

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

PRINTED: 04/29/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/15/2010
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206	
(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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted 04/13/10 through 04/15/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. A complaint investigation was initiated 04/13/10 and concluded on 04/15/10 investigating KY00014561 and KY00014682. KY00014561 and KY00014682 were substantiated and deficiencies were cited.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to ensure their policy on abuse prevention was operationalized. The facility failed to protect a resident from further abuse and failed to report timely an allegation of abuse for one (1) resident (#8) of the twenty-two (22) sampled residents. The findings include: Record review for Resident #8 revealed an admission date of 04/26/10 with diagnoses of Malignant Neoplasm of the Bladder, Chronic Psychotic Dementia and Depression. The facility assessed the resident on the Quarterly MDS	F 226	F226 Develop/Implement Abuse/Neglect Policies 1. CNA # 5,6,,and LPN # 5 were retrained on Abuse/Neglect Policy and Procedures on 3-6-10 by the Director of Nursing Services. Staff have received additional education related to the Abuse/Neglect protocols 3-30-10 by Day shift supervisor. 2. All residents have potential to be affected. 3. Weekly meetings with supervisors to be completed by the DNS/ADNS to ensure understanding of the Abuse /Neglect policy and procedure. Any concerns, possible training needs of staff will be discussed with additional training provided as indicated. 4 .DNS, ADNS, DCE and unit managers will randomly question staff on their awareness and knowledge of Neglect and Abuse Policy weekly. Training will be provided to individuals as needs are identified by the nursing management team listed above. ED/DNS monitor results and report to QA & A monthly to identify trends/concerns, f/u with further training as indicated. Compliance Date of 5-30	5-30-10

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

TITLE

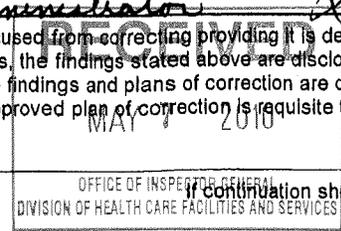
(X8) DATE

Mary J. Cavanaugh

Administrator

5-7-10

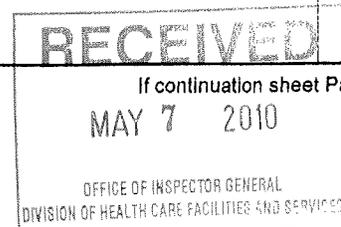
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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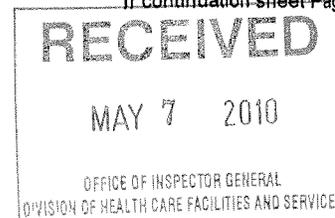
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F 226	<p>Continued From page 1 dated 03/11/10 as confused and poor decision making abilities.</p> <p>Review of the facility's investigation revealed CNA #6 witnessed physical abuse towards Resident #8 by CNA #5 on 03/04/10 when CNA #5 hit Resident #6 twice on the back of the head. CNA #6 finished the shift and did not report the incident even though CNA #5 was still in the building. CNA #6 reported to the facility charge nurse (LPN #5) on 03/05/10 at the end of the shift even though CNA #5 worked the entire shift. In addition, LPN #5 waited until the night shift nurse arrived before reporting the allegation and failed to protect Resident #8 from further abuse by allowing CNA #5 to remain on the floor to care for other residents. The night shift nurse reported immediately to the Assistant Director of Nursing; however, this was not reported to the Director of Nursing until 03/06/10.</p> <p>Review of the facility's faxed information to the state agency revealed it was received on 03/09/10.</p> <p>Attempted interview with CNA #6 on 04/14/10 at 11:20am revealed the contact phone number provided by the facility was not available and a message could not be left.</p> <p>Attempted interview with LPN #5 on 04/14/10 revealed the LPN was away on vacation.</p> <p>Interview with the Director of Nursing on 04/15/10 at 3:00pm revealed her contact number was provided incorrectly and the staff were unable to reach her until 03/06/10. An investigation was started and then reported as the facility had 24 hours to report the incident to the state agency.</p>	F 226	<p style="text-align: right;">5.30.10</p>



