STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185238	A. BUILDING _____ B. WING _____	05/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - VANCEBURG	58 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		

A Recertification Survey was initiated on 04/29/14 and concluded on 05/02/14. Deficiencies were cited with the highest Scope and Severity of an "E".

F 241 SS=D 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to promote care for residents in a manner and an environment that maintained or enhanced each resident's dignity, for two (2) of nineteen (19) sampled residents (Residents #12 and #13). Resident #12 and Resident #13 experienced incontinent episodes while waiting for staff to respond to their call lights.

The findings include:

Review of the facility's policy titled, "Dignity", revised October 2009, revealed treating residents with dignity and respect maintained and enhanced each resident's self-worth and improved his/her psychosocial well-being and quality of life.

Review of the facility's policy titled, "Call Lights, Use of", dated 2006, revealed all facility

F 241

F-241

Resident # 13 states she had one occasion of incontinence while waiting on a employee to answer her call light approximately 4-5 months ago however, she could not provide an exact date. She reports no other occurrences and she is now independent with toileting.

Resident #12 states she has experienced occasional episode of incontinence. She does not relate all to call light response. Currently, she is participating with therapy and is becoming more independent and utilizes bed pan and bedside commode with assist as needed. Resident #12 states staff respond and assist when needed.

-cont

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BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	LNHA	6/2/14

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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F 241	Continued From page 1	F 241		

personnel were to be aware of resident call lights at all times, and staff were to respond to all call lights promptly.

1. Review of Resident #12's clinical record revealed the facility admitted the resident on 12/24/13, with diagnoses which included Diabetes, Right Below the Knee Amputation (BKA), Renal Failure, Chronic Respiratory Failure, and Obesity.

Review of Resident #12's Quarterly Minimum Data Set (MDS) Assessment, dated 04/02/14, revealed the Brief Interview for Mental Status (BIMS) score was fifteen (15), which indicated no cognitive impairment. Further review of the MDS revealed the facility assessed Resident #12 as always being continent and to require extensive assist of one (1) staff person for transfers and toileting.

Review of the Comprehensive Care Plan, dated 01/17/14, revealed Resident #12 required assistance with toileting. Continued review revealed the resident's call light was to be placed within reach and staff was to remind the resident to use the call light when assistance was needed.

Interview with Resident #12, on 05/01/14 at 7:45 PM, revealed he/she rang the call light at approximately 5:30 PM "four or five days ago" to request assistance with applying his/her prosthetic leg in order to go to the bathroom. Resident #12 stated he/she was unable to wait for help and therefore "wet the bed" (was incontinent of urine). Resident #12 further stated when he/she was incontinent it made her "feel awful". Continued interview revealed a Certified Nurse Assistance (CNA) explained to the resident

The facility printed an Assessment Scoring Report to assess any Resident with a BIMS score of nine or greater to see if the deficient practice had occurred. Upon interview by DNS and ADNS, the facility determined that no further concerns were voiced by any other resident.

Call light audits will be conducted 3x weekly for 4 weeks during various times during a 24 hour shift, to include meal times to assure appropriate staff response time.

5/16/14

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she could not stop to take him/her to the bathroom because she was passing dinner trays.

Interview with CNA #9, on 05/02/14 at 11:15 AM, revealed the dining schedule allows for only one (1) CNA on the floor during meal service, which maked it difficult to get the residents' call lights answered timely.

Interview with CNA #4, on 05/02/14 at 12:30 PM, revealed there had been times when she was unable to get to the residents in time to toilet them, which had resulted in episodes of incontinence. CNA #4 stated on second shift there was only one (1) CNA left on the floor to feed residents in their rooms and answer call lights. She stated a second CNA was assigned to assist with feeding in the dining room. Continued interview revealed CNA #4 felt if another CNA was on the floor during dining time it could prevent residents from having toileting accidents.

Interview with CNA #6, on 05/02/14 at 1:25 PM, revealed she was unable to answer call lights during meal service because she had to pass the trays on the floor and feed residents, while the other CNA was in the dining room feeding. She indicated the facility's dining schedule left only one (1) CNA on the floor during the evening meal to pass trays, feed residents and answer call lights.

2. Review of Resident #13's clinical record revealed the facility admitted the resident on 07/11/13, with diagnoses which included Difficulty Walking, Muscle Weakness, Anemia, Esophageal Reflux and Joint Pain.

Review of the Quarterly MDS Assessment, dated

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04/12/14, revealed Resident #13's BIMS score was fifteen (15), which indicated no cognitive impairment. Further review of the MDS revealed the facility assessed Resident #13 as always continent and to require limited assist of one (1) person for toileting.

Review of the Comprehensive Care Plan, dated 07/18/13, revealed Resident #13 had a care plan for Activities of Daily Living (ADLs), which included an intervention for assistance with toileting.

Interview with Resident #13, on 05/01/14 at 8:00 AM, revealed the resident had been incontinent of urine, "about a month or two ago" at approximately 2:00 AM, while waiting for staff to answer the call light. Resident #13 stated it was "embarrassing", but he/she could not hold his/her urine because it had taken so long for staff to come. Continued interview revealed Resident #13's CNA told the resident she was washing wheelchairs when he/she rang the call light and could not answer the light. Resident #13 further stated the third shift only had one (1) CNA on duty on the unit for resident care and answer call lights.

Interview with CNA #6 on 05/01/14 at 1:25 PM, revealed call lights were not always answered timely and the CNA was aware residents had "wet" themselves while waiting for their call lights to be answered. Continued interview revealed the facility was "short-staffed", which made it difficult to meet residents' needs in a timely manner.

