

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

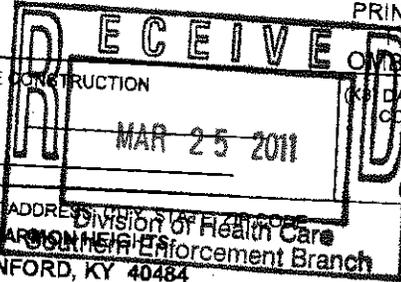
PRINTED: 03/23/2011
FORM APPROVED
NO. 0938-0391

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

185244

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____
B. WING _____



(X3) DATE SURVEY
COMPLETED

3/17/2011

NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER-STANFORD

STREET ADDRESS, CITY, STATE, ZIP CODE
105 HARRISON BLVD
STANFORD, KY 40484

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5)
COMPLETION
DATE

F 000

INITIAL COMMENTS

F 000

• There is no corrective action to be implemented for those residents found to have been affected by the practice.

F 164
SS=D

483.10(e), 483.75(f)(4) PERSONAL
PRIVACY/CONFIDENTIALITY OF RECORDS

F 164

• All residents have the potential to be affected by this practice.

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

• On 3-18-11 covers for the MARs have been provided to ensure privacy and confidentiality of the clinical record. An in-service was completed on Wednesday, March 23, 2011 by Director of Clinical Education to all licensed staff regarding privacy of the medical record. There were 2 licensed staff identified as being on a leave at this time and have been contacted via phone that before they can return to duty they must received the educational in-service.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

An in-service was completed 3-23-11 by the Director of Clinical Education for all employees regarding the right of the resident to personal privacy, i.e. privacy curtains pulled, blinds closed, doors closed during resident care. This information will be discussed during orientation and at least annually by the Director of

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

James Thomas

TITLE

Executive Director

(X6) DATE

3-25-11

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

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484
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F 164 Continued From page 1
Based on observation, interview, and record review, it was determined the facility failed to provide visual privacy for one (1) of twenty-four (24) sampled residents (resident #19). In addition, the facility failed to provide privacy of the medication administration record of one (1) sampled resident (resident #24) and one (1) unsampled resident during a medication pass on March 16, 2011.

The findings include:

1. An observation conducted on March 16, 2011, at 2:10 p.m., revealed the Physical Therapy Assistant (PTA) standing beside resident #19 performing incontinence care. Resident #19 stood in an upright position, unclothed from the waist down. Resident #19's privacy curtain was open between the resident and the resident's roommate (resident #11.) Resident #11 was lying in bed, eyes open, observing while the staff performed incontinence care for resident #19. Resident #19 was unclothed in full visual view of resident #11.

Record review of resident #19's Minimum Data Set (MDS) dated February 11, 2011, revealed the resident was assessed as oriented on the cognitive interview summary.

An interview conducted on March 17, 2011, at 10:00 a.m., with the PTA revealed the PTA had gone into resident #19's room to take the resident for a walk. Resident #19 had a bowel movement and resident #19 had asked to be cleaned up so he/she could attend Bingo. In addition, the PTA stated he/she went into the hallway to look for a Certified Nurse Assistant (CNA) to assist, but none was available, and the PTA proceeded to

F 164

Clinical Education. There were 5 employees identified as being on a leave at this time and have been contacted via phone that before they can return to duty they must receive the educational in-service.

- The Director of Nursing Services (DNS) will conduct an observation audit weekly for 4 weeks to ensure the resident's personal privacy and confidentiality of his or her personal and clinical records are protected which will include monitoring for the use of the cover to protect the privacy of the medication administration record, and visual privacy, i.e. privacy curtains pulled, blinds closed, doors closed during resident care. Results of this audit will be presented during the monthly Quality Assurance and Assessment meeting which includes the medical director. Audits will continue monthly thereafter by the Assistant Director of Nursing Services. Findings will be reported during the monthly Quality Assurance and Assessment meeting.