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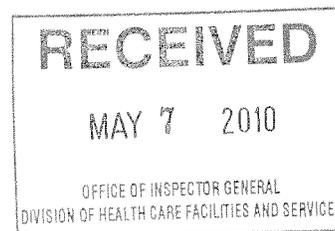
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F 226	Continued From page 2 Interview with the Executive Director on 04/15/10 at 4:10pm revealed reporting was not done timely. CNA #6 was afraid to report it, and afraid of retaliation by the other CNA. CNA #6 reported it to the first person she felt comfortable with. The nursing staff should have reported it immediately. The supervisor should have called the ED directly and sent the CNA #5 home. The Executive Director did not know why the system broke down. Review of the facility's policy Investigation and Reporting of Alleged Violations of Federal and State Laws InvolvingAbuse dated 07/01/08 revealedany employee who suspects an alleged violation shall immediately notify the Executive Director of the facility or the designee. In the event an alleged violation occurs when neither of these people is in the facility, the charge nurse is responsible for initiating the investigation procedure. If the suspected perpetrator is an employee, the ED shall place the employee on immediate investigatory suspension.	F 226		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to	F 252	F252 Safe/Clean/ Comfortable /Home like environment. 1. No specific resident identified. No actual harm occurred. Resident bathrooms on east and west halls were deep cleaned by housekeeping staff and will be on weekly deep cleaning schedule. All other bathrooms will be cleaned per the deep cleaning schedule. 2. All residents have potential to be affected. 3. Housekeeping supervisor will in-service housekeeping staff on importance of reporting lingering odors and problem areas. Houskeeping staff will be inserviced on the deep cleaning protocol. Housekeeping staff will have bathrooms cleaned on a	5.30.10



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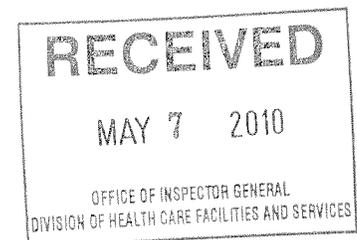
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F 252	<p>Continued From page 3</p> <p>assure a clean and homelike environment by preventing odors of urine from residents' bathrooms on the east and west hallways.</p> <p>The findings include:</p> <p>Observation of the east and west hallways on 04/13/10 at 8:30am revealed during the initial tour a strong urine odor was noted coming from resident bathrooms on each hallway. Urine smells coming from the floors in bathrooms were also detected. Observation on the east and west hallways on 04/14/10 at 8:00am revealed strong urine smells coming from resident bathrooms on the east and west halls and could also be smelled in hallways.</p> <p>Interview on 04/14/10 at 4:10pm with the Housekeeping Manager revealed that urine smells on the east and west halls were present. She stated "possible urine smells coming from the tiles on the floor and around the base board." She stated there was a schedule they go by to deep clean rooms monthly.</p> <p>Interview on 04/14/10 at 2:45pm with the District Manager of Housekeeping revealed that urine smells on the east and west halls were present. He stated possible scrubbing of the tiles would remove the smell.</p> <p>Interview on 04/15/10 at 2:45pm with the District Manager of Housekeeping revealed that he personally scrubbed the bathroom floors with a scrub brush and cleaner.</p> <p>Record Review of the Policy for the Deep Clean Room Schedule dated 01/01/00 revealed removal of all build up from the floor, around the bowl,</p>	F 252	<p>weekly deep cleaning schedule to include hand scrubbing all bathroom floors with brush and soft scrub. Old caulking will be removed from around commodes and replaced. Problem bathrooms will be cleaned weekly and as needed.</p> <p>4. Housekeeping manager will monitor daily cleaning per a quality control inspection. The district manager will complete weekly visits to ensure all processes are completed. ED/designee will make weekly rounds to ensure schedules are followed and areas are clean and odor free. Results of inspection audits will be reported in monthly QAA meetings with additional plans developed as indicated.</p> <p>Compliance date by 5-30-10</p>	5-30-10



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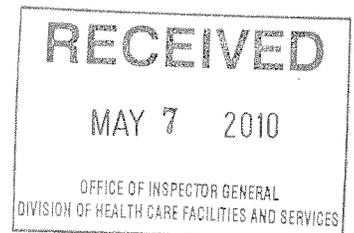
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F 252 F 253 SS=E	<p>Continued From page 4 door frame, corners, and edges were completed monthly.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interviews it was determined the facility failed to keep the East Hall Shower room free from pests. In addition, maintenance failed to keep heater doors in repair, tables on the North Hall Dining area from drooping in the middle, a window was not screened in the North Hall Dining, and a window free from cracks in the Ocean Breeze Day Room.</p> <p>The findings include:</p> <p>Observation on 04/13/10 of the East Hallway Shower revealed gnats flying around in the room and were found in the resident tub. Observation on 04/14/10 of the East Hall shower with the Maintenance Director revealed gnats were flying above the toilet and around the tub area.</p> <p>Interview on 04/15/10 at 9:45am with Maintenance Director revealed he was not aware there was a gnat issue on the East Hall in the shower room. Nursing staff did not voice any concerns. Nurses understand that issues and concerns are entered in the computer and if they do not know how then the Maintenance Director stated he would show them. He stated he looked at computer print-outs daily to assure items are</p>	F 252 F 253	<p>F253 Housekeeping and Maintenance Services.</p> <p>1. No specific resident identified. No actual harm occurred. East hall shower room was cleaned with a solution of EcoLab drain cleaner was applied to the drain. The maintenance director replaced the radiator doors in rms 116 and rms. 126. The three tables identified on the north wing dining area were checked and repaired the table surfaces. A replacement screen was special ordered and will be replaced by the maintenance director . The window in the day room on Ocean Breeze hall was replaced on 4-30-10.</p> <p>2. All residents have potential to be affected. All areas have potential to be affected. No harm occurred d/t above identified concerns.</p> <p>3. Monthly maintenance rounds to be completed by the Maintenance director and Executive director. Management staff to participate daily with non-clinical rounds. Areas of needed attention to be reported as identified with f/u monitored by the ED and maintenance director.. Drains to be included in daily inspections with treatments as</p>	5.30.10