Interview with CNA #5 on 05/01/14 at 11:10 PM, revealed she recalled one (1) resident "wet"

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F 241	Continued From page 4 themselves because the CNA was unable to respond to the light in time. CNA #5 further revealed the third shift was "short-staffed", with only one (1) CNA on duty for the unit to provide resident care and answer call lights. Interview with Registered Nurse (RN) #4, on 05/02/14 at 4:04 PM, revealed she felt there would be less residents with incontinent episodes if the facility was staffed appropriately to meet the residents' needs.	F 241	F-280 Resident #5 and Resident #10 Care Plans were updated with Every 15 minute checks, however the intervention was resolved off the Care Plan and transferred to Kardex which is the Nurse Aide Care Plan for both Resident #5 and Resident #10. Resident was on every 15 minute checks and documentation was given to surveyors that is was being completed. Both Resident Care Plans was revised to reflect the intervention for each fall however some interventions had been resolved. A screen view was observed with the surveyor. All Residents Care Plan with 15 minute checks have been reviewed to assure that 15 minute checks is on the Care Plan in the computer and the Nurse Aide Kardex, by the DNS, ADNS, and RNAC and updated accordingly.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280		

-Cont- 6/11/14

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F 280	Continued From page 5 Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to ensure the Comprehensive Plan of Care was revised for two (2) of nineteen (19) sampled residents (Resident #5 and #10). Record review revealed Resident's #5 and Resident #10 sustained falls while residents of the facility and the Interdisciplinary Team (IDT) made recommendations after the falls. However, review of the Comprehensive Care Plans revealed it was not revised to include all the IDT recommendations. The findings include: Review of the facility's, "Falls Management Clinical Guidelines", revised 2013, revealed appropriate interventions were to be implemented and updated on residents' care plans. Review of the facility's policy titled, "Care Plan Completion" revised December 2002, revealed the care plan should be revised on an on-going basis to reflect changes in the resident and for the care the resident was receiving. 1. Record review revealed the facility admitted Resident #5 on 08/16/13, with diagnoses which included a Right Intertrochanteric Hip Fracture with repair after a fall at home, Dementia, and Alzheimer's. Review of the Immediate Plan of Care dated 08/16/13, revealed the facility had identified or assessed the resident to be a fall risk with a care plan for the risk and interventions in place. Review of Resident #5's Quarterly Minimum Data Set (MDS) Assessment dated 02/14/14, revealed the facility assessed the	F 280	The Interdisciplinary Progress Team will review all falls during Enhanced Start Up and review the Post Fall Investigation to assure that interventions to prevent re-occurrence is updated on the Kardex and Care Plan. The Interdisciplinary Team will then sign off on the Post Fall Investigation Form. Care plans will be updated during Enhanced Start Up, During the weekend the Unit Manager will be responsible to run orders to assure Updates in the care plan has been made, -cont	

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resident to be severely cognitively impaired and to have a history of falls with no injury. Review of the Comprehensive Care Plan dated 04/30/14, revealed a care plan for Resident #5's assessed risk for falls. Review of the "At risk for falls" care plan revealed interventions were in place which included assisting Resident #5 with Activities of Daily Living (ADLs) and to bed earlier in the evening; bed in low position to where the resident's feet would align with the floor normally, fall mats on the floor beside the bed, tab (personal) alarm in place to alert staff of unassisted transfers and toileting schedule.

Observation of Resident #5 and his/her room on 04/29/14 at 4:10 PM revealed the resident sitting up in a wheelchair with a tab alarm in place. Continued observation revealed the bed had an air mattress in place with contoured sides.

Review of a "Verification of Investigation Falls Report" dated 10/25/13 for Resident #5 revealed the resident experienced a fall, without injury, when attempting to ambulate self from the bed without supervision on 10/25/13 at 6:30 AM. Continued review of the Falls Report, dated 01/21/14, revealed Resident #5 attempted to stand without assistance and supervision on 01/21/14 at 6:10 AM and fell. Further review of both of these Falls Reports revealed the IDT recommended fifteen (15) minute checks of Resident #5 be performed by staff. However, continued review of the Comprehensive Care Plan revealed no documented evidence it had been revised to include the IDT intervention for fifteen (15) minute checks.

Additionally, review of a "Verification of Investigation Falls Report" dated 04/05/14 for

The Interdisciplinary Team will also review orders on Mondays to assure all orders, and incidents have been reviewed and updated over the weekend. The Facility will re-educate all nurses regarding updating Care Plan and Kardex.

The Facility will monitor compliance during Enhanced Start Up 5x/weekly. A Enhanced weekend form will be completed by the Unit Manager on Weekend and/or Designee. Weekly audit of 5 Resident orders will be audited by DNS/ ADNS/ RNAC to assure orders have been updated on the Facility Computer System Point Click Care, time four weeks. Any further issues will be brought to QA-A for further action plans, and plans of correction.

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Resident #5, revealed the resident sustained a fall, without injury, on 04/05/14 at 11:30 PM. Continued review of the Falls Report revealed the resident's tab alarm had sounded and staff found Resident #5 sitting on the floor on the left side of the bed with his/her feet under the bed. Further review of the Falls Report revealed the IDT recommended fifteen (15) minute checks and to offer plenty of fluids every 2 hours while the resident was awake. However, further review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised of the IDT's interventions for fifteen (15) minute checks or to offer plenty of fluids every two (2) hours while the resident was awake.

