tiles. Some of the ceiling tiles were stained with a brown substance and ceiling lights had brown/black spots like bug stains. The windows in that area were cloudy and dirty. The wooden window sills were chipped and badly deteriorated.</p>	F 253	<p>Any damaged furniture will be documented and reported to the maintenance supervisor and administrator to ensure proper replacement of furniture. A/C vents were cleaned by maintenance director and painted on 7/22/14. the substance on exit door ,sticky substance on activity window offices window, and activity door was scraped and cleaned by housekeeping . the door facing, chipped and splintered was smoothed and finished by maintenance Director . the loose baseboard at the entrance of the activity room was fixed and is fully attached back to the wall this was done on 7/22/14 by maintenance director.</p> <p>Heavily soiled chair with black substance was immediately removed by maintenance director along with the chairs that has loose armrest and the one that was missing entire armrest. Activity director will monitoring activity area weekly and report finding to the IDT weekly for three months .</p> <p>West Hall: Over head air vents located at the exit door of the smoking area, floor at the exit door with visible piles and dead bugs at the corner of the wall were cleaned by housekeeping on 0711/14 floor technician was informed of the uncleanness of that area. on 7/11/14, housekeeping manager is to conduct</p>	
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F 253 Continued From page 10

Interview with the Maintenance Director and Housekeeping Supervisor, at the time of the observations, revealed they had not noticed this area was in this condition. The Maintenance Director stated he had been busy with other projects that he just didn't look at this area. The Housekeeping Supervisor stated it was the job of the floor tech to clean this area and it appeared that had not been done. He stated he would conduct inspections of the common areas but his focus had been on residents rooms. He acknowledged he had not inspected this area.

5. Observation of the main dining room, on 07/09/14 at 12:10 PM, revealed the vents on two (2) of two (2) A/C units were soiled with a gray substance. Six (6) of eight (8) chandeliers had multiple light bulbs that were burned out. One overhead tile located above the A/C unit at the rear of the dining room was discolored with a black and pink stain. Two (2) of two (2) ceiling fans located directly over the dining room tables had heavy build-up of dust on the fan blades. On 07/09/14 at 3:00 PM, the Maintenance Director was observed replacing the light bulbs of the chandeliers in the main dining room.

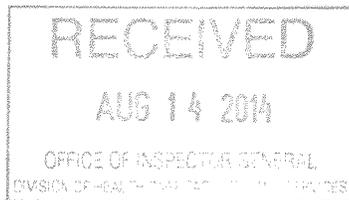
Interview, on 07/10/14 at 11:20 AM, with the Maintenance Director revealed he was not aware of the stained ceiling tile in the main dining room. He stated he had not noticed the heavy build-up of dust on the dining room ceiling fans during his daily maintenance rounds. He further stated dining room chandeliers were checked weekly for burned out bulbs. He indicated it was difficult to maintain all of the chandelier light bulbs because they were "always burning out".

F 253

daily rounds, spot checking areas of concern and rectify the issues . Administrator and housekeeping director are to conduct monthly environmental round issues of concern are to be reported to QAPPI and safety meeting monthly .

Room 106 brown colored build -up on floor at the base of the toilet is a result of the grout needing to be replace, maintenance Director has replaced grout around toilet and clean vents on the lower portion of the two bathrooms on 8/6/14. housekeeping also clean the bathroom on 7/25/14 monitoring of toilets /bathroom/ and vents condition will be done by maintenance director on a monthly basis finding are to be reported to QAPPI .

West Hall weight room, Air conditioning vent was cleaned and painted by maintenance Director on 7/18/14. facility audits was conducted A/C units identified was fixed and cleaned by housekeeping and maintenance. soiled .Windows and exit door windows were cleaned by housekeeping on 7/23/14 monitoring of A/C units conditions has been added to our daily non clinical rounds issues are to be reported to the IDT team and QAPPI monthly .