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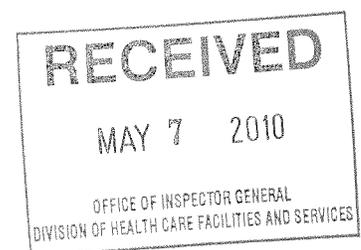
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F 253	Continued From page 5 taken care of. The pest control company comes the first Thursday of each month. Interview on 04/14/10 at 5:10pm with the Nursing Supervisor of the East Hall revealed that she was not aware there was a gnat issue in the East Hall bathroom. Interview on 04/15/10 at 1:55pm with the Housekeeper of the East Hall revealed she only observed one gnat in the bathroom and no one was notified of the gnat being in the bathroom. Upon going into the bathing areas with the housekeeper, multiple gnats were observed around the bottom of tub. The housekeeper verbalized she did not notice the gnats around the tub. The environmental tour on 04/14/10 revealed that room 116 and room 126 had broken front heater doors. In addition, the North Hall Dining area had three (3) tables which drooped in the middle. The North Hall Dining area, toward the right of the room, revealed no screen in the window and the Ocean Breeze Day Room window toward to back of room was cracked. Interview with the Maintenance Director on 02/15/10 at 9:45am revealed that the areas identified would be fixed.	F 253	needed. Monthly exterminator f/u will be completed. Staff to receive training of importance of timely pest reporting by the maintenance director. Staff to receive training. Findings of pests will be reported to the Executive Director and or designee per the maintenance log and/or building engines on the computer . The maintenance director will be notified of pest sightings per the maintenance log and/or building engines on the computer. 4.Results of maintenance and non clinical rounds will be collected and reported in the monthly QAA meeting. Any areas of concern will be addressed with follow-up as concerns identified. Compliance Date of 5-30-10.	5.30-10
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279	F279 Develop Comprehensive Care Plans 1. Resident # 11 was re-assessed with care the plan reviewed and updated as indicated. 2. All residents have the potential to be affected.	



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F 279	<p>Continued From page 6</p> <p>objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to review and revise the care plan for one (1) of twenty-two (22) sampled residents. Resident #11's care plan was not updated to reflect the physician order not to wear a shoe on the right foot only a slipper/sock.</p> <p>The findings include:</p> <p>Record review revealed Resident #11 was admitted with Peripheral Vascular Disease, Left Above the Knee Amputation and a Toe Amputation on the right foot. The resident was not to wear a shoe on his/her right foot, only a slipper or sock.</p> <p>Observation on 04/13/10 between 12:30pm and 3:15pm revealed Resident #11 wearing a tennis shoe on his/her right foot. Observation on 04/14/10 between 8:55am and 10:20am revealed</p>	F 279	<p>3. Nurses will receive additional instruction on the Care Plan updates to accurately reflect present condition and care needs by the Director of Nursing, DCE, MDS team. Resident care plans will be reviewed DNS, ADNS, IDT to ensure care plans reflect physician orders. Care plans will be reviewed by 5-30-10.</p> <p>4. Random care plan audits to be completed monthly by the DNS or designee. Physician orders, changes in resident status are to be reviewed each morning in enhanced stand up meeting. Results from audits are to be reviewed and discussed at monthly QA & A meeting.</p> <p>Completion date for all areas by 5-30-10</p> <p style="text-align: right;">5-30-10</p>