2. Record review revealed the facility re-admitted Resident #10 on 07/13/13, with diagnoses which included Delirium, Dementia, Alzheimer's, Anxiety, and a history of a Fractured Left Hip. Review of the Quarterly MDS Assessment dated 01/20/14, revealed the facility assessed Resident #10 to be severely cognitively impaired and no history of falls in the past six (6) months. Review of the Comprehensive Care Plan dated 04/30/14, revealed a care plan for Resident #10's assessed risk for falls related to his/her severe cognitive impairment. Review of the "At risk for falls" care plan revealed interventions were in place which included assisting Resident #10 as needed, call light or personal items available and in easy reach, footwear to prevent slipping, and tab alarm to alert staff as ordered.

Review of a "Verification of Investigation Falls Report" dated 07/10/13, for Resident #10 revealed the resident experienced a fall, with injury, when attempting to get up out of bed without assistance on 07/10/13 at 2:53 AM.

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Continued review of the Falls Report revealed Resident #10 when assessed by the nurse had "severe pain" of the left leg. Review of the Falls Report revealed the resident was transferred to the hospital via ambulance. Continued record review revealed Resident #10 was re-admitted to the facility on 07/13/13 with a diagnosis of a Fractured Left Hip with repair.

Review of Resident #10's "MDS Kardex Report" dated 12/17/12, which Certified Nursing Assistants (CNAs) used to know what type of care residents required, revealed under the section ADL Self-Performance documentation which stated every fifteen minute checks were to be performed. Review of the "15 Min Check Sheets" dated 04/21/14 through 04/30/14, revealed staff were performing every fifteen (15) minute checks as indicated on the Kardex Report. However, further review of the Comprehensive Care Plan revealed no documented evidence it had been revised to include the intervention for every fifteen (15) minute checks.

Interview with CNA #3 on 05/02/14 at 12:30 PM, revealed she worked on the unit where Resident #5 and Resident #10 resided and had provided care for these residents. She stated these residents were on every fifteen (15) minutes checks as indicated on the Kardex Report.

Interview with Licensed Practical Nurse (LPN) #1 on 04/30/14 at 9:35 AM, revealed Resident #5 and Resident #10 were on every fifteen (15) minute checks when in their rooms.

Interview with the Director of Nursing (DON) on 05/01/14 at 6:15 PM, revealed the IDT made the

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decision to implement fifteen (15) minute checks for Resident #5 and Resident #10 related to the residents' risk for falls. She stated the fifteen (15) minute checks and offering of liquids every two (2) hours for Resident #5, and the fifteen minute checks for Resident #10 were not on the Comprehensive Care Plan; however, were on the Kardex Report utilized by the CNAs. The DON stated the fifteen minute checks for both residents, and offering liquids every two (2) hours for Resident #5 should have been on the Comprehensive Care Plan.

F 280

F 312 SS=E 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to ensure residents received the necessary services to assist with maintaining good personal hygiene for six (6) of nineteen (19) sampled residents (Residents #2, #4, #6, #8, #10 and #11). Record review revealed Residents #2, #4, #6, #8, #10 and #11 did not receive showers as scheduled.

The findings include:

Interview with the Director of Nursing (DON), on 05/02/14 at 12:01 PM, revealed residents were scheduled to receive showers three (3) days a

F 312

F 312

Resident #2, 4, 6, 8, 10, 11 showers were not recorded in the Facility Care Tracker System it was not coded on the computer. The facility has daily shower sheets that have been completed by the CNA who administer the showers, they are kept in separate file. The Shower Sheets are forms that the CNA document their findings and give to nurse to sign off to assure showers have been give. However, upon further investigation by the facility the Paper Shower sheets were reviewed from last 6 months and revealed that resident had received

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F 312	Continued From page 10 week, either on Mondays, Wednesdays, and Fridays, or on Tuesdays, Thursdays, and Saturdays. Further interview revealed some residents refused showers, which would be indicated as such on the Activities of Daily Living (ADL) Detail report. Interview with the Executive Director, on 05/02/14 at 4:12 PM, revealed her expectation was for residents to receive three (3) baths or showers each week as scheduled. 1. Review of the clinical record revealed the facility admitted Resident #4 on 11/27/13, with diagnoses which included Urinary Incontinence, Diarrhea, Anxiety, and Depressive Disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/19/14, revealed the facility assessed Resident #4 to have a Brief Interview for Mental Status score of eight (8) of fifteen (15), which indicated the resident was moderately impaired in cognition. Further review of the MDS revealed the facility assessed Resident #4 to be totally dependent upon staff for bathing and to require extensive assistance with personal hygiene. Review of Resident #4's Activities of Daily Living (ADL) Detail report for the dates of 01/16/14 through 04/30/14 revealed no documented evidence the resident received three (3) showers a week as the DON had indicated were to have been scheduled. Continued review of the ADL Detail report revealed one (1) documented shower for Resident #4 during the time frame indicated, from 01/16/14 through 04/30/14. Further review of the ADL Detail report numerous documented "partial" baths during this period of time.	F 312	their shower and was recorded on the shower sheets, but was not properly documented in the Facility Computer System, Care Tracker. The paper shower sheets also revealed that on occasion some of the above Resident had refused a shower. Staffing is staggered during meal times. At no time is just one person available on the units. At any time there is also a Nurse and Unit Manager. The Group Assignment Sheets reflect this information. The Shower Bathing Detail By Day Report was reviewed for last 30 days it did reflect some missed coding in the Facility Care Tracker Computer system.	

