

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

PRINTED: 08/18/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/03/2010
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - VANCEBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 68 EASTHAM STREET VANCEBURG, KY 41179	
(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		
F 226 SS=D	<p>An Abbreviated Survey Investigating AROs #KY00014730, KY00014773, and KY00014991 was initiated on 08/01/10 and concluded on 08/03/10, with deficiencies cited. ARO KY00014730 was substantiated with deficiencies cited. AROs KY00014773 and KY00014991 were unsubstantiated with no deficiencies.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Interview and record review it was determined the facility failed to ensure facility staff implemented the facility's abuse policy related to reporting of alleged abuse, for one (1) of nine (9) sampled residents (Resident #1).</p> <p>The findings include:</p> <p>Review of the facility's investigation of an allegation of abuse, dated 03/14/10 revealed three (3) staff members had witnessed a fourth staff member forcible walk Resident #1 into the dining room.</p> <p>Interviews, on 08/02/10 at 5:05 PM, with State Registered Nurse Aide (SRNA) #1 revealed she had witnessed the alleged perpetrator force Resident #1 into the dining and to sit in a chair. The SRNA stated she did not report this incident to Licensed Practical Nurse (LPN) #1, until after</p>	F 226	<p>A re-assessment was completed on resident #1 and was found to have no injury from this occurrence.</p> <p>Each resident will be identified upon individual reporting of an alleged incident. The employees will be able to verbalize the need for immediate reporting of an alleged incident to the Executive Director, Director of Nursing, Assistant Director of Nursing, & Social Service Director.</p> <p>Residents were interviewed at time of incident (2/3/10) to assure no other residents were identified as affected by any occurrence of alleged abuse. An in-service was issued to all employees on 2/9/2010 on abuse policy & resident rights regarding abuse. As a result of the in-service and of the re-in-servicing to employees as above, no other resident was identified or affected by any occurrence of alleged abuse.</p> <p>On 8/19/2010 the employees and the contract service employees (Aegis & Health Care Services) were re-in-serviced on the Abuse/Neglect Policy, to include reporting of alleged abuse/neglect by the Director of Nursing, and Assistant Director of Nursing. New hire employees will be educated on the Abuse/Neglect Policy, to include reporting, during their orientation process. Be-annual in-services will continue to be conducted on Abuse/neglect Policy.</p> <p>Reported alleged abuse/neglect incidents will be taken to the monthly QA&A Committee by the Director of Nursing or designee for 3 months, then quarterly X 2. Action plans will be implemented as indicated.</p>	Sept 15, 2010

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

TITLE

(X6) DATE

Judy A. Cavall *Executive Director* *8/26/10*

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

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - VANCEBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 60 EASTHAM STREET VANCEBURG, KY 41179		
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F 226	Continued From page 1 the meal was completed, approximately one (1) hours later. She stated she felt Resident #1 was safe as the alleged perpetrator was no longer in the dining room, and she did not think about the other residents the alleged perpetrator was assigned to provide care. Interview, on 08/03/10 at 1:44 PM, with LPN #1 revealed SRNA #1 reported the allegation of abuse to her some time after 7:00 PM on March 13, 2010. The LPN stated she was busy with another resident and was not able to deal with the report. She explained the incident was reported to a Registered Nurse (RN) who had come on duty at 7:00 PM, and she did not know what was done to prevent the alleged perpetrator from having contact with other residents. Interview, on 08/03/10 at 2:26 PM, with the alleged perpetrator revealed she had assisted Resident #1 into the dining room. In additional interview the alleged perpetrator stated she had completed her shift about 10:00 PM and gone home. Review of the facility's abuse policy revealed all allegations of abuse were to be reported immediately. In addition the policy stated that if an alleged perpetrator is an employee, the employee will be suspended immediately pending the outcome of an investigation.	F 226			
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents.	F 469			

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F 469	Continued From page 2	F 469	F 469 F	
	<p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to have an effective pest control system in place. Flies were observed throughout the facility for three (3) days of survey.</p> <p>The findings include:</p> <p>Observations, from 08/01/10 through 08/03/10, revealed flies in resident rooms, all hallways, and the dining room. Observation during the lunch meal revealed the Dietary Manager and Dietician were standing waving flies away from the steam table. The two staff members were discussing how bad the fly problem was in the facility.</p> <p>Interview, on 08/03/10 at 10:27 AM, with the Maintenance Director revealed the facility was treated for pest every month. He stated the flies had become an issue and was not sure when the last visit from the exterminator occurred. He stated he was unaware of any extra visits to address the flies.</p> <p>Review of the facility's receipts revealed the exterminator last treated the facility on 07/07/10.</p>		<p>Pest control came into building next day and treated. No harm to any resident as a result of incident.</p> <p>Have contract with new company to treat for large flies for the months of heaviest infestation-- May through August. This will include treating outside entrance/exit areas; targeted interior areas; trash & dumpster sights; around building borders; and replacing 3 current lights inside with heavier-duty ones & adding 2 more at exits in other areas of building.</p> <p>Also purchasing Air Curtain for door leading to smoking patio. This is most heavily used door & is located directly across from dining area. This barrier, combined with extra treatment, will be an effective system for controlling flies coming into building, & preventing future infestations.</p> <p>Maintenance Director will monitor for timely treatment, and call for extra treatments if any further issue should arise. This will be part of daily maintenance rounds during the months listed above. Will be forwarded to QA&A for action plans, should there be any further issues.</p>	Sept 15, 2010
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p>	F 514		

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F 514	<p>Continued From page 3</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure records were accurate for one (1) of nine (9) sampled residents (Resident #6) related to the discontinuation of medication.</p> <p>The findings include:</p> <p>Record review revealed a physician's order dated 06/29/10, to discontinue Doxepin and start Lexapro 10 milligrams (mg) per day.</p> <p>Review of the Medication Administration Record (MAR) revealed Resident #6 received the Doxepin and Lexapro until 07/25/10 when the Doxepin was no longer available.</p> <p>Interview, on 08/03/10 at 4:36 PM, with Registered Nurse (RN) #1 revealed she was the nurse responsible for transcribing the medication order. Further interview with RN #1 revealed she did not recall the details of the order. She stated she should have yellowed out the Doxepin on the MAR</p> <p>Interviews, on 08/03/10 at 4:22 PM and 4:26 PM, with Licensed Practical Nurses (LPNs) #1 and #2 revealed unless the medication was discontinued on the MARs and highlighted, they would</p>	F 514	<p>F 514 D</p> <p>A medication error report related to the improper transcription of physician orders were completed and noted for resident #6. The family, physician, & pharmacy were notified at the time of the reported error with no orders at this time. There were no adverse effects related to this transcription error.</p> <p>The Director of Nursing & the Assistant Director of Nursing completed audits on 8/17/2010 for current/active physician orders to include audits of medication carts & medication administration records for other potential transcription errors. No other residents were affected by this occurrence.</p> <p>The Assistant Director of Nursing and Certified Medication techs will review newly transcribed physician orders daily during the start up process to include audits of medication car and medication administration records for accuracy of transcription of physician orders on a daily basis. A re-in-service was conducted on 8/19/2010 by the Director of Nursing and Assistant Director of Nursing regarding "transcription of physician orders", for current nurses. New hire nurses will receive education on "transcription of physician orders" during their orientation process.</p> <p>The Assistant Director of Nursing will submit any concerns with transcription of physician orders to the QA&A Committee for review and discussion. Action plans will be developed as indicated.</p>	Sept 15, 2010