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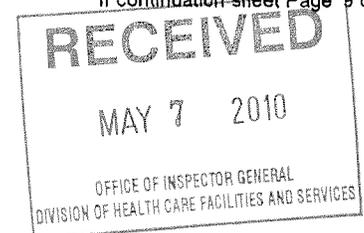
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F 279	Continued From page 7 the resident had a Kerlix wrap to the right foot. Record review revealed a physician order on 03/08/10 for no shoe on the right foot, only a slipper/sock. The care plan dated 02/10/10 did not include an update for the physician order. The resident had two (2) stasis ulcers on the right foot. One ulcer was scabbed over on the great toe measuring 0.2cm by 0.2cm and on the third toe eschar measuring 0.4cm by 0.4cm. Interview with the Minimum Data Set (MDS) Coordinator on 04/15/10 at 12:50pm revealed the care plan was not updated. She acknowledged the care plan did not state the resident was not to wear a shoe on the right foot only a slipper/sock. The MDS Coordinator stated it was everyone's responsibility to update the care plan when a new order is received. She acknowledged there was a risk for Resident #11 to wear a shoe on the right foot which could cause unwanted pressure on the foot and toes.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to follow the written care plans for two (2) out of the twenty-two (22) sampled residents (#5 and #16). Resident #16 was care planned for supervised smoking but was observed smoking	F 282	F 282 Services by qualified person persons /per Care Plan. 1. Res. #16 has been discharged from the center. Res. #5 has been reassessed for need for the assistive device to the wheel chair (foot rest). This has been discontinued per therapy recommendations. The care plans were updated to reflect this resident's current needs/interventions. . 2. All residents have the potential to be affected.	5. 30-10

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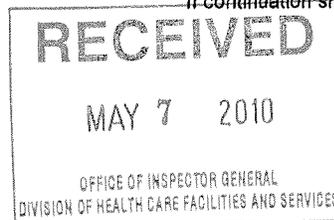
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F 282	<p>Continued From page 8</p> <p>unsupervised. Resident #5 was care planned to utilize an assistive device to the wheelchair foot rest, which was not observed to be in use.</p> <p>The findings include:</p> <p>1. Record review of Resident #16 on 04/14/10 at 4:00pm revealed the resident had been admitted to the facility on 12/30/05 with the diagnoses of Depressive Disorder, Stroke, Neurotic Disorders, Diabetes, Anemia, Respiratory Disease, Hypertension, Pain, Urinary Tract Infection, Osteomyelitis, Obesity and Pneumonia.</p> <p>Record review on 04/14/10 of Resident's #16's written Nursing Plan of Care dated 11/07/07 and updated on 12/05/09, 02/02/10, and 04/14/10 revealed the resident is on the supervised smoking list.</p> <p>Observation of Resident #16 on 04/13/10 at 12:10pm and on 04/14/10 at 4:00pm revealed the resident smoking outside in the smoking area, unsupervised. Interview with Resident #16 at that time revealed the resident stated he/she was allowed to smoke unsupervised.</p> <p>Interview with Social Worker #2 on 04/15/10 at 8:00am revealed that Resident #16 refused to sign a smoking contract with the facility, and continued to smoke unsupervised. She stated that she realized the facility is responsible to keep residents safe. The Social Worker further stated that someone from the outside keeps bringing in cigarettes and lighters for the resident to use.</p> <p>Interview with LPN #1 on 04/15/10 at 8:10am revealed the Resident was in his/her "right mind", and had a right to go outside by him/herself to</p>	F 282	<p>3. Resident #5: Nurses will receive additional instruction on care plan updates to accurately reflect actual condition and care needs and importance of following care plans as developed. Resident # 16. was discharged from the center. Staff will receive additional training as to the smoking protocol by the DCE.</p> <p>Nurses will receive additional instruction on the Care Plan updates to accurately reflect present condition and care needs by the Director of Nursing, DCE, MDS team. Resident care plans will be reviewed by DNS, ADNS, IDT to ensure care plans reflect physician orders. And compliance with care plan interventions. Care plans will be reviewed by 5-30-10</p> <p>4. Physician orders and changes in resident status to be reviewed daily at enhanced start up meeting by the DNS, ADNS, IDT members. . Care plans will be reviewed to ensure accurate reflection of resident care needs, interventions are being followed. Random care plan audits to be completed by DNS, ADNS, Restorative Nurse, and IDT daily.</p> <p>Compliance date of 5-30-10</p>	5.30.10