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2. Review of Resident #8's clinical record revealed the facility admitted the resident on 01/15/14, with diagnoses which included Anxiety, Depression, Neurogenic Bladder, and Chronic Airway Obstruction. Review of the Admission MDS dated 01/22/14, revealed the facility assessed Resident #8 to be totally dependent upon staff for bathing and to require extensive assistance for hygiene.

Review of Resident #8's ADL Detail report from 01/15/14 through 04/30/14 revealed Resident #8 no documented evidence Resident #8 received a shower three (3) times a week as the DON had indicated were to have been scheduled. Continued review of the ADL Detail report revealed two (2) weeks of three (3) showers were documented during the this period of time. Further review of the ADL Detail report revealed Resident #8 had only twenty-one (21) documented showers from 01/15/14 through 04/30/14.

3. Review of the clinical record revealed Resident #6 was admitted by the facility on 03/20/14, with diagnoses which included Anxiety, Chronic Obstructive Pulmonary Disease (COPD), and Chronic Back Pain.

Review of the Quarterly MDS Assessment dated 04/03/14, revealed the facility assessed Resident #6 to score a fifteen (15) of fifteen (15) on the BIMS, which indicated no cognitive impairment. Further review of the MDS revealed the resident was assessed to require extensive assistance of two (2) staff for hygiene and bathing. Review of the Comprehensive Care Plan dated 04/12/14, revealed Resident #6 required extensive

Shower boards have been updated to correspond with a more even assignment of showers. Will continue with Monday-Wednesday-Friday group and Tuesday-Thursday-Saturday Group. Showers are being divided between both day shift and evening shift with request of Resident preference in the assigned shower days and times. In review of recorded detail shower sheets were compared to missed entries into Caretracker detailed bathing report. There was some missed opportunities however the shower sheet were accounted for and the Resident did receive full bed bath, shower, or refused. The daily shower sheets will be collected for the day by the Night Shift Manager and reviewed

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GOLDEN LIVINGCENTER - VANCEBURG	58 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
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assistance of two (2) persons for mobility, transfers and ADLs.

Review of the ADL Detail report for the month of April 2014 revealed Resident #6 no documented evidence the resident received a shower three (3) times a week as indicated was to be scheduled by the DON from 04/12/14 through 04/23/14. Continued review of the ADL Detail report revealed Resident #6 did not receive a complete bed bath for the eleven (11) day period between 04/12/14 and 04/23/14.

Interview with Resident #6 on 05/02/14 at 3:35 PM, revealed he/she required the use of a mechanical lift for transferring in and out of the bed. The resident stated this caused several of his/her showers to be missed because it required two (2) people to perform the transfer, but there was often only one (1) aide on the hall where he/she resided.

Interview with CNA #9, on 05/01/14 at 11:15 AM, revealed she was not always able to get Resident #6 showered. She stated Resident #6 required a mechanical lift by two (2) staff for transfers. She stated she could not take the resident to the shower if there was not another CNA to help with the transfer. CNA #9 further stated there was often only one (1) CNA on the floor, especially when the second CNA was in the dining room to assist with meals.

4. Review of the clinical record revealed Resident #2 was admitted by the facility on 02/17/05, with diagnoses which included Psychosis, Dementia, and Congestive Heart Failure.

with the shower schedule Care Tracker compliance with the showers will be reviewed by the Night Manager to assure that showers were properly coded in the Care Tracker Computer system. The Group Assignment Sheet has been updated with appropriate Assignments to assure coverage on all units during meals times. Re-education on Group Assignment Sheet Changes to include Dining Room duty. Re-education on Shower Sheet completion, Re-education on Documentation in Care Tracker bathing type detailed report to reflect with every shower, bed bath, partial bed bath be appropriately recorded. Re-education on missed care tracker entry and late entry.

6/16/14

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F 312	Continued From page 13 Review of the Annual MDS Assessment dated 02/07/14 revealed the facility assessed Resident #2 to have a score of twelve (12) of fifteen (15) on the BIMS, which indicated moderate cognitive impairment. Continued review revealed Resident #2 required extensive assistance of two (2) staff for bathing. Review of the ADL Detail for January through April 2014 revealed no documented evidence Resident #2 received scheduled showers three (3) times a week as indicated by the DON. Continued review of the ADL Detail report revealed: one (1) shower provided the week of 01/05/14 through 01/11/14; one (1) shower provided the week of 02/09/14 through 02/15/14; and no documented evidence of a shower provided during the seven (7) day period between 04/16/14 and 04/23/14. Further review of the ADL Detail report revealed only "partial" bathing was provided as an alternative to a shower throughout these periods. Interview with Resident #2 on 04/30/14 at 10:30 PM, revealed the resident did not remember why the showers were not given but indicated he/she "missed them". Continued interview revealed Resident #2 always felt "clean and good" after a shower. The resident stated it was one of his/her favorite times of the week and he/she had looked forward to it. 5. Clinical record review revealed the facility admitted Resident #11 on 09/07/2000, with diagnoses which included Alzheimer's Disease, Osteoarthritis, Parkinson's Disease, and Congestive Heart Failure. Review of the Quarterly MDS Assessment dated 3/18/14, revealed Resident #11 scored a two (2) on the	F 312	The Facility will monitor compliance by having the Night Shift manager review all shower sheets and review coding for proper entry in the Care Tracker Computer system. If facility identifies missed opportunities the facility will track and trend for certain CNA missed coding entries, and a verbal-education will be completed by the Night Manager and/or designee. This will be a ongoing process. The DNS and ADNS, will receive daily reports from the Night unit manager regarding missed opportunities in the Care Tracker system, or refusal of showers, This will be reviewed in Enhanced Start Up with Interdisciplinary Team, and if further issues or missed opportunities occur this will be forwarded to QA/A committee. The facility will interview Resident with BIMS score of 9 or greater on weekly basis times four weeks to assure showers are being given, Then monthly times four weeks.	5/16/14

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BIMS, which indicated severe cognitive impairment. Continued review revealed the resident was assessed by the facility to require extensive assistance of two (2) people for hygiene and bathing.