3-25-11

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F 164	<p>Continued From page 2</p> <p>clean the resident because the resident was in a hurry to go to Bingo. The PTA stated he/she was rushed to get the resident to Bingo and resident #19 was not provided visual privacy during the incontinence care.</p> <p>Review of the facility's policy (no date) stated residents had a right to personal privacy during medical treatments and personal care.</p> <p>2. Observation during a medication pass on March 16, 2011, at 8:35 a.m., revealed Registered Nurse (RN) #1 entered the room of an unsampled resident to administer medications to the resident. Further observation revealed the Medication Administration Record (MAR) on top of the medication cart in the hallway had been left open which exposed the resident's personal, confidential information.</p> <p>Further observation of the medication pass revealed RN #1 prepared ten medications to administer to resident #24. RN #1 entered the resident's room and failed to ensure the MAR information was not exposed while administering medications to resident #24. An unsampled resident was observed sitting in the hallway near the medication cart. A visitor was observed to pass by the medication cart while RN #1 was in resident #24's room.</p> <p>Continued observation of the medication pass revealed an unsampled resident in the hallway. The resident was visibly upset and informed RN #1 another resident had soiled the bathroom. RN #1 left the medication cart to assist the unsampled resident. The MAR remained on top of the medication cart with the resident's private and personal information exposed.</p>	F 164			

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F 164	Continued From page 3 Interview on March 16, 2011, at 11:00 a.m., with RN #1 revealed the RN was aware the MAR had been left open during the medication pass. The RN stated residents' medical information is confidential and he/she should have kept the information covered. A review of the facility's policy titled Safeguarding and Storage of Protected Information, dated November 1, 2010, revealed medical records should not be unattended in public areas and should be closed when not in use.	F 164		
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide comfortable temperature levels and maintain a temperature range of seventy-one (71) to eighty-one (81) degrees Fahrenheit in the 200 Hall shower room. The findings include: A group interview conducted with ten alert and oriented residents on March 16, 2011, at 1:00 p.m., revealed the 200 Hall shower room was cold and the 200 Hall shower room did not have any heat.	F 257	<ul style="list-style-type: none"> There is no corrective action to be implemented for those residents found to have been affected by the practice. All residents have the potential to be affected by this practice. A bid was received and accepted on Monday, March 21, 2011 to provide and install a new 1250 watt ceiling mounted heater with line voltage thermostats. Heaters were ordered on Wednesday, March 23, 2011 with expected delivery within 10 days and installation completed by Friday, April 8, 2011. <p>The Director of Maintenance will monitor temperature levels in all shower rooms weekly x 4 weeks then monthly thereafter and</p>	

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F 257	Continued From page 4 Observations of air temperatures of the 200 Hall shower room conducted on March 17, 2011, at 9:00 a.m. and 11:00 a.m., revealed the air temperature to be 68 degrees Fahrenheit. An interview conducted with the facility Maintenance Director on March 17, 2011, at 11:00 a.m., revealed the thermostat to control the air temperature in the shower room was located in the hallway and made adjusting the temperature of the shower room difficult. Further interview revealed the Maintenance Director was not aware of any resident complaints regarding resident shower rooms being cold and had not received any work orders related to the shower room temperatures. In addition, the Maintenance Director stated the air temperature in the facility shower rooms was not monitored.	F 257	maintain documentation of results. Any results found outside of the acceptable range of 71-81 degrees Fahrenheit will be reported to the Executive Director. All staff have been educated on the procedure for notifying maintenance of work orders or environmental complaints. In-service was completed by the Director of Clinical Education on 3-23-11. There were 5 employees identified as being on leave at this time and have been contacted via phone that before they can return to duty they must receive the educational in-service.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to follow professional standards of quality for two (2) of twenty-four (24) sampled residents (residents #11 and #24). Resident #11 was observed to have a dressing applied to the right lower extremity without a physician's order for the dressing. In addition, during medication observation on March 16, 2011, an extended release medication that should not be crushed was crushed and administered to resident #24.	F 281	<ul style="list-style-type: none"> The Executive Director (ED) will monitor the documented results of temperatures quarterly to ensure the facility provides comfortable and safe temperature levels. Findings will be presented during the monthly Quality Assurance and Assessment meeting. The dressing was removed from resident #11 on 3-16-2011. A new order was received for resident #24 for a liquid medication. 	3-25-11	