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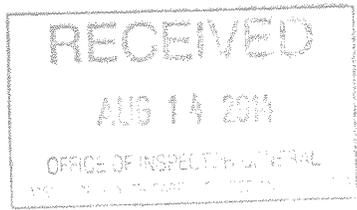
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F 253	<p>Continued From page 11</p> <p>Interview during environmental tour, on 07/10/14 at 11:23 AM, with the Housekeeping Supervisor revealed housekeeping was responsible for cleaning the dining room ceiling fans as needed. He stated he had not noticed the build-up of dust on the dining room ceiling fans during his daily spot checks.</p> <p>6. Observation, on 07/08/14 at 1:00 PM, of the outdoor smoking area revealed a large amount of paper debris and gum wrappers in the landscaping mulch. There were many cigarette butts in the landscaping mulch and on the patio.</p> <p>Interview, on 07/10/14 at 11:00 AM, during environmental tour with the Housekeeping Supervisor revealed housekeeping was responsible for sweeping the patio and removing the trash twice a day. He further revealed maintenance was responsible for picking up the cigarette butts in the landscaping mulch surrounding the edges of the patio.</p> <p>Interview, on 07/10/14 at 11:00 AM, during environmental tour with the Maintenance Director revealed he was responsible for performing daily rounds of the facility grounds. He further revealed he was responsible for maintaining the cleanliness of the grounds. He stated he had not noticed the paper debris, gum wrappers, or dozens of cigarette butts in the mulch during his morning rounds. The Maintenance Director revealed the litter in the mulch attracted pests to the patio area and the building.</p> <p>7. Interview, on 07/09/14 at 10:55 AM, with Unsampled Resident B revealed he/she had noticed strong odors in her hallway (North Hall). The resident revealed he/she had also</p>	F 253	<p>East Hall shower room: Air conditioning and ceiling vent was cleaned by maintenance Director on 7/18/14. facility audits was conducted A/C vents identified were fixed and cleaned by housekeeping and maintenance. the grout on shower stall was cleaned by housekeeping, in addition housekeeping also clean all the shower room including the stall walls on 7/21/14. shower room are schedule to be machine clean monthly by floor technician continuing monitoring will be done by housekeeping manager on a weekly basis and monthly for six months</p> <p>Room 119 and 312 Soiled broken baseboard in room 119 has been fixed by maintenance director on 8/06/14. baseboard audits was conducted identified rooms with the baseboard issues was fixed by maintenance director. audits of baseboard condition are to be done monthly by maintenance director. finding are to be reported to QAPPI monthly.</p>	
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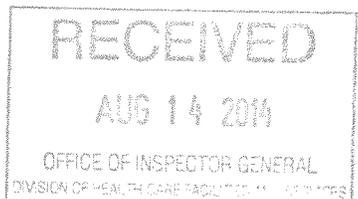
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F 253	<p>Continued From page 12</p> <p>periodically noticed the odor of feces in the hallway. Resident B stated that he/she kept the door to the room closed and used a deodorizer in the room because he/she "liked the room to smell good".</p> <p>Interview, on 07/10/14 at 3:00 PM, with Resident #14 revealed he/she felt the facility could "keep the halls sprayed a little better" to improve the odor in the hallway.</p> <p>Interview, on 07/10/14 at 11:05 AM, with the Housekeeping Supervisor during the environmental tour revealed the carpets were vacuumed daily and cleaned three to four times a week. He revealed the frequent carpet cleaning had not eliminated the odors. The supervisor stated the carpets were old, stained and needed to be replaced. He indicated installation of new flooring was a priority on the facility's project list.</p> <p>Review of the annual Veterans Affairs (VA) Inspection/Review findings, dated January 6, 2014, revealed the VA 'strongly recommend all carpeting be replaced throughout the building due to problems with odors and possible fall hazards due to age and deteriorating condition of the carpet.</p> <p>Interview with the Administrator, on 07/10/14 at 12:53 AM, revealed he made daily rounds of the facility in the morning, at lunchtime, and in the evening. He further revealed he had identified the problems with the carpet prior to the VA inspection. He stated he had submitted a list of improvement requests to the corporate office, which included the removal and replacement of the existing carpet. The Administrator revealed corporate had approved the replacement of the</p>	F 253	<p>Room 326 scuffed and chipped off paint on door was fixed by maintenance director on 07/15/14, blacks on exits door were clean by housekeeping on 07/17/14 and door was repainted by maintenance director on 07/18/14, stain ceiling tiles were replaced by maintenance director on 7/18/14 in addition the ceiling lights were clean on 07/18/14, and rusting metal strip metal strip has be brushed down and repainted by maintenance director. Maintenance director will be monitoring ceiling lights and metal stripes , wooden window sills were also fixed by maintenance director on 07/018/14 .monthly for one year. finding are to be reported to the safety meeting and QAPPI Monthly .</p> <p>Dining room over head tile has been replaced on 7/26/14. On 7/09/14 Maintenance director replaced the burned chandelier light bulb in dining room. Air conditioning Units was cleaned and painted by maintenance Director on 7/18/14. facility audits was conducted on A/C units identified vents was fixed and cleaned by housekeeping and maintenance.</p> <p>Maintenance and environmental rounds are to be conducted by Maintenance and housekeeping directors along with the administrator bi weekly for 3 months and monthly for a year. finding and recommendation are to be reported to QAPPI and safety committee meetings.</p>	
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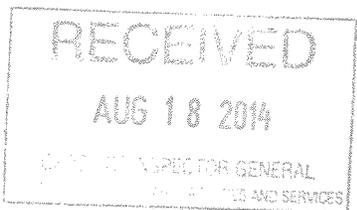
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F 253	<p>Continued From page 13</p> <p>carpet and he was getting estimates. The Administrator also revealed the area of carpet by Room 214 had been "patched" due to a water leak. He stated the loose edges were a fall risk to the residents and agreed the carpet should have been trimmed. The Administrator stated that he had also noted problems with the cleanliness of the facility and had changed cleaning companies in June 2013. He revealed the current contract cleaning services started April 2014. The Administrator revealed he had placed a complaint to the contract cleaning services a few months ago because he had noticed the facility was not getting cleaned properly. He further revealed the new housekeeping manager was "catching up" because the old manager was not doing a good job.</p> <p>Continued interview with the Administrator revealed he had conducted weekly tours with the contract Housekeeping Supervisor and the Regional Manager would be coming to the facility to monitor the situation. The Administrator stated additional housekeeping staff were needed to maintain the facility. The Administrator stated he had also identified the need for additional staff to assist the Maintenance Director. He stated the Maintenance Director had requested additional help prior to the survey. He stated he had submitted a request to hire an additional maintenance person, but had not yet received approval from corporate. He projected he would be approved to hire additional maintenance staff by November 2014. The Administrator revealed he had been more focused on patient care and resident rooms, rather than the common areas of the building.</p>	F 253	<p>Smoking area: On 08/01/14 Resident that smokes has been educated on the concerns of throwing cigarette butts in the landscaping mulch and surrounding edges of the patio in other to maintain a clean and safe living. cleaning schedule has been added to the daily floor technician check list , smoking area is to be clean daily by floor technician . Maintenance director is responsible for picking up cigarettes butts, paper debris, gum wraps etc on the landscaping mulch daily housekeeping manager is to conduct daily rounds issues of concern are to be reported to resident council monthly and QAPPI.</p> <p>Sitting Area: Furniture in the sitting area was thrown away by housekeeping on 0710/14. facility audits was conducted by maintenance director all furniture that needed fixing, cleaning or replacement was taking care off on 07/14/14. furniture will be wiped down on a daily basis, and any soiled areas will be thoroughly cleaned by extraction. Total furniture extraction will be done on a bi-weekly schedule monitoring of furniture has been added to our monthly environmental rounds finding are to be reported to QAPPI monthly</p> <p>Correction Date: 8/06/14</p>	
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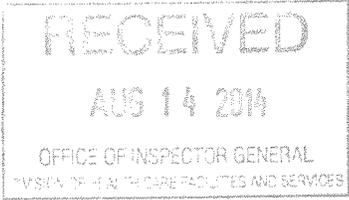
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F 253	<p>Continued From page 14</p> <p>8. Interview during the resident group meeting, conducted on 07/08/14 at 3:00 PM to 4:15 PM, revealed Resident #8 was concerned about the cleanliness of the facility and felt the facility was dirty and had urine odors.</p> <p>Interview with Resident #3's family member, on 07/10/14 at 8:28 AM, revealed upon entering the facility a strong pervasive urine smell was present within the facility and further stated the smell could be coming from the dirty carpets.</p> <p>9. Observation, on 07/09/14 at 10:50 AM, of the sitting area outside the main dining area revealed a large wing backed, pink leather chair. The chair's armrest were cracked with tears in both arms. The foam beneath the leather was exposed. The chair's wooden legs were scarred with no finish left on the wood. A resident was observed sitting in the chair. At 2:00 PM another resident was observed sitting in the chair and again on 7/10/14 at 7:45 am, a resident was observed sitting in the pink chair. This was a high traffic area for staff and visitors.</p> <p>Observation of the blue wing back cloth chairs (4) in the front lobby, on 07/09/10 at 10:52 AM, revealed the arms to the chairs were soiled and dirty. On 07/10/14 at approximately 11:00 AM, during the environmental tour with the Maintenance Director and House Supervisor revealed the chairs were the same. Observation revealed two residents sitting in the chairs and one visitor.</p> <p>Interview with the Housekeeping Supervisor, during the tour on 07/10/14, revealed the chairs are cleaned when needed. He stated the housekeeper who cleaned the lobby should</p>	F 253		