Review of the ADL Detail for January 2014 revealed Resident #11 received only one (1) shower during each of the seven (7) day periods between 01/12/14 and 01/18/14, and 01/19/14 through 01/25/14. Review revealed no documented evidence of three (3) showers provided per week as indicated by the DON.

6. Clinical record review revealed Resident #10 was admitted by the facility on 04/29/11 with diagnoses which included Alzheimer's Disease, Anxiety, and Depression.

Review of the ADL Detail report for the month of April 2014 revealed no documented evidence Resident #10 received a shower for the twenty-one (21) day period from 04/10/14 through 04/30/14.

Interview with CNA #4, on 05/02/14 at 12:30 PM, revealed there had been days when aides were not able to complete resident showers due to "rushing around to get other things done". CNA #4 stated she could not be in the shower room with a resident if there were no other aides on the floor, such as during meal times. CNA #4 further stated she cared for several residents who had to be transferred with mechanical lifts, which required two staff to perform; however, there were not always two (2) staff available so residents had to wait. CNA #4 revealed the aides were expected to leave their unit and go looking for a second aide to help them with mechanical

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lifts; but, they were not allowed to take an aide out of the dining room. Continued interview revealed CNA #4 was not able to take her time providing care to residents, because there were so many things to do. CNA #4 stated she provided basic care but was not always able to give the scheduled showers to the residents.

Interview with CNA #7 on 05/02/14 at 12:57 PM, revealed she was able to get the residents up and dressed in the morning, but not showered. She explained there was not time to provide a shower early because residents went to the dining room to eat; and when residents returned from the dining room, the CNA had to go to the dining room to assist with the second dining.

Interview with CNA #8 on 05/02/14 at 1:08 PM, revealed there had been instances when residents were not provided their showers as scheduled due to all the other tasks the CNA was responsible for.

Interview with the Executive Director, on 05/02/14 at 4:12 PM, revealed she had not had complaints from residents or families related to not getting their showers. She stated the DON, Assistant Director of Nursing (ADON) and herself were available if staff required assistance. The ED stated she did not know what "partial" meant on the ADL Detail report in regards to bathing. She indicated she felt residents were getting their showers.

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F-353

In review of time records, the facility determined there were times when the facility had to use overtime for coverage. However, the facility did have a mandated coverage policy in place to assure that the nursing department did have appropriate staffing levels. Staffing is based on the number of residents in house each shift and adjusted as needed.
Resident #2, 4, 6, 8, 10, 11 showers were not recorded in the Facility Care Tracker System it was not coded on the computer. The facility has daily shower sheets that have been completed by the CNA who administer the showers, they are kept in separate file. The Shower Sheets are forms that the CNA document their findings and give to nurse to sign off to assure showers have been give.

F 353 SS=E 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS

F 353

The facility must have sufficient nursing staff to provide nursing and related services to attain or

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maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.

Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure sufficient nursing staff were provided for residents to ensure showers and toileting assistance was provided to maintain the residents' well-being as evidenced by interview with staff who indicated the facility was "short-staffed" at times, record review revealed four (4) residents did not receive showers as scheduled (Residents #4, #6, #8, and #10); and two (2) interviewable residents who experienced incontinent episodes while waiting on staff to respond to call lights (Residents #12 and #13). In addition, the facility failed to ensure

However, upon further investigation by the facility the Paper Shower sheets were reviewed from last 6 months and revealed that resident had received their shower and was recorded on the shower sheets, but was not properly documented in the Facility Computer System, Care Tracker. The paper shower sheets also revealed that on occasion some of the above Resident had refused a shower. Staffing is staggered during meal times. At no time is just one person available on the units. At any time there is also a Nurse and Unit Manager. The Group Assignment Sheets reflect this information.

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6/11/14

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F 353	Continued From page 17 medications were administered during the two (2) hour time period indicated by facility policy. The findings include: Interview with the Director of Nursing (DON) on 05/01/14 at 12:01 PM, revealed the facility utilized a formula for determining the number of staff to resident ratio and Certified Nursing Assistant (CNA) to resident ratio. Review of the facility's employees, "Punch Detail History" for the month of April 2014, revealed several dates were not provided which included the following dates: 04/02/14 through 04/03/14; 04/08/14 through 04/09/14; 04/12/14 through 04/13/14; 04/15/14 through 04/16/14; 04/18/14 through 04/22/14; and 04/23/14 through 04/24/14, a total of fifteen (15) days. Review of the Census and Condition (672) revealed the facility was at full capacity with ninety-four (94) residents during the survey. Based on the formula provided by the DON, compared to staff hours worked, the facility staffing for the month of April 2014 revealed the facility did not have the nurse to resident ratio on 04/26/14 through 04/27/14; and did not have the CNA to resident ratio on 04/01/14 through 04/02/14, 04/07/13 through 04/08/13, 04/09/13 through 04/10/13, 04/26/14 through 04/27/14, and 04/27/14 through 04/28/14. 1. Interview with the DON on 05/02/14 at 12:01 PM, revealed residents were scheduled showers three (3) days a week, either on Monday, Wednesday, and Friday, or on Tuesday, Thursday, and Saturday. The DON stated some residents refused showers, which would be	F 353	The Shower Bathing Detail By Day Report was reviewed for last 30 days it did reflect some missed coding in the Facility Care Tracker Computer system. Shower boards have been updated to correspond with a more even assignment of showers. Will continue with Monday-Wednesday-Friday group and Tuesday-Thursday-Saturday Group. Showers are being divided between both day shift and evening shift with request of Resident preference in the assigned shower days and times. In review of recorded detail shower sheets were compared to missed entries into Caretracker detailed bathing report. There was some missed opportunities however the shower sheet were accounted for and the Resident did receive full bed bath, shower, or refused. The daily shower sheets will be collected for the day by the Night Shift Manager and reviewed with the shower schedule Care Tracker compliance with	