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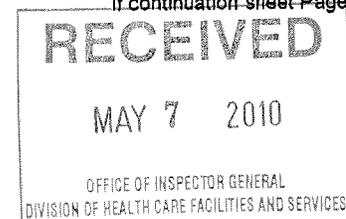
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/15/2010
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F 282	<p>Continued From page 9</p> <p>smoke, and did. The LPN stated the residents are not to keep their own smoking materials in their rooms.</p> <p>Interview with LPN #2 on 04/15/10 at 8:15am revealed that all residents should be supervised while smoking, including Resident # 6. This resident is non-compliant with our smoking rules, and goes outside to smoke unsupervised.</p> <p>Interview with Social Worker #2 on 04/15/10 at 2:00pm revealed the plan of care for the resident had not been changed in hopes that the family and the Resident would become compliant with the supervised smoking rules.</p> <p>2. Review of the medical record revealed Resident #5 was admitted on 02/01/06 with diagnoses that included; Seizure Disorder, Dementia with Behavior and Hypertension. Resident #5 has a history of contractures of the hands and feet. Resident #5 was ordered to have a positioning device on the right footrest to assist with aligning the right lower extremity in neutral while up in the wheelchair. Observations revealed the facility failed to provide the assistive device to the wheelchair. The medical record revealed that the facility failed to evaluate the results of the intervention and revise the interventions as necessary for Resident #5.</p> <p>Observation of Resident #5 on 04/13/10 at 3:25pm, on 04/14/10 at 12:00pm, and 04/14/10 at 5:00pm revealed no positioning device to the right footrest of the resident's wheelchair. While up in the wheelchair, Resident #5 crossed the right leg over the left leg, and kept it in that position most of the time. The resident did propel them self in the wheelchair by rolling the wheels.</p>	F 282	5.30.10



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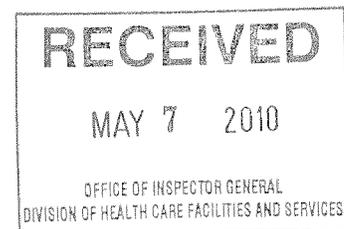
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F 282	<p>Continued From page 10</p> <p>Review of the medical record revealed that the positioning device to the right footrest of Resident #5's wheelchair had been implemented on 02/08/06. Resident #5 had a decline in mobility and weight loss that triggered a Significant Change Minimum Data Set (MDS) that was completed on 03/31/10. The MDS revealed the resident used the wheelchair for the primary mode of transportation. The Resident Assessment Protocol Summary (RAPS) completed on 03/31/10 for activities of Daily Living (ADL) functional rehabilitation potential revealed Resident #5 was receiving restorative services that included orders for a positioning device on the right footrest while up in the wheelchair. The Comprehensive Care Plan for Resident #5 dated 03/26/10 revealed an intervention to have a positioning device on the right footrest to assist with aligning the right lower extremity in neutral while up in the wheelchair.</p> <p>Interview with Certified Nursing Assistant (CNA) #2 on 04/13/10 at 3:25pm revealed she had not seen a positioning device to Resident #5's right footrest since she has been employed which is about two (2) months.</p> <p>Interview with CNA #4 on 04/14/10 at 12:10pm revealed she had not seen a positioning device to Resident #5's right footrest since she has worked at the facility. CNA #4 stated she has worked at the facility for about one year.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 04/15/10 at 3:40pm revealed she reviewed the monthly Physician orders, and treatment orders for the main hallway. She stated that the floor nurses are suppose to check if the resident is</p>	F 282		5.30.10



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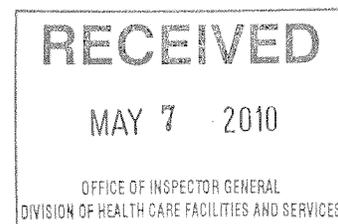
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F 282	Continued From page 11 using assistive devices and if not they are suppose to notify the Physician or Nurse Practitioner to get it discontinued. Interview with LPN #4 on 04/15/10 at 3:45pm revealed that Resident #5 had not used the positioning device lately, but did not know how long it had been. Review of the Medication Administration Record for Resident #5 with LPN #4 revealed no one had signed off on the positioning device. LPN stated it's not an as needed order and that Resident #5 should have had it on, or we should have left a note for the Physician to discontinue the order. An interview with the Restorative Nurse on 04/15/10 at 3:30pm revealed she is responsible for the restorative care plan. She stated because there was a Physician's order for the positioning device, it was added to the Care Plan. The Restorative Nurse continued to say she was not aware the resident had a positioning device to the right footrest of the wheelchair. She continued to state that the Floor Nurses are to ensure accuracy of the Physician Orders. The facility policy for Care Plans effective 05/01 states the interdisciplinary care plan is reviewed, revised, and updated quarterly and more frequently if warranted by a change in the resident's condition.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309	F309 Provide Care/Services for Highest Well Being. 1. Res. #5 was identified with no actual harm. Res.#5 was reassessed by nursing and therapy, the adaptive device was discontinued on 4-15-10, care plan updated to reflect res. current status. 2. All residents have the potential to be affected. 3. 3. Resident #5: nurses will receive additional instruction by the DCE, DNS, ADNS on care plan updates to accurately reflect actual condition and care needs and importance of following care plans as developed. 4. Physician orders and changes in resident status to be reviewed daily at Clinical IDT	5.30.10