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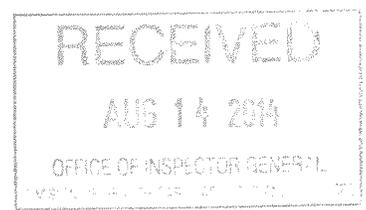
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F 253	<p>Continued From page 15</p> <p>observe the chairs for the need to be cleaned. He stated the chairs get dirty easily and must be cleaned often. He had not noticed the condition of the lobby chairs during his inspection rounds. He stated the pink leather chair would have to be removed because due to the tears and foam exposed, they could not clean properly.</p> <p>Review of the non-clinical rounds forms, most recent date of 07/07/14, revealed only the residents' rooms were included, not the common areas of the facility. The residents' rooms were to be monitored for cleanliness, dust, need of touch up paint, AC units, and trash containers. The facility could only provide eight (8) inspection sheets and those did not include the rooms identified with problems during the survey. In addition, only five rooms are inspected during the rounds. Further review revealed the same rooms were inspected during the 07/02/14 and 07/07/14 rounds.</p> <p>Interview with the Administrator, on 07/10/14 at 12:52 PM, revealed administrative staff are to conduct non-clinical rounds on five random resident's rooms and report if there are any problems found. He stated if any problems are found on the rounds, they are discussed during the next morning meeting. He stated evaluation of the non-clinical rounds resulted in call lights being added to check. He revealed the common areas of the facility used to be on the non-clinical rounds to be inspected, but they were removed. The rounds only include the residents' rooms.</p> <p>Interview with the Area Vice President of Operations, on 07/10/14 at 4:15 PM, revealed she visited the facility two weeks ago and toured with the Regional Contract Housekeeping</p>	F 253		
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F 253 Continued From page 16
Supervisor. She stated the corporation had reviewed the needs of this facility and for better outcomes would provide additional training and oversight, would need to provide additional monitoring and have in place specific actions. For the physical plant, new flooring had been approved and she had requested additional capital funds for furniture and other needs. She stated the Corporate Regional Environmental Director would work with this facility's Maintenance Director on skills and more efficient time management.

F 253

F 431
SS=F 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked,

F 431

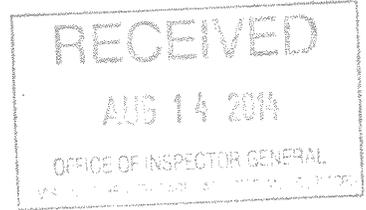
F 431

Corrective Actions for Targeted Residents:

No individual was affected by the deficient practice. Medication room audit was conducted on 7-8-14 by staff nurse and MDS nurse discarded all found outdated items.

Identification of Other Residents with Potential to Be Affected:

A limited number of residents have a potential to be affected by this practice. Medication cart and medication room audit done on 07/08/14 found expired medications were discarded by MDS nurse .



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PRINTED: 07/24/2014
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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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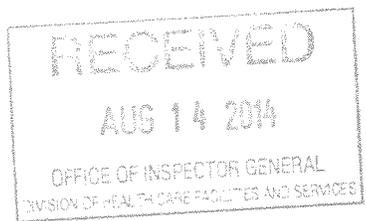
F 431 Continued From page 17
permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, review of pharmacy policies for medications, monthly Consultant Pharmacist report for July 2014 and audits of the medication rooms and carts it was determined the facility failed to ensure drugs and biologicals were not expired for one (1) of two (2) medication rooms, and four (4) of five (5) medication carts inspected. The inspection found insulin, multi-dose vials, liquid medication, solutions and Tuberculosis serum opened with no date. In addition, an expired antibiotic medication was found in the Emergency Drug Kit (EDK) in the Main medication room.

The findings include:
Review of the facility's policy titled Storage of Medications, revised November 2011, Section 4.1 revealed drugs repackaged by the pharmacy staff would generally carry an expiration date determined by the Pharmacist. Drugs dispensed in the manufacturer's original container would be labeled with the manufacturer's expiration date. The nurse would place a "date opened" sticker on the medication and enter the date opened and the new date of expiration. The expiration date of

F 431 Systemic Changes:
All nurses are to date insulin, multi-dose vials, liquid medication, solutions and Tuberculosis serum upon opening. Pharmacy Consultant to check medication rooms and medication carts monthly for expired medication and non dated insulin, multi-dose vials, liquid medication, solutions and Tuberculosis serum. Unit managers are to check medication cart and medication room fro expire and unlabeled medication. DCE in-service all staff started on 7-8-14 in addition during new hires orientation dating and labeling medication will be given extra focus .

In-service on medication storage and dating has been started on 07/08/14 continuing in-service will be held quarterly on medication by pharmacy consultant. New employee will be in-serviced on procedures on dating and medication storage. Facility will request Facility Performance Assessment audits yearly with special focus on medication administration, dating and storage by Corporate Team Leader.



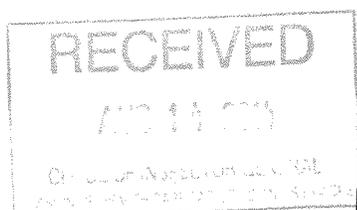
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F 431	<p>Continued From page 18</p> <p>a vial or container would be thirty (30) days unless the manufacturers recommends another date. All expired medications would be removed from the active supply and destroyed in the facility, regardless of the amount remaining. Another policy titled Expiration Dating, created 02/21/12, revealed all medications received from the pharmacy would have an expiration date clearly stated on the label or medication packet.</p> <p>The facility provided information regarding insulin medication (no date) that stated all insulin once opened for administration, must be dated when opened. Most multidose vials of insulins are stable for twenty-eight (28) days, with the exception of Novolin 70/30 which was stable for thirty (30) days.</p> <p>Review of the facility's policy titled Emergency Starter Dose Use (E-kits), revised 01/16/14, revealed E-kits included emergency drugs, antibiotics, and certain controlled substances that are supplied in limited quantities in portable, sealed containers in compliance applicable state regulations. Pharmacy personnel would check for outdated drugs in the E-kit at least once a month and every time the kits are exchanged or replenished. When an outdated drug was found in the emergency drug supply kit, pharmacy personnel would exchange the kits and remove the outdated drug from the emergency drug kit.</p> <p>Observation of the Main Medication Room, on 07/08/14 at 8:46 AM, with License Practical Nurse (LPN) #5, revealed medication stored in a refrigerator in the room. Inspection of the medication refrigerator revealed an opened vial of insulin (Levemir) with no date when opened. The insulin belonged to Unsampled Resident A and</p>	F 431	<p>Monitoring: Pharmacy Consultant to check EDK boxes monthly and monitor for expiration dates. If EDK expired then consultant is to call pharmacy for a replacement and pharmacy is to send new EDK box on the nightly run on that day.</p> <p>Pharmacy will monitor which EDK boxes they send and when they are to expire and send out box for replacement. Third shift nurses are to review medication cart and medication room once per week. Unit managers will audit medication carts and medication rooms weekly for one month, then biweekly for one month then monthly for one year. These audits will include lab supplies, all biological, and all medication. Compliance audits will be conducted monthly for one year by the ADNS. All audits will be turned into the DNS when completed. Findings from these audits will be reported to the QAPI meeting monthly for one year. Initial audits to be completed by the Unit Manager and Assistant Director of Nursing by August 8, 2014.</p> <p>Correction Date: 8-8-2014</p>	