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documented on the Activities of Daily Living (ADL) Detail report for each resident as a refusal.

Review of Resident #4's clinical record revealed the facility admitted the resident with diagnoses which included Urinary Incontinence, Diarrhea, Anxiety State Unspecified, and Depressive Disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/19/14, revealed the facility assessed Resident #4 as requiring extensive assistance for hygiene and to be totally dependent upon staff for bathing. Review of Resident #4's ADL Detail report from 01/16/14 through 04/30/14, revealed no documented evidence Resident #4 received three (3) showers per week as indicated by the DON. Continued review revealed Resident #4 had one (1) documented shower from 01/16/14 through 04/30/14.

Review of Resident #8's clinical record revealed the facility admitted the resident on 01/15/14, with diagnoses which included Neurogenic Bladder, and Chronic Airway Obstruction. Review of the Admission MDS dated 01/22/14, revealed the facility assessed Resident #8 as requiring extensive assistance for hygiene and totally dependent upon staff for bathing. Review of Resident #8's ADL Detail report from 01/15/14 through 04/30/14 revealed Resident #8 received twenty-one (21) showers during this period of time. However, there was no documented evidence Resident #8 received a shower three (3) times a week as indicated by the DON as there were only two (2) weeks of three (3) showers documented as performed during this time period.

Review of Resident #10's clinical record revealed

the showers will be reviewed by the Night Manager to assure that showers were properly coded in the Care Tracker Computer system. The Group Assignment Sheet has been updated with appropriate Assignments to assure coverage on all units during meals times. Re-education on Group Assignment Sheet Changes to include Dining Room duty. Re-education on Shower Sheet completion, Re-education on Documentation in Care Tracker bathing type

detailed report to reflect with every shower, bed bath, partial bed bath be appropriately recorded. Re-education on missed care tracker entry and late entry.

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F 353	Continued From page 19	F 353	The facility is completing the following task to assure appropriate staffing levels. The schedule is completed for a six week rotation. Paid time off (PTO) will be granted for employees requesting 30 days in advance so scheduled coverage can be utilized by part-time or as needed staff. If staff is unavailable, called off, or on leave of absence- coverage will be utilized by part time staff or volunteer. If no volunteer is available, the facility is utilizing the Dot and Star program to replace employees. (The Dot and Star is pre-determined on the schedule to inform staff they may be required to work an extra shift). Staff assignment will be completed by the 300 wing nurse daily. The 300 wing nurse will be responsible for unit assignments and to assist with coverage for call offs. If coverage cannot be obtained	

the facility admitted the resident on 04/29/11, with diagnoses which included Alzheimer's Disease, Anxiety, and Depression. Review of the ADL Detail report for the month of April 2014 revealed Resident #10 did not receive a shower for a twenty-one (21) day period from 04/10/14 through 04/30/14.

Review of Resident #6 's clinical record revealed the facility admitted the resident on 03/20/14, with diagnoses which included Anxiety, Chronic Obstructive Pulmonary Disease (COPD), and Chronic Back Pain. Review of the Quarterly MDS Assessment dated 04/03/14, revealed Resident #6 scored a fifteen (15) of fifteen (15) Brief Interview for Mental Status (BIMS), which indicated no cognitive impairment. Further review of the MDS revealed the resident was assessed to require the extensive assistance of two (2) staff for hygiene and bathing. Review of the ADL Detail report for the month of April 2014, revealed Resident #6 did not receive a shower for an eleven (11) day period from 04/12/14 through 04/23/14.

Interview with Resident #6 on 05/02/14 at 3:35 PM, revealed the resident required use of a mechanical lift for transfers. Resident #6 stated this caused him/her to miss several showers as it required two (2) people to transfer him/her; however, there was often only one (1) aide on the hall where Resident #6 resided.

Interview with CNA #4 on 05/02/14 at 12:30 PM, revealed there had been days when CNAs were not able to get to residents' showers due to "rushing around to get other things done". CNA #4 stated she could not be in the shower room with a resident, when no other CNAs were on the

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floor, such as during meal times. CNA #4 reported she cared for several residents who required mechanical lifts to be transferred and this took two (2) staff to perform. She stated if there were not two (2) CNAs to use the lift, the facility expected the CNA requiring assistance to leave their unit and try to find another CNA to help them. However, CNA #4 stated they were not allowed to take other CNAs from the dining room if it was during meals.

Interview with CNA #9 on 05/01/14 at 11:15, AM revealed it was hard to get residents' showers done, because there were at least five (5) mechanical lift residents on her hall and lots of times there was no other CNA available to provide assistance.