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F 281	<p>Continued From page 5</p> <p>The findings include:</p> <p>1. Resident #11 was admitted to the facility on November 11, 2008, with medical diagnoses of Psoriasis, Peripheral Neuropathy, and Alzheimer's Disease.</p> <p>An observation of resident #11 conducted on March 15, 2011, at 3:40 p.m., and March 16, 2011, at 8:40 a.m. and 2:45 p.m., revealed the resident with a dressing on the right lower extremity.</p> <p>An observation of a skin assessment for resident #11 performed by Licensed Practical Nurse (LPN) #3, conducted on March 17, 2011, at 9:00 a.m., revealed the LPN removed a dressing from resident #11's right lower extremity and applied Cetophil Cream. An interview conducted on March 17, 2011, with LPN #3 revealed he/she was unsure why resident #11 had a dressing on the right lower extremity and did not think the resident needed a dressing to the leg. The LPN further revealed resident #11 had an order for Cetophil Cream for a diagnosis of Psoriasis.</p> <p>An interview conducted on March 17, 2011, at 9:10 a.m., with LPN #5 revealed he/she was responsible for the wound care for resident #11 and was unaware of a physician's order for a dressing to resident #11's right lower extremity. The LPN further revealed he/she was unaware of why the resident had the dressing on the right lower extremity.</p> <p>An interview conducted on March 17, 2011, at 11:15 a.m., with the Administrator revealed the facility staff was required to have a physician's order to apply a dressing to a resident.</p>	F 281	<ul style="list-style-type: none"> All residents have the potential to be affected by this practice. A skin audit was completed on 3-21-11 for all residents. 3 residents were found to have a dressing. All 3 dressings were removed as there was no order nor skin impairment noted. <p>An up-to-date listing of medications not to be crushed was placed in the MAR books on 3-22-11. A list of all residents requiring crushed medications was generated by the DNS and provided to the pharmacist for recommendations. Recommendations were received on 3-22-11 and forwarded to the attending physicians on 3-23-11. Orders received and implemented as directed by physicians on 3-24-11. An in-service was conducted for all licensed staff regarding the necessity to obtain orders for any type of dressing and the procedure for crushing medication. The in-service was conducted by the Director of Clinical Education. There were 2 licensed staff identified as being on leave at this time</p>		

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F 281	Continued From page 6 Review of the physician's orders for resident #11 dated March 2011 revealed there was not a current order for a dressing to the right lower extremity. 2. Observation of a medication pass on March 16, 2011, at 8:50 a.m., revealed RN #1 prepared ten medications to be administered to resident #24. The medications were Ativan, Multivitamin, Seroquel, Potassium Chloride, Glipizide, Lamictal, Metformin, Metoprolol, Ultram, and Ibuprofen. RN #1 crushed nine of the medications and mixed the medications with applesauce. A whole tablet (Multivitamin) was also administered with applesauce. Review of the monthly physician's orders directed staff to administer Potassium Chloride Extended Release tablets (Gen-L) 20 milliequivalents (meq) once daily. Interview on March 16, 2011, at 11:00 a.m., with RN #1 revealed the RN was knowledgeable of the recommendation to not crush extended release medications. RN #1 checked the medication in the medication cart which revealed the medication box and individual medication packets were labeled with 'ER' to indicate extended release. The facility provided a copy of the list of medications that should not be crushed. Review of the list revealed Potassium Chloride should not be crushed.	F 281	and have been contacted via phone that before they can return to duty they must receive the educational in-service. Newly hired licensed staff will receive this education during the orientation process. • The Director of Clinical Education will conduct medication administration audits to include identifying if medications are administered correctly to include the crushing of medications if indicated for 2 licensed staff for each shift for 4 weeks, and present the findings to the Director of Nursing Services for any actions required. The results of the audits will be presented during the monthly Quality Assurance and Assessment meeting. The Director of Clinical Education will conduct medication administration audits on all licensed staff twice yearly. The findings of the audits will be presented during the monthly Quality Assurance and Assessment meetings which includes the medical director.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	• There is no correction. No residents were identified to have	3-25-11

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F 323	<p>Continued From page 7</p> <p>as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</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 the residents' environment was as free from accident hazards as possible. Observations during the environmental tour from March 15-17, 2011, revealed hand sanitizer, gallon-sized containers of shampoo/body wash, peri-cleanse, aftershave, and syringes, and a mechanical room on the 100 Hallway were not secured/locked and were accessible to residents. In addition, an operational cooking stove in the resident dining room on the 300 Hall was available to wandering residents.</p> <p>The findings include:</p> <p>Observation of the 300 Hall dining room on March 15, 2011, from 4:40 p.m. to 6:00 p.m., March 16, 2011, from 11:30 a.m. to 12:30 p.m., and March 17, 2011, at 8:30 a.m., revealed that an operating stove was available to wandering residents. Residents were observed in the 300 Hall dining room on March 15, 2011, at 4:30 p.m., and on March 16, 2011, at 8:30 a.m. and 4:00 p.m. Further observations revealed the nursing station was adjacent to the dining room; however, the stove was not in view of the 300 Hall nursing station.</p> <p>Observation of the supply closet on the 100 Hall</p>	F 323	<p>been affected by this practice.</p> <ul style="list-style-type: none"> All residents have the potential to be affected by this practice. On 3-17-11 the hand sanitizer, shampoo/body wash, peri-cleanse, aftershave and syringes were removed. The mechanical room keys were secured by the Director of Maintenance and the mechanical rooms are locked. A locksmith is scheduled to replace locks by Friday, April 1st. Locks to utility rooms, lab room, and supply areas have been secured with a key pad lock which locks automatically completed on 3-24-11. The stove in the 300-wing dining room was disabled on 3-21-11. The stove can be enabled upon request to maintenance to provide supervised cooking activities to the residents. The Director of Maintenance will monitor all supply areas, mechanical rooms, common areas weekly to ensure the facility remains as free of accident hazards as is possible which includes doors locked and supplies stored in the proper area. The Director of Clinical Education in-serviced all staff completed on 3-23-11 regarding the need to store supplies in the proper area and secured/locked 	