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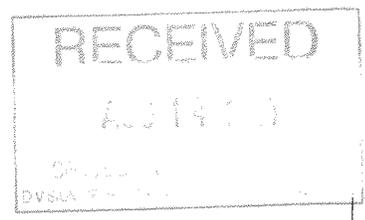
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F 431	<p>Continued From page 19</p> <p>record review revealed the resident received the insulin (46 units) at bedtime. In addition, there was a vial of Aplisol (tuberculosis serum) opened with no date when it was opened. In the cabinets, there was a 100 ml bottle of Normal Saline, opened but not dated.</p> <p>Interview with LPN #5, at the time of the inspection, revealed the insulin should have been dated when opened. She thought the insulin was good for thirty (30) days after opening. She stated the Aplisol was stock and used to give new employees their tuberculosis test. The bottle of Normal Saline should have been dated when opened. She stated she did not know when the insulin or Aplisol was opened, but all multi-dose vials are to be dated when opened. She stated the night shift nurse or Nurse Manager conducted audits of the Medication Room and medication carts on the unit.</p> <p>Continued inspection of the medication room revealed three (3) EDK boxes that were not locked. Inspection of the antibiotic kit revealed one tablet of Amoxicillin 250 mg with an expiration date of 05/31/14.</p> <p>Interview with LPN#5, at the time of the medication room inspection, revealed the pharmacist had inspected the K-kits last week and he had found an expired antibiotic medication.</p> <p>Interview with the Director of Nursing (DON), on 07/10/14 at 8:59 AM revealed the pharmacy was supposed to check the medications carts, medication room, and E-kit boxes during their monthly visit. She stated the pharmacists last visit was on 07/01/14 and he did find expired</p>	F 431		
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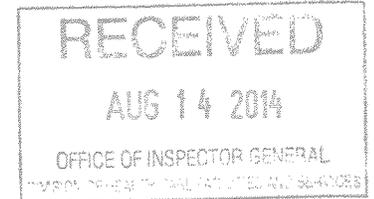
F 431	<p>Continued From page 20</p> <p>medication (antibiotic) in the E-kit box. She said the Unit Managers should be performing monthly audits of the medication room and medication carts. She revealed the last audit was conducted in June 2014 and no expired medications were found. She indicated the audits had been conducted since last year's standard survey when the facility was cited for expired medications. Refer to F-520.</p> <p>Continued interview with the DON, revealed the pharmacy had recently changed the way pills are packaged and new medications carts were provided by pharmacy. Pharmacy had provided training to the nurses. She stated it was the responsibility of the nurse to date insulin, solutions, and multi-dose medications when opened and all nurses had been trained. Although the audits showed compliance, the DON said non-compliance can occur at any time.</p> <p>Review of the audits conducted, on 05/16/14 and 06/24/14, revealed no problems found. Review of the Pharmacist report for 07/01/14 revealed an expired antibiotic (Zithromax) was found in the E-kit box. The pharmacist documented date and remove PPD (Tuberculosis serum) from the refrigerator.</p> <p>Interview with the Pharmacist, on 07/10/14 at 2:17 PM, revealed he checked all the E-kits boxes during his visit last week. He revealed he only spot checked the E-kits, medication refrigerator, and medication carts during his visits. He said the E-kit boxes had a list of contents and were locked last week. If a medication was close to an expiration date, he would pull that medication and alert the DON. He stated all insulins were to be dated upon opening.</p>	F 431		
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F 431	Continued From page 21 Multi-vials were dated when opened per policy. Solutions were the same, date upon opening. He stated he reported his findings to the DON. He continued to stated he checked the outside date on the K-kits and did not check each individual box. When a nurse removed a medication from the K-kit, they should notify the pharmacy and they would replace the entire kit. He stated he did not cross reference the list to what medications was in the K-kit box. He stated he depended on nursing to do that. He stated he had pulled a Tuberculosis serum vial that had no date when opened during his visit last week. When he finds a medication that had no date when opened, he removed it and gave it to the DON. 2. Observation, on 07/09/14 at 4:20 PM, of the medication cart on the East hallway revealed six (6) oral medications with the manufacture's expiration date of 07/07/14 and one (1) oral medication with the manufacture's expiration date of 07/08/14. Interview with Licensed Practical Nurse (LPN) #1, on 07/09/14 at 4:45 PM, revealed she wasn't aware of the expired medications and stated she had not checked the medication cart for expired medications that day. She stated that she only worked PRN (as needed) and was a floater and didn't know who or when the medication cart was checked and reviewed. 3. Observation of the Annex Hall Medication Cart #1, on 07/09/14 at 4:40 PM, revealed three (3) containers of Milk of Magnesia (MOM) opened, with no labeled dated of when medication was opened. Further observation of Medication Cart #1, revealed Miralax opened with no labeled date of when the medication was opened.	F 431			



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F 431	<p>Continued From page 22</p> <p>Observation of Annex Hall Medication Cart #2, on 07/09/14 at 4:50 PM, revealed two (2) containers of Docusate opened with no labeled date of when the medication was open. Further observation of Medication Cart #2, revealed one (1) container of MAPAP was opened with no labeled date of when the medication was opened.</p> <p>Interview with Registered Nurse (RN) #1, on 07/09/14 at 4:55 PM, revealed all nurses were responsible for the medication carts. RN #1 stated they labeled medications so that they know how long the medication had been opened or when the medication needed to be removed from the cart. RN #1 stated no one had informed her to check the medication carts to ensure medications were labeled.</p> <p>Interview with the Unit Manager on the Annex Hall, on 07/09/14 at 5:00 PM, revealed she was not aware the liquid medications were not labeled with dates when opened. The Unit Manager stated she instructed the nurses to check the medication carts weekly. She stated she had not checked the medication carts to ensure the nursing staff had completed that task. The Unit Manager stated she labeled medications to ensure the medications were not expired.</p> <p>4. Observation, on 07/09/14 at 3:45 PM, of the medication cart on the North Hallway revealed twenty-two (22) opened bottles of multiple dose oral medications with no open date labeled on the bottles.</p> <p>Interview, on 07/09/14 at 4:00 PM, with Licensed Practical Nurse (LPN) #3 revealed all multiple dose medications were to have an opened date</p>	F 431		
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F 431	<p>Continued From page 23</p> <p>written on the bottle. The LPN stated she had been trained on labeling of medications during the new-hire orientation with the facility. LPN #3 also stated it was facility policy to label medication bottles when opened with expiration dates. The nurse further revealed medication bottles were to be labeled with an opened date in order to determine the expiration date of the medication. LPN #3 could not give a reason why all of the multiple dose medications in the medication cart did not have the date when opened. In addition, the nurse revealed the Unit Manager and the third shift nurse conducted scheduled medication cart audits to check for expired medications.</p> <p>Interview, on 07/10/14 at 8:25 PM, with LPN #2 revealed all multiple dose medications were to be labeled with an opened date written on the bottle. The LPN further revealed the labeling and dating of opened medications was dependent upon the pharmacy protocol. LPN #2 revealed the assigned night shift nurse performed medication cart audits once a week. The nurse also revealed the Unit Manager conducted "spot checks" on the medication carts.</p> <p>Interview, on 07/10/14 at 4:30 PM, with the Director of Nursing (DON) revealed the assigned third shift nurses were responsible for cleaning, stocking, and removing expired medications from the medication carts. The DON revealed the day shift Unit Manager routinely monitored the medication carts and performed "spot checks" to ensure insulin, eye drops, and medications were labeled with an opened date. She further revealed the Unit Manager was also responsible for ensuring the assigned nurses completed the monthly medication cart audits for all halls. The</p>	F 431			