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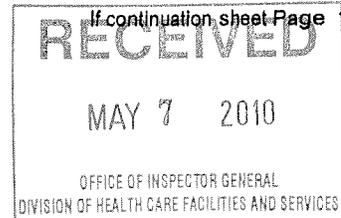
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F 309	<p>Continued From page 12 and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide necessary care and services to attain or maintain the highest practicable physical well-being for one (1) of twenty-two (22) residents sampled. Resident #5 was ordered to have a positioning device on the right footrest to assist with aligning the right lower extremity in neutral while up in the wheelchair. Observations revealed the facility failed to provide the assistive device to the wheelchair. The medical record revealed that the facility failed to evaluate the results of the intervention and revise the interventions as necessary for Resident #5.</p> <p>The Findings include:</p> <p>The facility policy for Care Plans effective 05/01 states the interdisciplinary care plan is reviewed, revised, and updated quarterly and more frequently if warranted by a change in the resident's condition.</p> <p>Observation of Resident #5 on 04/13/10 at 3:25pm, on 04/14/10 at 12:00pm, and 04/14/10 at 5:00pm revealed no positioning device to the right footrest of the resident's wheelchair. While up in the wheelchair, Resident #5 crossed the right leg over the left leg, and kept it in that position most of the time. The resident did propel them self in the wheelchair by rolling the wheels.</p> <p>Review of the medical record revealed that the</p>	F 309	<p>start up meeting. Care plans will be reviewed to ensure accurate reflection of resident care needs, interventions are being followed. Random care plan audits to be completed by DNS, ADNS, Restorative Nurse, and IDT daily in Extended morning start-up. Audit results will be reviewed monthly by the QAA committee for additional training needs.</p> <p>Compliance date of 5-30-10</p>	5.30.10



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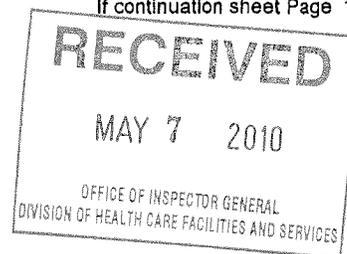
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F 309	<p>Continued From page 13</p> <p>positioning device to the right footrest of Resident #5's wheelchair had been implemented on 02/08/06. Resident #5 had a decline in mobility and weight loss that triggered a Significant Change Minimum Data Set (MDS) that was completed on 03/31/10. The MDS revealed the resident used the wheelchair for the primary mode of transportation. The Resident Assessment Protocol Summary (RAPS) completed on 03/31/10 for activities of Daily Living (ADL) functional rehabilitation potential revealed Resident #5 was receiving restorative services that included orders for a positioning device on the right footrest while up in the wheelchair. The Comprehensive Care Plan for Resident #5 dated 03/26/10 revealed an intervention to have a positioning device on the right footrest to assist with aligning the right lower extremity in neutral while up in the wheelchair.</p> <p>Interview with Certified Nursing Assistant (CNA) #2 on 04/13/10 at 3:25pm revealed she had not seen a positioning device to Resident #5's right footrest since she has been employed which is about two (2) months.</p> <p>Interview with CNA #4 on 04/14/10 at 12:10pm revealed she had not seen a positioning device to Resident #5's right footrest since she has worked at the facility. CNA #4 stated she has worked at the facility for about one year.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 04/15/10 at 3:40pm revealed she reviewed the monthly physician orders, and treatment orders for the main hallway. She stated that the floor nurses are suppose to check if the resident is using assistive devices and if not they are suppose to notify the Physician or Nurse</p>	F 309		5.30.10



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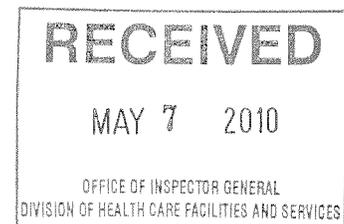
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F 309	Continued From page 14 Practitioner to get it discontinued. Interview with LPN #4 on 04/15/10 at 3:45pm revealed that Resident #5 had not used the positioning device lately, but did not know how long it had been. Review of the Medication Administration Record for Resident #5 with LPN #4 revealed no one had signed off on the positioning device. The LPN stated it's not an as needed order and that Resident #5 should have had it on, or a note should have been left for the Physician to discontinue the order. An interview with the Restorative Nurse on 04/15/10 at 3:30pm revealed she is responsible for the restorative care plan. She stated because there was a Physician's order for the positioning device, it was added to the Care Plan. The Restorative Nurse continued to say she was not aware the resident had a positioning device to the right footrest of the wheelchair. She continued to state that the Floor Nurses are to ensure accuracy of the Physician Orders.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to	F 323	F323 Free of accident hazards/supervision/devices. 1. Resident # 16 has been discharged from the center 2. All residents have potential to be affected. 3. Staff will receive additional instruction on the Facility's Smoking Policy and procedure .	5-30-10