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F 323	Continued From page 8 on March 15-17, 2011, revealed the storage closet to be unlocked and one 27-ounce container of protection plus hand sanitizer and two gallon-sized containers of shampoo/body wash were unsecured. Further observation revealed a sign on the storage room door that stated to leave the storage room door unlocked. Observation on March 17, 2011, at 8:50 a.m., revealed a soiled linen room on the 100 Hall was not secured and an unlabeled bottle of aftershave was not secured. In addition, a mechanical room on the 100 Hallway with a hot water heater and an air compressor was observed to be left unsecured. Further observations revealed the 100 Hall laboratory room was not secured. The room contained 40 3cc medication syringes, 60 1cc syringes, and five bottles of peri-cleanser labeled for external use only and unsecured. An interview with the Director of Nursing (DON) on March 17, 2011, at 3:10 p.m., revealed keys to the closets and storage rooms were available throughout the facility. According to the DON, nurses were required to check the closets twice a day to ensure the closets were locked/secured. Further interview revealed the DON was not aware the closets and storage rooms were unsecured. A review of the facility policy for Hazardous Chemicals, dated June 1995, revealed no evidence of any guidance as to securing hazardous chemicals.	F 323	as indicated. There were 5 employees identified as on leave. These employees were notified via phone that they must receive in-service prior to returning to duty. • The Executive Director will monitor supply areas, mechanical rooms, common areas monthly to ensure the facility remains as free of accident hazards as is possible which includes doors locked and supplies stored in the proper area. The results of the Executive Director's findings will be reported during the monthly Quality Assurance and Assessment meeting which includes the medical director.	3-25-11	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431	• There is no corrective action to be implemented for those residents found to have been affected by the practice.		

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F 431	<p>Continued From page 9</p> <p>of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to store all drugs and biologicals in accordance with currently accepted professional principles. Observation on March 16, 2011, of a morning</p>	F 431	<ul style="list-style-type: none"> All residents have the potential to be affected by this deficient practice. All medications rooms and medication refrigerators were audited on 3-21-11 to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions and the expiration date when applicable. Medications found to be stored improperly or not dated were destroyed and reordered on 3-22-11. The Director of Clinical Education provided in-service education regarding the labeling and storage of drugs, i.e. date of opening medication, importance of medication remaining in original package and locking the medication cart if it is out of site to all license staff on 3-23-11. Two licensed staff are on leave at this time and have been contacted via phone that before they can return to duty they must receive the education. <p>The Director of Clinical Education will conduct medication administration audits to include identifying if a medication cart is left unattended on 2 licensed staff</p>		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484		
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F 431	<p>Continued From page 10</p> <p>medication pass revealed staff failed to ensure a medication cart was secured/locked when not in use. Additionally, the facility failed to ensure multi-dose medication vials were dated as to the date opened. On March 17, 2011, two vials of injectable medication were stored opened and not dated as to date opened in the 300 Hall medication room.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Prior to medication pass observation on March 16, 2011, at 8:35 a.m., RN #1 was observed to be in a resident's room and administering medications to an unsampled resident. Observation revealed the medication cart was positioned near the entryway of the resident's room. Further observation revealed the medication cart was not locked. <p>Observation of the medication pass revealed RN #1 prepared four medications for an unsampled resident in room 207. RN #1 entered the resident's room and administered the oral medications to the resident; however, RN #1 failed to ensure the medication cart/drawers were locked.</p> <p>Further observation revealed RN #1 prepared ten medications for an unsampled resident in room 206. RN #1 entered the resident's room, administered the oral medications, but failed to lock/secure the medication cart. Upon returning to the medication cart, a resident (visibly upset) approached RN #1 and voiced concern of the resident's bathroom being soiled by a resident in the adjoining room. RN #1 left the unlocked medication cart that was positioned in the hallway, near the doorway of resident room 206,</p>	F 431	<p>for each shift for 4 weeks, and present the findings to the Director of Nursing Services for any actions required. The results of the audits will be presented during the monthly Quality Assurance and Assessment meeting. The Director of Clinical Education will conduct medication administration audits on</p> <ul style="list-style-type: none"> • Medication Rooms and medication refrigerators will be monitored monthly by Assistant Director of Nursing Services to ensure drugs and biologicals used in the facility are labeled in accordance with current accepted professional principles, including the appropriate accessory and cautionary instructions, and the expiration date when applicable. The Director of Nursing Services will inspect the medication rooms and medication refrigerators quarterly and report the results of the inspections to the monthly Quality Assurance and Assessment meeting which includes the medical director. 	3-25-11	