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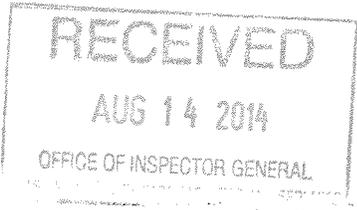
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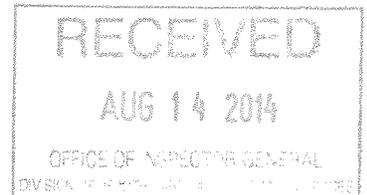
<p>F 431</p> <p>F 468 SS=E</p>	<p>Continued From page 24</p> <p>DON stated she had conducted a "spot check" of the medication carts a few weeks ago; however, she stated she had no documentation of the spot checks or the findings.</p> <p>483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS</p> <p>The facility must equip corridors with firmly secured handrails on each side.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure that corridors were equipped with handrails that were firmly secured to walls and free from splinters/chipped wood for three (3) of five (5) hallways (Annex, West, and East hallways).</p> <p>The findings include:</p> <p>Observation, on 07/08/14 at 2:05 PM, revealed a broken handrail next to the women's bathroom near the front desk. The end section of the handrail was freely moveable from the rest of the rail.</p> <p>Observation, on 07/09/14 at 8:15 AM, revealed a nail sticking out of the hand rail about an inch beside Room 304.</p> <p>Observation, on 07/09/14 at 9:40 AM, revealed a chipped and splintered handrail next to the laundry chute on the West hallway.</p> <p>Observation, on 07/09/14 at 11:04 AM, revealed a</p>	<p>F 431</p> <p>F 468</p>	<p>F 468</p> <p><u>Corrective Actions for Targeted Residents:</u></p> <p>No individual was affected by the deficient practice. The nail showing in handrail by room 304 was removed on 07/14/14 by maintenance director</p> <p><u>Identification of Other Residents with Potential to Be Affected:</u></p> <p>A limited number of residents have a potential to be affected by this practice. facility handrail audit was conducted on 07/10/14, identified handrails were fixed on 07/14/14</p> <p><u>Systemic Changes:</u></p> <p>On 7/14/14 Maintenance director has fixed loose handrails, splinters/chipped woods, hand rails are now smooth to touch, secured and well stain.</p> <p><u>Monitoring:</u></p> <p>Weekly hand rails checks has been added to our environmental and maintenance rounds to be perform by maintenance director finding are to be reported to the interdisciplinary team weekly and monthly to QAPPI and safety committee meetings.</p> <p>Correction Date: 8-8-2014</p>	
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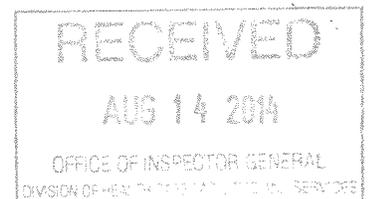
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F 468	Continued From page 25 severely worn and splintered handrail at the North/East nurses' station. Observation, on 07/10/14 at 11:10 AM, revealed a chipped and splintered handrail next to the shower room on the East hallway. Interview with the Maintenance Director, on 07/10/14 at 10:10 AM, revealed he was responsible for ensuring handrails were secure and in good repair. The Maintenance Director revealed he had conducted weekly checks of the handrails, but could not provide documentation of those checks or the findings. He stated that he had not noticed the condition of the handrails during the weekly checks. He further revealed there had been no work orders submitted for repair of the handrails. The Maintenance Director indicated all staff were responsible for submitting work orders to report maintenance issues. He acknowledged the splintered handrails were in need of repair. In addition, he stated the splintered handrails posed a safety risk to the residents. Record review of the facility's preventive maintenance schedule revealed the facility's interior rounds and inspection were to be performed on a daily basis. However, this did not include the handrails.	F 468			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520	F 520 <u>Corrective Actions for Targeted Residents:</u> No individuals were affected by the deficient practice. Medication room and medication cart audit was conducted on 7-8-14 by staff nurse and MDS nurse discarded any outdated items.		



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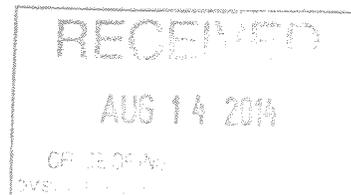
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	<p>Continued From page 26 facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the Casper reports, and past cited deficiencies, it was determined the facility failed to have an effective Quality Assurance (QA) committee to identify and correct quality deficiencies to ensure ongoing compliance with federal and state regulations. The facility was cited for failure to have an effective system to ensure drugs and biologicals were not expired for four out of the last five Recertification surveys. (2010, 2012, 2013, and 2014) Review of the plan of correction submitted for the June 2013 survey revealed the facility was to monitor noncompliance through the QA committee. The facility failed to have an effective QA committee to identify problems and utilizing</p>	F 520	<p><u>Identification of Other Residents with Potential to Be Affected:</u></p> <p>A limited number of residents have a potential to be affected by this practice. Medication cart and medication room audit done immediately and expired medications were discarded.</p> <p><u>Monitoring:</u></p> <p>All audit for Survey results will be brought to the QA meeting monthly review by the committee for one year. If findings show non compliance a plan of correction will be done and put into effect to ensure compliance is met. On starting of Monthly QA prior month QA minutes will be reviewed for follow up of the action plan identified in the previous month. Our next QA meeting is schedule on 08/20/14. Golden living clinical consultant and Area Vice president will review our QAPPI Meeting document monthly to ensure accountability and follow up of finding and recommendation of various audit tools put in place are working effectively for one year per paper review starting on 8-20-14. Director of nursing is assign to make sure make QA action plan are completed and follow- up on. On 7/25/14 Director of nursing In -service QA team on effective</p>		



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

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OMB NO. 0938-0391

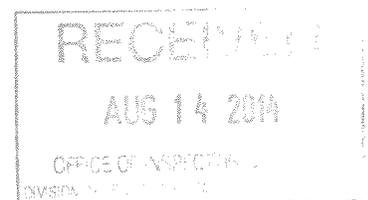
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F 520	<p>Continued From page 27</p> <p>audits that would maintain compliance. The facility was cited again for failure to ensure multi-dose vials were dated when opened and expired medications were not available for use. Refer to F-431.</p> <p>The findings include:</p> <p>Review of the facility's Casper reports, dated 07/03/14, revealed for the Recertification surveys of April 2010, March 2012, and June 2013, the facility was cited at F-431. Review of the past statement of deficiencies revealed the deficient practice involved expired biologicals from two (2) of two (2) medication rooms, expired laboratory specimen collection containers, expired Central Line dressing change kit, Lift Loc Safety Infusion with a Hueber needle attached, IV catheter and Normal Saline from the crash cart stored in the Main Medication Room. The Annex Medication Room contained blue top blood collection Vacutainers and stool specimen collection containers that had expired.</p> <p>Review of the Plan of Correction for the June 2013 survey revealed the facility would conduct audits and those audits would be reviewed in the QA meetings to ensure compliance was achieved and maintained.</p> <p>Review of the QA signature sheet revealed the facility conducted QA meetings at least quarterly with the required members. The last QA meeting was held on 06/25/14 with a physician representative in attendance.</p> <p>1. Observation of the Main Medication Room, on 07/08/14 at 8:46 AM, with License Practical Nurse (LPN) #5, revealed medication was stored in a refrigerator in the room. Inspection of the medication refrigerator revealed an opened vial of</p>	F 520	<p>QA process and effectiveness. In addition All QA committee members are to take education on Quality Assurance and Performance Improvement in Golden Living Learning Management System by 8-20-14. All certificates of completion to be turned into the ED to assure compliance.</p> <p><u>Correction Date: 08/20/14</u></p> <p>8-21-14 <i>per Chm</i></p> <p><i>kyro</i></p>		