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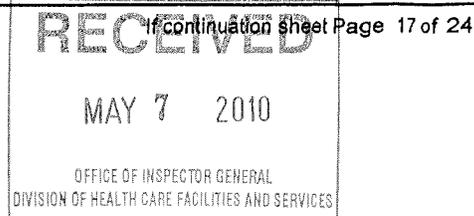
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F 323	<p>Continued From page 15</p> <p>ensure that one (1) out of the twenty-two (22) sampled residents (#16) received adequate supervision during smoking.</p> <p>The findings include:</p> <p>Record review of Resident #16 on 04/14/10 at 4:00pm revealed the resident had been admitted to the facility on 12/30/05 with the diagnoses of Depressive Disorder, Stroke, Neurotic Disorders, Diabetes, Anemia, Respiratory Disease, Hypertension, Pain, Urinary Tract Infection, Osteomyelitis, Obesity and Pneumonia.</p> <p>Record review on 04/14/10 of the facility Smoking Policy revealed all cigarettes will be kept at the nurses' station and in the activities office. No resident is allowed to have a lighter or cigarettes on them at any time. Smoking times will be supervised by a staff member. Family members or friends are not allowed to give residents cigarettes or lighters. Cigarettes and lighters must be turned into the main nurse's station, the activities office or the social services personnel. Non compliance of the rules will be addressed by the Executive Director and Social Services Personnel, and could result in discharge from the facility.</p> <p>Continued record review on 04/15/10 of the Resident's Smoking Safety Assessment dated 12/01/08 revealed Resident #16 required supervised smoking.</p> <p>Observation of Resident #16 on 04/13/10 at 12:10pm and on 04/14/10 at 4:00pm revealed the resident smoking outside in the smoking area, unsupervised. Interview with Resident #16 at that time revealed the resident stated that he/she was</p>	F 323	<p>4. Residents who smoke, family members, significant others will receive additional information by social services related to the center's smoking policy and importance of ensuring smoking residents are compliant with policy to ensure the safety and well-being of all residents and staff members. Resident smokers/families/significant others will receive this additional instruction/information by 5-30-10. Additionally, staff have been inserviced: "In the event of seeing a non compliant resident smoking without supervision, they are to stay with the resident until resident finishes smoking and/or remove smoking materials from the resident's possession and report to Social Worker or designee who will follow up with resident/family.</p> <p>Compliance Date of 5-30-10</p>	5.30.10



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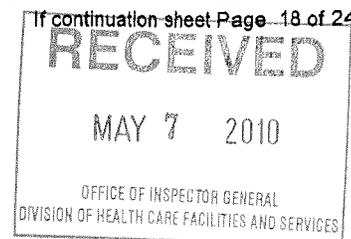
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F 323	<p>Continued From page 16 allowed to smoke unsupervised.</p> <p>Record Review on 04/15/10 at 11:00am of Resident #16's MDS dated 12/18/08, 03/06/09, 05/29/09, 08/20/09, 11/11/09, and 02/05/10 revealed the resident was assessed cognitively by the facility as making poor decisions with cues and supervision required.</p> <p>Interview with Social Worker #2 on 04/15/10 at 8:00am revealed that Resident #16 refused to sign a smoking contract with the facility, and continued to smoke unsupervised. She stated that she realized the facility is responsible to keep residents safe. The Social Worker further stated that someone from the outside kept bringing in cigarettes and lighters to the resident.</p> <p>Interview on 04/15/10 at 8:50am with the Facility Administrator revealed that Resident #16 was non-compliant with the smoking rules. She acknowledged the facility was responsible to keep the resident and the other residents safe.</p> <p>Interview with LPN #1 on 04/15/10 at 8:10am revealed that Resident #16 is in his/her "right mind", and had a right to go outside by him/herself to smoke, and did. She stated that the residents are not to keep their own smoking materials in their rooms.</p> <p>Interview with LPN #2 on 04/15/10 at 8:15am revealed that all residents should be supervised while smoking, including Resident #16. The LPN state the resident was non-compliant with the facility's smoking rules, and goes outside to smoke unsupervised.</p> <p>Interview with CNA #1 on 04/15/10 at 12:30pm</p>	F 323		5.20.10