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F 431	<p>Continued From page 11 and entered resident room 202 (two doors down from where the medication cart was positioned). RN #1 checked the bathroom which adjoined resident room 200, the room of the resident that had voiced the complaint. RN #1 failed to ensure the medication cart was locked while unattended in the hallway.</p> <p>Interview on March 16, 2011, at 11:00 a.m., with RN #1 revealed the RN was knowledgeable of the requirement to keep the medication carts locked when not in direct view. RN #3 stated the RN did not pass medications on a regular basis and just failed to ensure the medication cart was locked.</p> <p>Interview on March 16, 2011, at 2:30 p.m., with the House Supervisor revealed medication carts should be locked when entering a resident's room.</p> <p>Review of the facility's policy titled Storage of Medication, dated September 2010, revealed medications should only be accessible to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Further review revealed the policy directed staff to keep medication supplies locked when not in use or attended by authorized persons.</p> <p>2. Observation of the 300 Hall medication room conducted on March 17, 2011, at 3:30 p.m., revealed a 5ml vial of Flu vaccine and a 1ml vial of Apilisol Protein Purified Derivative (PPD) stored in the refrigerator, open and not dated as to when opened, available for resident use.</p> <p>An interview conducted with LPN #6 on March 17, 2011, at 3:30 p.m., revealed LPN #6 was not</p>	F 431			

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F 431	Continued From page 12 aware of when the vials of medication had been opened and that the medications were required to be dated when opened.	F 431			
F 465 SS=E	A review of the facility policy titled Storage of Medication, dated December 2008, revealed no guidance for dating open vials of injectable medication. According to the policy, only insulin vials were required to be dated when opened. 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. A fan heater for the 300 Hall shower room was not functioning. Torn, loose wallpaper was observed in the 100 Hallway. A hole was observed in the wall in the 100 Hall dining room. Fire doors on the 100 Hall were observed with chipped and splintered edges. A towel rack was observed to be loose with a part missing in a 200 Hall shower room. The findings include: Observations conducted during an environmental tour with the Maintenance Director on March 17, 2011, at 10:45 a.m., revealed the following items in disrepair:	F 465	<ul style="list-style-type: none"> There is no corrective action to be implemented for those residents found to have been affected by the deficient practice. All residents have the potential to be affected by this practice A contractor with AllState Construction has been secured on 3-23-11 to repair/replace any torn or loose wallpaper to the 100-hall. Repair the hole to the wall in the 100-dining room. Replace/repair fire doors to the 100-hall. Replace the towel rack to the 200-hall shower room. Repair the fan-heater to the 300-wing shower room completed 3-21-11. All staff have been educated on the procedure for notifying maintenance of work orders or environmental complaints or issues. Wallpaper repairs are to be completed by June 15, 2011. Other repairs will be completed by Friday, April 15, 2011. 		

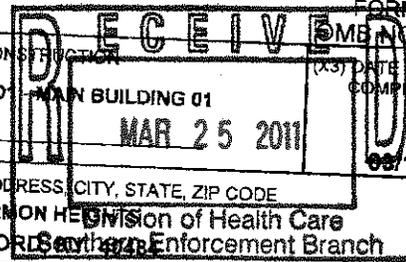
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F 465	<p>Continued From page 13</p> <ul style="list-style-type: none"> -A forced air fan heater was observed to not be functioning in the 300 Hall shower room. -Torn and loose wallpaper was observed in the 100 Hallway. -Scratched/scarred walls were observed in the 100 Hallway. -Chipped/splintered fire doors were observed on the 100 Hallway. -A hole was observed in a wall in the 100 Hall dining room. -A towel rack was observed to be loose with missing parts in a 200 Hall shower room. -Toilet bolt covers were observed to be missing in resident rooms 106, 126, and 208. <p>An interview conducted with the facility Maintenance Director on March 17, 2011, at 10:45 a.m., revealed the Maintenance Director was made aware of items in need of repair by a computerized work order system and by making daily rounds of the facility. Additional interview revealed the Maintenance Director had been newly hired and was receiving help from another facility Maintenance Director to identify and repair items in need of repair.</p> <p>A review of uncompleted facility work orders revealed no evidence the items in need of repair had been identified or scheduled for repair.</p>	F 465	<ul style="list-style-type: none"> • The Executive Director will complete environmental inspection of the facility monthly to ensure the facility is providing a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The results of the environmental inspection will be presented during the monthly Quality Assurance and Assessment meeting which includes the medical director 	3-25-11	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