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F 520	<p>Continued From page 28</p> <p>insulin (Levemir) and a vial of Aplisol (tuberculosis serum) opened with no date when opened. Inspection of the cabinets revealed a 100 ml bottle of Normal Saline, opened but not dated. In addition, continued inspection of the medication room revealed three (3) Emergency Drug Kit (EDK) boxes were not locked. Inspection of the antibiotic kit revealed one tablet of Amoxicillin 250 mg with an expiration date of 05/31/14.</p> <p>2. Observation, on 07/09/14 at 3:45 PM, of the medication cart on the North Hallway revealed twenty-two (22) opened bottles of multi-dose oral medications with no open date labeled on the bottles.</p> <p>3. Observation, on 07/09/14 at 4:20 PM, of the medication cart on the East Hallway revealed six (6) oral medications with the manufacture's expiration date of 07/07/14 and one (1) oral medication with the manufacture's expiration date of 07/08/14.</p> <p>4. Observation of the Annex Hall Medication Cart #1, on 07/09/14 at 4:40 PM and Medication Cart #2, on 07/09/14 at 4:50 PM, revealed three (3) containers of Milk of Magnesia (MOM), a container of Miralax, two (2) containers of Docusate, and one (1) container of MAPAP opened with no date when the medication was opened.</p> <p>Interview with the Administrator, on 07/10/14 at 1:42 PM, revealed the Quality Assurance (QA) Committee met monthly and a physician representative was present. He stated since last year's Recertification Survey, the Unit Managers had conducted weekly audits then monthly audits</p>	F 520		



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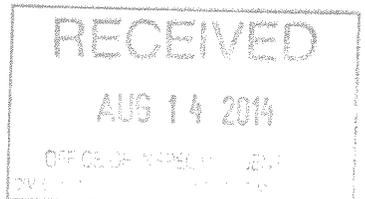
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F 520	Continued From page 29 of the medication rooms and carts. He stated compliance audits were conducted monthly for six months by the Assistant Director of Nursing (ADON). Findings from those audits were brought to the QA meeting monthly times six (6) months. Those audits are not taken to the QA now. If there was a problem identified on the audit, education would be provided. He stated all nurses were educated on expired drugs and to date medications when opened.	F 520		
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) floor and a partial basement, Type III Unprotected Construction.</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments on the Ground Floor.</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II 18.5 KW generator. Fuel source is natural gas.</p> <p>A Recertification Life Safety Code Survey was conducted on 07/08/14. The facility was found not in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000		
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BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Chan</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>X 8/13/14</i>
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Every deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution provides 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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If continuation sheet Page 1 of 19

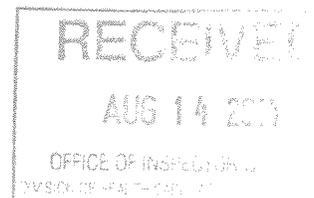
OFFICE OF INSPECTOR GENERAL

DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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K 000 K 029 SS=D	<p>Continued From page 1</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, residents, staff and visitors. The facility had one-hundred and ten (110) certified beds and the census was ninety (90) on the day of the survey.</p> <p>The findings include:</p> <p>1. Observation, on 07/08/14 at 8:43 AM, with the Director of Maintenance revealed the door to the Medical Records Room located in the South Hall, was equipped with a self-closing device, but did</p>	K 000 K 029	<p>K 029</p> <p><u>Corrective Actions for Targeted Residents:</u></p> <p>No individual was affected by the deficient practice.</p> <p><u>Identification of Other Residents with Potential to Be Affected:</u></p> <p>A limited number of residents have a potential to be affected by this practice.</p> <p><u>Systemic Changes:</u></p> <p>Medical records door hinges has been replaced on 0724/14 door is completely closing.</p> <p><u>Monitoring:</u></p> <p>Maintenance Director will test self closing door monthly for proper closure and report finding to safety committee meetings. Self closing door test has been added to our preventive maintenance schedule. Hole in activity room storage closet has been patch and seal with a rated sealant. Monitoring of activity room is to be conducted by Activity director weekly finding are be reported to maintenance director who will then take care of issues and reported to the safety committee meetings and QAPPI monthly.</p> <p><u>Correction Date: 7/25/14</u></p>	



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K 029 Continued From page 2
not close completely and latch when tested.

Interview, on 07/08/14 at 8:45 AM, with the Director of Maintenance revealed the hinges on the door had become loose and would not close completely and latch and was not capable of resisting the passage of smoke in the event of an emergency. He was not aware of the hinges being loose and stated he had not received a work order to repair the door's hardware to function properly.

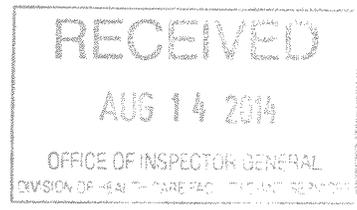
2. Observation, on 07/08/14 at 10:07 AM, with the Director of Maintenance revealed the Storage Closet located within the Activities Room had a three (3) inch by six (6) inch opening cut out of the interior drywall and a three (3) inch by four (4) inch opening cut out in the drywall ceiling. The openings had not been patched and sealed with a rated sealant and were not capable of resisting the passage of smoke in the event of an emergency.

Interview, on 07/08/14 at 10:09 AM, with the Director of Maintenance revealed he was not aware of the openings cut out of the interior drywall and ceiling and not being patched and sealed with a rated sealant. He acknowledged the room was not smoke-tight and able to resist the passage of smoke in the event of an emergency.

The census of ninety (90) was verified by the Administrator, on 07/08/14. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 07/08/14.

Reference:

K 029



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K 029 Continued From page 3
 NFPA 101 (2000 Edition).

19.3.2 Protection from Hazards.
 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:

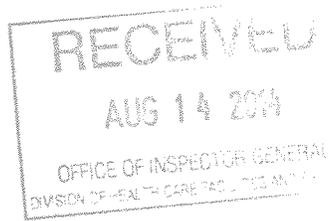
- (1) Boiler and fuel-fired heater rooms
- (2) Central/bulk laundries larger than 100 ft² (9.3 m²)
- (3) Paint shops
- (4) Repair shops
- (5) Soiled linen rooms
- (6) Trash collection rooms
- (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction
- (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.

Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.

K 029

K 038 NFPA 101 LIFE SAFETY CODE STANDARD
 SS=D

K 038



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K 038 Continued From page 4
Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, approximately twenty-five (25) residents, staff and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety (90) on the day of the survey. The facility failed to ensure doors equipped with delayed egress had the proper signage displayed for egress.

The findings include:

Observation, on 07/08/14 at 9:28 AM, with the Director of Maintenance revealed the exit access doors located across from the Nurses' Station within the Annex Hall, were equipped with delayed egress magnetic locks, but did not display the proper signage on the doors, advising the doors opening are delayed for fifteen (15) seconds after the release device was pushed to open.

Interview, on 07/08/14 at 9:30 AM, with the

K 038
K 038
Corrective Actions for Targeted Residents:
No individual was affected by the deficient practice.

Identification of Other Residents with Potential to Be Affected:

A limited number of residents have a potential to be affected by this practice.

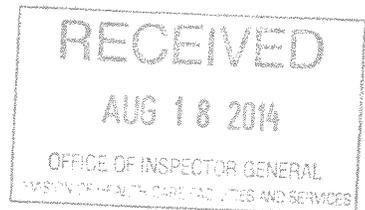
Systemic Changes:

Proper signage advising the door opening are delayed for fifteen (15) seconds after the release device was pushed to open. has been ordered and received and placed on 7/24/14.

Monitoring:

Maintenance director will monitor signage bi weekly for 6 months. findings are to be reported to safety committee meeting and QAPPI monthly. in the event of remodeling or repairs in the future appropriate signage will be audited to ensure posting/signage is in place.

Correction Date: 7/25/14



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K 038 Continued From page 5
Director of Maintenance revealed he was not aware the delayed egress doors did not display the proper signage required for doors equipped with delayed egress hardware.

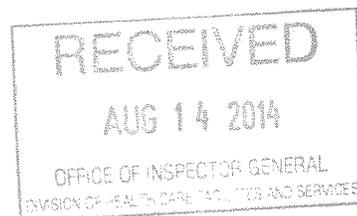
The census of ninety (90) was verified by the Administrator, on 07/08/14. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 07/08/14.

Reference:
NFPA 101 (2000 edition)

7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.

(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in

K 038



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K 038	Continued From page 6 accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 038	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved.	K 054	

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AUG 14 2014
OFFICE OF HEALTH SERVICES
DIVISION 11

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/08/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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K 054 Continued From page 7
maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3

This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure smoke detectors were inspected and tested in accordance with National Fire Protection Association (NFPA) Standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety (90) on the day of the survey. The facility failed to provide evidence that a smoke detector sensitivity test had been performed within the past two (2) year period.

The findings include:

Review of the Fire Alarm System, on 07/08/14 at 12:52 PM, with the Director of Maintenance revealed the facility did not have evidence of a Smoke Detector Sensitivity Test being performed on the fire alarm smoke detectors within the last two years. The last test conducted was dated 05/04/12.

Interview, on 07/08/14 at 12:54 PM, with the Director of Maintenance revealed he was not aware the facility did not have a sensitivity test conducted on the fire alarm smoke detectors within the past two (2) year period.

The census of ninety (90) was verified by the Administrator, on 07/08/14. The findings were acknowledged by the Administrator and verified

K 054

Corrective Actions for Targeted Residents:

No individual was affected by the deficient practice.

Identification of Other Residents with Potential to Be Affected:

A limited number of residents have a potential to be affected by this practice.

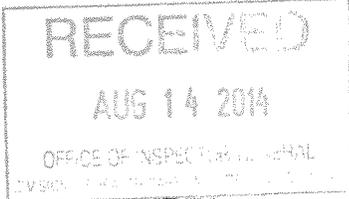
Systemic Changes:

Smoke detector sensitivity test was conducted by FESCO on 7/11/14.

Monitoring:

Yearly audits are to be conducted by maintenance director as part of preventive maintenance Facility maintenance Director will notify FESCO two months before due date for sensitivity test is due.

Correction Date: 7/12/14



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K 054 Continued From page 8
by the Director of Maintenance at the exit interview on 07/08/14.

Reference: NFPA 72 (1999 edition)

7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.

To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:

- (1) Calibrated test method
- (2) Manufacturer ' s calibrated sensitivity test instrument
- (3) Listed control equipment arranged for the purpose
- (4) Smoke detector/control unit arrangement whereby the

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K 054 Continued From page 9
detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range
(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction
Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced.

K 054

Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced.

Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2.

The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.

K 066 SS=D NFPA 101 LIFE SAFETY CODE STANDARD
Smoking regulations are adopted and include no less than the following provisions:

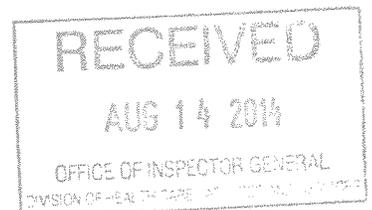
K 066

(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

K 066

Corrective Actions for Targeted Residents:

No individual was affected by the deficient practice.



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K 066 Continued From page 10 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

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure the designated outdoor smoking area for residents had approved metal ashtrays with self-closing lids to empty ashes into, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect residents using the smoking areas and staff. The facility has one-hundred and ten (110) certified beds and the census was ninety (90) on the day of the survey.

The findings include:

Observation, on 07/08/14 at 10:56 AM, with the Director of Maintenance revealed the designated outdoor smoking area for residents did not have an approved metal container with a self-closing lid to empty ashtrays into. The facility was using

K 066

Identification of Other Residents with Potential to Be Affected:

A limited number of residents have a potential to be affected by this practice.

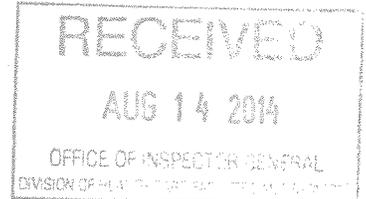
Systemic Changes:

Metal container with self closing device cover device into which ashtrays can be emptied has be purchased from Direct Supply and is in used .

Monitoring:

Monitoring of the device will be conducted monthly by maintenance Director and report to QAPPI. In service on the smoking regulations was given to Maintenance Director on 7/15/14 by administrator.

Correction Date: 07/20/14



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K 066 Continued From page 11
a small metal trash container with an unattached lid to empty ash trays into.

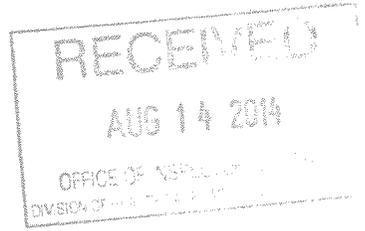
Interview, on 07/08/14 at 10:58 AM, with the Director of Maintenance revealed he was not aware of the requirement that the designated, outdoor smoking area for residents was to be equipped with an approved metal container with a self-closing lid to empty ash trays into.

The census of ninety (90) was verified by the Administrator on 07/08/14. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 07/08/14.