Interview with CNA #7 on 05/02/14 at 12:57 PM revealed, she is unable to get showers done due to lack of staff.

Interview with CNA #6 on 05/01/14 at 1:25 PM revealed, she is unable to complete tasks or give showers. CNA #6 revealed, there is not enough staff to meet the residents needs.

2. Review of Resident #12's clinical record revealed the facility admitted the resident on 12/24/13, with diagnoses which included Right Below the Knee Amputation (BKA), Chronic Respiratory Failure, and Obesity. Review of Resident #12's Quarterly Minimum Data Set (MDS) Assessment, dated 04/02/14, revealed the facility assessed the resident to have a BIMS score of fifteen (15) which indicated no cognitive impairment. Continued review of the MDS revealed the facility assessed Resident #12 to be continent of bowel and bladder, and to require

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implementation of the Dot and Star will be utilized. The DNS, ADNS, ED will be notified. The ED, DNS and ADNS will review staffing in morning stand up meeting to assure appropriate staffing for the next 24 hour period. In the morning stand up meeting, the ED, DNS and ADNS will review daily census and any planned admissions or discharges and staffing

will be planned accordingly. The morning stand up meeting on Friday will also include weekend review of staffing. The staffing logs will be posted in the front hallway daily.

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extensive assist of one (1) staff for transfers and toileting.

Interview with Resident #12, on 05/01/14 at 7:45 PM, revealed "four or five days ago" he/she rang the call light at approximately 5:30 PM to request assistance with applying his/her prosthetic leg in order to go to the bathroom. According to Resident #12, staff did not come and he/she was unable to wait and "wet the bed" (was incontinent of urine) because of this. Resident #12 stated this made him/her "feel awful". Resident #12 stated a CNA had told him/her she was unable to stop passing trays to take him/her to the bathroom.

Review of Resident #13's clinical record revealed the facility admitted the resident on 07/11/13, with diagnoses which included Difficulty Walking, Muscle Weakness, and Joint Pain. Review of the Quarterly MDS Assessment, dated 04/12/14, revealed the facility assessed Resident #13 to have a BIMS score of fifteen (15) which indicated the resident was cognitively intact. Further review of the MDS revealed the facility assessed Resident #13 to always be continent of bowel and bladder, and to require limited assist of one (1) person for toileting.

Interview with Resident #13 on 05/01/14 at 8:00 AM, revealed "about a month or two (2) ago" he/she had been incontinent of urine at approximately 2:00 AM, while waiting for staff to answer his/her call light. Resident #13 stated this had embarrassed him/her; however he/she could not hold his/her urine as it had taken so long for staff to come. Resident #13 reported the CNA told him/her she could not answer his/her call light as she had been washing wheelchairs.

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The Facility will monitor compliance by having the Night Shift manager review all shower sheets and review coding for proper entry in the Care Tracker Computer system. If facility identifies missed opportunities the facility will track and trend for certain CNA missed coding entries, and a verbal-education will be completed by the Night Manager and/or designee. This will be a ongoing process. The DNS and ADNS, will receive daily reports from the Night unit manager regarding missed opportunities in the Care Tracker system, or refusal of showers, This will be reviewed in Enhanced Start Up with Interdisciplinary Team, and if further issues or missed opportunities occur this will be forwarded to QA/A committee. The facility will interview Resident with BIMS score of 9 or greater on weekly basis times four weeks to assure showers are being

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	185238	A. BUILDING _____ B. WING _____	05/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - VANCEBURG	58 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 353	Continued From page 22	F 353		

According to Resident #13, third shift only had one (1) CNA on duty on the unit for resident care and to answer call lights.

Interview with CNA #9, on 05/02/14 at 11:15 AM, revealed the dining schedule allowed for only one (1) CNA on the floor during meal service, which made it difficult to get the residents' call lights answered timely. CNA #9 indicated therefore residents sometimes were incontinent before staff could answer the call light.

Interview with CNA #4 on 05/02/14 at 12:30 PM, revealed she was unable to get residents' call lights answered in time to toilet them and this resulted in the residents' being incontinent. According to CNA #4, on second shift there was only one (1) CNA left on to feed residents in their rooms and answer call lights during meal times. CNA #4 stated there was a second CNA assigned to the dining room to assist with feeding. CNA #4 reported she felt if another CNA was on the floor during meals it could prevent residents from having incontinent episodes.

Interview with CNA #7 on 05/02/14 at 12:57 PM, revealed there have been residents who have wet on themselves, because staff was unable to answer the call light timely.

Interview with CNA #6 on 05/01/14 at 1:25 PM, revealed she was aware residents sometimes were "wet" on themselves while waiting for their call light to be answered and she knew their call lights were not always answered timely by staff. CNA #6 stated the facility was "short-staffed", which made it difficult to meet residents' needs in a timely manner. Additional interview with CNA #6 on 05/02/14 at 1:25 PM, revealed during

given, Then monthly times four weeks. Medication pass will be monitored 3x/weekly for 4 weeks to assure medication are administered timely by DNS/ADNS/RNAC. Then weekly times 4 weeks by the DNS/ADNS/RNAC. Any further issues will be addressed in QA-A.