185244

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01
B. WING

(X3) DATE SURVEY COMPLETED

03/16/2011

NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER-STANFORD

STREET ADDRESS, CITY, STATE, ZIP CODE

105 HARMON HEDDENSON
STANFORD, IN 47784
Division of Health Care
Enforcement Branch

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

K 000

INITIAL COMMENTS

K 000

42 CFR 483.70

K3 BUILDING: 0101
K6 PLAN APPROVAL: 1988
K7 SURVEY UNDER: 2000 EXISTING
K8 SNF

TYPE OF STRUCTURE: 1991 One-story unprotected frame Type 111(200) with a complete automatic sprinkler system throughout.

A life safety code survey was initiated and concluded on March 16, 2011. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). Golden LivingCenter-Stanford was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.

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

K 018
SS=E

NFPA 101 LIFE SAFETY CODE STANDARD

K 018

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3

Roller latches are prohibited by CMS regulations in all health care facilities.

- No residents were identified to have been affected by this practice.
- All residents have the potential to be affected by this practice.
- Vending machines were moved on 3-17-11 to ensure the door could close. The door jamb latching plate was replaced on 3-18-11. Corridor

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

James Thomas

TITLE

Executive Director

(X6) DATE

3-25-11

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

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor doors were maintained according to NFPA standards. This deficient practice affected two (2) of five (5) smoke compartments, staff, and approximately twenty-seven (27) residents. The facility has the capacity for 128 beds with a census of 113 on the day of the survey. The findings include: During the Life Safety Code tour on March 16, 2011, from 10:00 a.m. to 10:45 a.m., with the Director of Maintenance (DOM), a corridor door to the vending machine room would not close due to the vending machine blocking the door. The door jamb was also observed to be missing a latching plate. The corridor door to resident room 103 was observed not to latch. Corridor doors must close and latch to help resist the passage of smoke in a fire situation. An interview on March 16, 2011, at 10:00 a.m., with the DOM revealed the DOM was not aware these doors were not operating correctly. An interview with the DOM on March 16, 2011, at 10:20 a.m., revealed the DOM had been working	K 018	door to resident room 103 was repaired on 3-23-11 to latch. All doors in the facility were inspected on 3-23-11. There were 24 doors identified in need of repair. A contractor has been secured to assist in repair of doors or latches. Repairs to be completed by Friday, April 29, 2011. All staff have been in-serviced regarding the procedure to notify the Director of Maintenance of repairs and that corridor doors must close and latch to help resist the passage of smoke in a fire situation. The in-service was completed on 3-24-11. The Housekeeping and Laundry Supervisor in-serviced this department. The Rehab Program Manager in-serviced the therapy department. The Director of Clinical Education in-serviced dietary, administration and nursing. There are 5 employees identified as being on leave. These employees have been contacted via phone that before they can return to duty they must receive the educational in-service.		

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K 018	Continued From page 2 for the facility for three days. The DOM stated the DOM was not aware of the life safety code requirements. Reference: NFPA 101 (2000 Edition). 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors. 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted A. 19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches	K 018	<ul style="list-style-type: none"> The Director of Maintenance will inspect 10 doors per month x 3 months to ensure they are maintained according to NFPA standards to include free of blockages, close easily and latching mechanisms are in good repair. Results of inspections will be presented during the monthly Quality Assurance and Assessment meeting which includes the medical director. The Director of Maintenance will then inspect all doors quarterly to ensure they are not blocked, close easily and latching mechanisms are in good repair. The results of the audit will be presented during the monthly Safety Meeting. any issues identified will be reported to the monthly Quality Assurance and Assessment meeting. 	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems.	K 025	<ul style="list-style-type: none"> There is no correction. No residents were identified to have been affected by this practice. All residents have the potential to be affected by this practice. 	3-25-11