Reference: NFPA 101 Life Safety Code (2000 edition)

19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions:
(1) Smoking shall be 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 areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.
Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.
(2) Smoking by patients classified as not

K 066



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			(X5) COMPLETION DATE

K 066 Continued From page 12 responsible shall be prohibited.
Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision.
(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.
(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

Reference: S & C Letter: 12-04-NH;
Date: November 10, 2011 Smoking Safety in Long Term Care Facilities

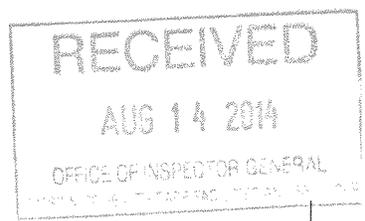
K 076
SS=E
NFPA 101 LIFE SAFETY CODE STANDARD
Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.

K 076

(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.

(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

K 076
Corrective Actions for Targeted Residents:
No individual was affected by the deficient practice.



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K 076 Continued From page 13

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure two (2) outdoor oxygen storage compartments were locked and empty cylinders were identified with an empty sign, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety (90) on the day of the survey.

The findings include:

Observation, on 07/08/14 at 9:13 AM, with the Director of Maintenance revealed two (2) outdoor oxygen storage compartments were unlocked and not secured against unauthorized entry. The storage compartment for full cylinders was identified by a full sign; however, the storage compartment for empty cylinders was not identified by an empty sign.

Interview, on 07/08/14 at 9:15 AM, with the Maintenance Director revealed he was unaware the two (2) outdoor oxygen storage compartments were left unlocked and acknowledged the requirement for locking the compartments to prevent unauthorized entry. He stated an empty sign had been provided and may have come off as a result of changing weather conditions.

The census of ninety (90) was verified by the Administrator, on 07/08/14. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 07/08/14.

K 076

K 076

Corrective Actions for Targeted Residents:

No individual was affected by the deficient practice.

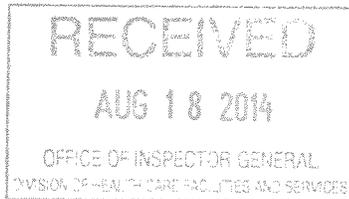
Identification of Other Residents with Potential to Be Affected:

A limited number of residents have a potential to be affected by this practice.

Systemic Changes:

Oxygen tank storage has been moved from out side into the facility, we allocate only for oxygen storage, this room was previous used for oxygen tanks and supplies storage but now it will used for oxygen tanks storage only. Administrator made a called out to our oxygen supplier (AirGas) who agreed in collaborating in change of storage location. Non smoking signs has be put on door, empty and full oxygen tanks signs has been place too. Door to this room also have a self closing device and is locked to prevent unauthorized entry this storage location is protected by an automatic sprinkler system.

*8-1-14
per Action
by PB
8-25-14*



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K 076 Continued From page 14

K 076

Reference: NFPA 101 (2000 edition)

8-3.1.11.2

Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3)

(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.

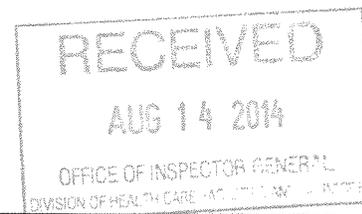
(d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4.

(e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations.

(f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d.

(g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13.

(h) Cylinder or container restraint shall meet



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K 076 Continued From page 15
4-3.5.2.1(b)27.
(i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations.
(j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.

K 076

K 130 NFPA 101 MISCELLANEOUS
SS=D OTHER LSC DEFICIENCY NOT ON 2786

K 130

K 130
Corrective Actions for Targeted Residents:

No individual was affected by the deficient practice.

Identification of Other Residents with Potential to Be Affected:

A limited number of residents have a potential to be affected by this practice.

Systemic Changes:

The kick down floor stop device was immediately removed by maintenance director on 07/08/14.

Monitoring:

On 07/15/14 Maintenance director received In -service on the used of unproved device within a required means of egress by Administrator . monitoring of unapproved devices will be conducted by maintenance director monthly as part of maintenance and environmental rounds finding are to be reported to QAPPI .

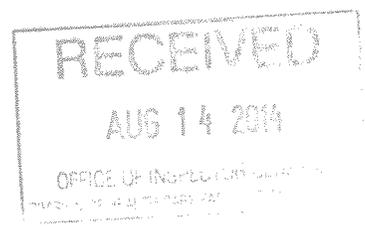
Correction Date: 08/09/14

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to maintain doors within a means of egress, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety (90) on the day of the survey.

The findings include:

Observation, on 07/08/14 at 9:37 AM, with the Director of Maintenance revealed the door to the conference room located near the entrance lobby was being held open with an unapproved device [a kick-down floor stop] that was installed on the egress side of the door to the exit access corridor.

Interview, on 07/08/14 at 9:39 AM, with the



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K 130 Continued From page 16
Director of Maintenance revealed he was unaware the door hold-open device was prohibited and agreed that it would be a deterrent to closing the door from the room to the exit access corridor to prevent the spread of smoke in the event of an emergency situation.

The census of ninety (90) was verified by the Administrator on 07/08/14. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 07/08/14.

Reference: NFPA 101 (2000 Edition)

19.2.2.2.4
Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.

K 147 SS=D
NFPA 101 LIFE SAFETY CODE STANDARD

Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

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 National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, approximately twenty-five (25) residents, staff and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety

K 130

K 147

K 147

Corrective Actions for Targeted Residents:

No individual was affected by the deficient practice.

Identification of Other Residents with Potential to Be Affected:

A limited number of residents have a potential to be affected by this practice.

Systemic Changes:

On 07/11/14 Paper storage room was moved to different storage area on north hall. new location has a self closing door, and door is lock for authorized users only.

Monitoring:

Maintenance Director will monitor storage area monthly for a year and report to QAPPI .

Correction Date: 07/11/14

*7-12-14 per action
mjb 8-16-14*

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

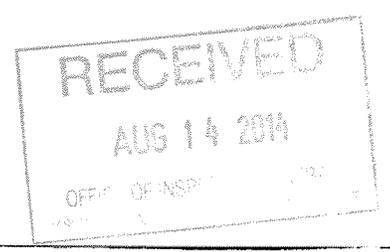
PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/08/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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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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K 147	<p>Continued From page 17 (90) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/08/14 at 9:46 AM, with the Director of Maintenance revealed access to the main electrical panel located within the East Hall Electrical Room, had been blocked by nine (9) boxes of copy paper.</p> <p>Interview, on 07/08/14 at 9:48 AM, with the Director of Maintenance revealed he was aware of the clear access requirements around electrical panels, but unaware of items temporarily stored within three (3) feet of the electrical panel.</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>110-26. Spaces</p> <p>10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>(A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)</p>	K 147		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 147 Continued From page 18
 (1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.

Table 110.26(A)(1) Working Spaces

Nominal Voltage to Ground	Minimum Clear Distance		
	Condition 1	Condition 2	Condition 3
0-150	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)
151-600	900 mm (3 ft)	900 mm (3 ft)	1 m (3½ ft)
1.2 m (4 ft)			

K 147