The ED, DNS, ADNS and/or 300 unit nurse will monitor staffing daily and any further issues will be reviewed in Quality Assurance Committee monthly. Staff work sheet will be completed daily by the 300 wing nurse with per patient day posted in front lobby. Weekly medication audit on compliance will be conducted by the Unit Supervisor and any further issues will be forwarded to DNS/ADNS and further issues and actions plans will be addressed in QA-A

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meals she was not able to answer call lights as she had to pass residents' trays on the floor and feed the residents requiring assistance. CNA #6 stated another CNA was in the dining room feeding residents there during the meal service. According to CNA #6, the facility's dining schedule left only one (1) CNA on the floor during the evening meal to pass trays on the floor, feed residents and answer call lights.

Interview with CNA #5 on 05/01/14 at 11:10 PM, revealed she recalled one (1) resident was incontinent of urine because the CNA was unable to answer the light in time. CNA #5 stated third shift was "short-staffed", with only one (1) CNA on duty for the unit to provide resident care and answer call lights.

Interview with Registered Nurse (RN) #4, on 05/02/14 at 4:04 PM, revealed she felt there would be less residents with incontinent episodes if the facility was staffed appropriately to meet the residents' needs.

3. Review of the facility's policy titled, "Medication Administration", revision date June 2005 revealed Medications were to be administered one (1) hour before or one (1) hour after the scheduled time. Continued review of the policy revealed medication orders related to before, after, and during meals, were to be administered as ordered. Further review of the policy revealed unless otherwise specified by the Physician, routine medications were administered according to the established medication administration schedule for the facility.

Interview with RN #4 on 05/01/14 at 4:04 PM, revealed residents' "routine" medications were

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	185238	A. BUILDING _____ B. WING _____	05/02/2014

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late sometimes. She indicated this was due to not having enough nurses some days even though "corporate" said the facility was "staffed appropriately". She stated she ensured pain medication and residents with scheduled appointments took priority when she passed medications.

Interview on 05/02/14 at 12:24 PM with RN #7 revealed when there were three (3) nurses scheduled to do medication pass it usually took two and a half (2 ½) to three (3) hours to get the morning medication pass completed. She stated if there four (4) nurses scheduled it usually took one and a half (1 ½) to two (2) hours to complete the morning medication pass. RN #7 stated "when we have four (4) nurses I have time to complete my duties". She stated however, when there were only three (3) nurses it was harder to get her duties performed. RN #7 indicated it also depended on how much care her residents required, as she had one (1) resident who had a tracheostomy (trach), gastrostomy tube (g-tube) and a decubitus ulcer and he/she required "a lot of care".

Interview on 05/02/14 at 11:55 AM with LPN # 2, revealed when there were three (3) nurses present to pass medications it usually took about two and a half (2 ½) to three (3) hours to complete. She stated when four (4) nurses were present it usually only took about one and a half (1 ½) hours. She stated "some days" were "super busy" and she needed "some help".

Interview on 05/02/14 at 1:05 PM with RN #8, revealed when there were three (3) nurses present to do medication pass it usually took about two and a half (2 ½) to three (3) hours to

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	185238	A. BUILDING _____ B. WING _____	05/02/2014

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complete the morning medication pass. RN #8 stated if there were four (4) nurses present the medication pass could be completed in less than two (2) hours. She stated sometimes when there were only three (3) nurses it was harder to get everything done, but when there were four (4) nurses, it was "much better". RN #8 stated she did not have as much time to spend with her residents as she used to have. According to RN #8, it was harder for the nurses to help the CNAs, because now they had to spend so much of their time on the medication passes.

Interview with RN #9 on 05/02/14 at 11:30 AM, revealed when there were four (4) nurses on the floor it usually took one and a half (1 ½) hour to two (2) hours to pass the morning medications. She stated if there were only three (3) nurses it could take up to two and a half (2 1/2) to three (3) hours to pass the medications.

Interview with the DON on 05/01/14 at 5:00 PM, revealed that it was her expectation for all the nursing staff administering medication to perform this as ordered within the one (1) hour before and after the dose was scheduled as per the policy. She stated she would look into the situation regarding the longer medication pass times with three (3) nurses in comparison to four (4) nurses.

Interview with the Executive Director (ED) on 05/01/14 at 11:15 AM, revealed there was no way for the facility to print out the exact times medications were administered. Additional interview on 05/02/14 at 4:12 PM, with the ED revealed her expectation was for medications to be administered within an hour of the scheduled times. The ED stated she was not aware of any times the facility had fallen outside the guidelines

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	185238	A. BUILDING _____ B. WING _____	05/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 353	Continued From page 26 for medication administration. According to the ED, nurses could ask for help from the Unit Manager (UM) or Director of Nursing (DON) if necessary.	F 353		

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

PRINTED: 05/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185238	A. BUILDING 01 - MAIN B. WING	04/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - VANCEBURG	58 EASTHAM STREET VANCEBURG, KY 41179

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Survey under: NFPA 101 (2000 Edition) Plan approval: 1978 Facility type: SNF/NF Type of structure: One (1) story, Type III (unprotected) Smoke Compartment: Five (5) Fire Alarm: Complete fire alarm with smoke detectors installed in corridor, heat detectorsin mechanical rooms, laundry, kitchen, and sprinkler riser room. Upgraded 05/21/08. Sprinkler System: Complete sprinkler system (dry). Upgraded in 2006 with new main control valve and in 2008 with new dry valve. Generator: Type 2 generator powered by diesel installed May 2011. A Standard Life Safety Code Survey (using 2786S) was conducted on 04/30/14. The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was ninety-two (92). The facility is licensed for ninety-four (94) beds.	K 000		

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MAY 23 2014
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: LNHA — (X6) DATE: 5-26-2014 — 5/19/14

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.