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K 025	Continued From page 3 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to utilize proper access doors and maintain the fire/smoke wall assembly in the attic area. This deficient practice affected five (5) of five (5) smoke compartments, staff, and approximately ninety (90) residents. The facility has the capacity for 128 beds with a census of 113 on the day of the survey. The findings include: During the Life Safety Code survey on March 16, 2011, at 9:55 a.m., with the Director of Maintenance (DOM), observation revealed the facility had an unapproved makeshift access door in the rated fire/smoke barrier wall in the attic area of the 200 corridor. This type of access door is required to be of an approved device that is designed for the specific purpose to help prevent fire/smoke from spreading to other areas of the building in a fire situation. An interview with the DOM on March 16, 2011, at 9:55 a.m., revealed the DOM thought the makeshift doors in the fire/smoke barrier walls had been sealed or replaced with approved access doors. During the survey four other smoke barrier walls above the corridor fire doors were observed to have gaps around wiring and electrical conduit, holes, and missing rated panels. The facility was cited for this same deficient practice on April 28, 2010. An interview with the DOM on March 16, 2011, at 10:20 a.m., revealed the DOM had been working	K 025	<ul style="list-style-type: none"> A bid has been received and accepted for the repair to the access doors in the rated fire/smoke barrier wall in the attic on 3-21-11. The doors were ordered on 3-24-11. Completion of the repair is scheduled for Friday, April 15, 2011 or before. The Director of Maintenance will perform an inspection of the attic areas twice a year to ensure the smoke barriers in the attic are in good repair to provide at least a one half hour fire resistance rating in accordance with 8.3. The results of the inspections will be presented during the Safety Meeting twice a year following the inspection, April and October which is conducted by the Executive Director of the facility. 	3-25-11	

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K 025 Continued From page 4 for the facility for three days. The DOM stated the DOM was not aware of the life safety code requirements.

Reference: NFPA 101 (2000 Edition).
8.2.3.2.3.1
Every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protectives shall be as follows:

(3) 1/2-hour fire barrier - 20-minute fire protection rating

(1) 2-hour fire barrier - 1 1/2-hour fire protection rating

(2) 1-hour fire barrier - 1-hour fire protection rating where used for vertical openings or exit enclosures, or 3/4-hour fire protection rating where used for other than vertical openings or exit enclosures, unless a lesser fire protection rating is specified by Chapter 7 or Chapters 11 through 42

8.3.2* Continuity.
Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.

8.3.6.1
Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through

K 025

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K 025	Continued From page 5 floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose. 19.3.7 Subdivision of Building Spaces. 19.3.7.1 Smoke barriers shall be provided to divide every story used for sleeping rooms for more than 30 patients into not less than two smoke compartments. The size of any such smoke compartment shall not exceed 22,500 ft ² (2100 m ²), and the travel distance from any point to reach a door in the required smoke barrier shall not exceed 200 ft (60 m). Exception No. 1: Where neither the length nor	K 025			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2011
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484
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K 025	Continued From page 6 width of the smoke compartment exceeds 150 ft (45 m), the travel distance to reach the smoke barrier door shall not be limited. Exception No. 2: The area of an atrium separated in accordance with 8.2.5.6 shall not be limited in size.	K 025		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that a hazardous area door was equipped with a self-closing device. This deficient practice affected one (1) of five (5) smoke compartments, staff, and approximately sixteen (16) residents. The facility has the capacity for 128 beds with a census of 113 on the day of the survey. The findings include: During the Life Safety Code tour on March 16, 2011, at 10:20 a.m., with the Director of Maintenance (DOM), a corridor door to the	K 029	<ul style="list-style-type: none"> There is no correction. No residents were identified to have been affected by this deficient practice All residents have the potential to be affected by this practice. A closure was applied to the Medical Records Office on 3-24-11. Inspection of doors requiring a door closing device were inspected on 3-24-11. 11 doors were identified as needing a closing device. Devices were obtained on 3-24-11. Repairs to be completed by Friday, April 8, 2011. The Director of Maintenance will perform an inspection of all door twice a year to ensure the door closing device is functional. The results of the inspections will be presented during the Safety Meeting, April and October which is conducted by the Executive Director of the facility. 	3-25-11

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K 029	<p>Continued From page 7</p> <p>Medical Records room was observed not to have a door closing device. Door closing devices are required on doors to rooms deemed to be a hazardous area. An interview with the DOM on March 16, 2011, at 10:20 a.m., revealed the DOM had been working for the facility for three days. The DOM stated the DOM was not aware of the life safety code requirements.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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:</p> <ol style="list-style-type: none"> (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. 	K 029			

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K 029	Continued From page 8 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. 19.3.6.3.4 Door-closing devices shall not be required on doors in corridor wall openings other than those serving required exits, smoke barriers, or enclosures of vertical openings and hazardous areas.	K 029			
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, the facility failed to ensure that electrical power strips were being used in an approved manner. This deficient practice affected one (1) of five (5) smoke compartments, staff, and one resident. The facility has the capacity for 128 beds with a census of 113 on the day of the survey. The findings include: During the Life Safety Code tour on March 16, 2011, at 10:15 a.m., with the Director of Maintenance (DOM), a nebulizer was observed to be plugged into a multi-outlet adapter (power strip) in resident room 217. The receptacle cover plate was also observed to be missing resulting in a potential shock hazard to the resident.	K 147	<ul style="list-style-type: none"> The nebulizer was plugged directly into the electrical socket and the cover plate was replaced for resident identified on 3-23-11. All resident who utilize medical equipment requiring a power source identified as having the potential to be affected by this practice. All resident rooms were inspected on 3-23-11 for the proper use of power strips. No other residents were identified. All residents rooms were inspected for cracked or missing cover plates on 3-22-11. Rooms were identified and cover plates were obtained on 3-23-11. Anticipated completion of replacements is Friday, April 8, 2011. All staff have been in- 		

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K 147	<p>Continued From page 9</p> <p>Generally, multiple-outlet adapters with surge protection may be used for resident TVs, computers, radios etc., on an as-needed basis but not to be used with medical equipment to help prevent against electrical shock.</p> <p>An interview with the DOM on March 16, 2011, at 10:15 a.m., revealed the DOM was not aware of the proper use of power strips.</p> <p>An interview with the DOM on March 16, 2011, at 10:20 a.m., revealed the DOM had been working for the facility for three days. The DOM stated the DOM was not aware of the life safety code requirements.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-3.2.1.2 D 2. Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	<p>serviced regarding the use of power strips for non medical equipment and the procedure for reporting maintenance repairs. The in-service was completed on 3-24-11. Housekeeping and laundry supervisor completed in-service to this department, Rehab Program Manager in-serviced the therapy department, Director of Clinical Education in-serviced dietary, nursing and administration. 5 employees are identified as being on a leave at this time and have been contacted via phone that before they can return to duty they must received the educational in-service.</p> <ul style="list-style-type: none"> The Director of Maintenance will perform an inspection of all rooms for missing or cracked electrical plates and the proper use of power strips monthly for 3 months. The results of the inspections will be presented during the monthly Safety Meeting, which is conducted by the Executive Director of the facility. Inspections will then continue quarterly by the Director of Maintenance and the results reviewed during the Safety Meeting quarterly. Any issues identified will be reported to the monthly Quality Assurance and Assessment meeting. 	3-25-11	

golden living

Kitchen

EDUCATION / INSERVICE REPORT

TARGET AUDIENCE _____

DATE _____

TIME _____

TOPIC / SUBJECT Problems with any maintenance areas.

CE HOURS _____

NA _____

PURPOSE Educate

PRESENTER _____

METHOD(S) _____

OBJECTIVE(S): (1) No doors can be obstructed by any object at anytime.
(2) Report all maintenance issues to your supervisor.
(3) Multiple-outlet adapters with surge protection may be used for residents TVs, computers, radios, etc. on an as-needed basis but not to be used with medical equipment to help prevent against electrical shock.

LEARNING NEED IDENTIFIED THROUGH:

___ Management Review

___ Quality Assurance

___ New Equipment or Technique

___ Staff Request/Stated

___ Other: _____

ATTENDANCE/PARTICIPATION

<u>Melissa Caudill</u>	
<u>Cheryl Boyel</u>	
<u>Debbie Elliott</u>	
<u>Gamie Tankesky - verbal mg</u>	
<u>Debra Taylor - verbal mg</u>	
<u>Luann Wilder - verbal mg</u>	
<u>Gordon Rogers - verbal mg</u>	
<u>Kari Jenkins - verbal</u>	
<u>Myrna Phillips (via phone) mg</u>	
<u>Brenda Smith (via phone) mg</u>	
<u>Josie Noel (via phone) mg</u>	

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K 000	<p>INITIAL COMMENTS</p> <p>K3 BUILDING: 0101 K6 PLAN APPROVAL: 2007 K7 SURVEY UNDER: 2000 NEW K8 SNF</p> <p>A life safety code survey was initiated and concluded on March 16, 2011. During this survey, Building 2 of Golden LivingCenter-Stanford was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *James W. ...* TITLE *Executive Director* (X6) DATE *3-25-11*

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

Received Time Mar. 25, 2011 7:37AM No. 7376