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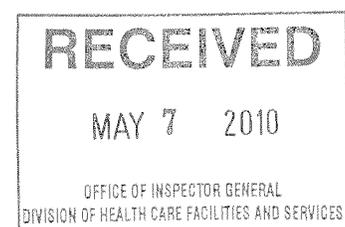
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F 323	Continued From page 17 revealed that Resident #16 always wants to go outside and smoke. The resident has his/her own cigarettes, probably from the family bringing them in. She continued to state that she had seen the resident in the smoking area, smoking, unsupervised. Interview with CNA #3 on 04/15/10 at 12:45pm revealed that Resident #16 basically smoked when he/she wanted to smoke, regardless of the rules for supervised smoking. Interview with Social Worker #2 at 9:00am on 04/15/10 revealed the resident's Power of Attorney (POA) had been called, and had retrieved a pack of cigarettes and a lighter from the resident's room	F 323			
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to store and prepare food under sanitary conditions as evidenced by bags and containers of frozen food opened and not properly labeled with the date and time. Also a bag of food and eggs were observed stored on	F 371	F371 Food Procure, Store/Prepare/Serve-Sanitary. 1. No actual harm to residents, no specific resident identified. The bags and containers of food opened and not properly labeled and dated were disposed of immediately. Stock on floor was placed in storage timely. Staff was re-educated on hand washing and temperature checks per facility policy by the dietary manager on 4-29-10. 2. All residents have the potential to be affected.	5/30/10	



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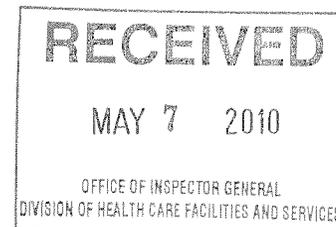
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/15/2010
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206	
(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 371	<p>Continued From page 18</p> <p>the freezer floor and kitchen floor. Kitchen staff were observed to go from clean to dirty items without proper hand sanitization, and prepared residents' food without obtaining proper temperature checks.</p> <p>The findings include:</p> <p>1. Observation of the facility's walk-in freezer on 04/13/10 at 8:05am revealed three (3) boxes of whole eggs stored on the kitchen floor.</p> <p>Interview on 04/13/10 at 8:05am with the chef revealed the eggs had been delivered about an hour and a half earlier, and that the stock usually sat on the floor until the kitchen staff had time to put it away. Continued interview on 04/15/10 at 2:30pm revealed that food should not sit on the floor because the floor is the dirtiest part of the building, and that the elderly residents had weak immune systems, and could become ill from contaminated foods that had been stored on the floor.</p> <p>Interview on 04/13/10 at 8:45am with the Dietary Director revealed that delivered foods usually did sit on the floor after delivery until the staff could put the items away. Continued interview on 04/15/10 at 3:00pm revealed a system needed to be put in place to keep the food from sitting on the floor, the floor is dirty.</p> <p>2. Observation of the facility's kitchen freezer on 04/13/10 at 8:05am revealed one (1) opened bag of frozen chicken patties, one (1) opened bag of beef crumbles containing ice crystals, one (1) opened pie crust containing ice crystals, one (1) opened box of freezer burned biscuits, and one (1) bag of corn open to air that had been</p>	F 371	<p>3. The supervisor closing check list was updated by the dietary manager to include freezer checks. Receiving and storing procedures will be followed per facility policy.</p> <p>All dietary staff was re-educated on hand-washing, and documentation of food temperatures by the dietary manager on 4-29-10.</p> <p>4. The ED and DSM will complete a weekly dietary audit and checklist for compliance. The closing supervisor will complete a closing checklist. DSM or designee will complete a daily start up checklist to ensure compliance. All checklists and audits will be reviewed for trends and compliance and reviewed in monthly QAA. All concerns will be reviewed with action plans developed as indicated.</p> <p>Compliance Date of 5-30-10</p>	5-30-10



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F 371	<p>Continued From page 19</p> <p>previously opened and not labeled with a date and time. Continued observation revealed one (1) bag of frozen cauliflower lying on the freezer floor. The Chef was noted to pick the package up and place it back onto the freezer shelf with the other frozen foods.</p> <p>Interview with the Chef on 04/13/10 at 8:10am and on 04/15/10 at 2:30pm revealed that he does not normally place food bags which had been on the floor back on the shelf. He continued to state that opened foods need to be dated because it helps the staff know when to properly rotate foods. Freezer burned foods are contaminated with bacteria which may cause an illness.</p> <p>3. Observation of the facility kitchen on 04/13/10 at 11:45am revealed a dietary assistant placing cookies onto plates with her bare hands. Observation of the same dietary worker on 04/14/10 at 12:30pm revealed the worker in the process of using her bare hands to put a piece of spaghetti back onto a resident's plate.</p> <p>Observation on 04/14/10 at 12:30pm revealed a dietary worker in the process of serving parmesan cheese onto a resident's plate using a contaminated serving spoon that she picked up out of a tub of parmesan with her bare hands.</p> <p>Interview with the Dietary Assistant on 04/15/10 at 1:30pm revealed gloves should always be worn and changed when dirty items are touched. She stated she had been in-serviced on Infection Control Issues frequently throughout the year, and that she knew better than to touch the cookies or spaghetti with her bare hands. Contaminated food should be thrown away because it can cause a resident to become sick.</p>	F 371	5.30.10



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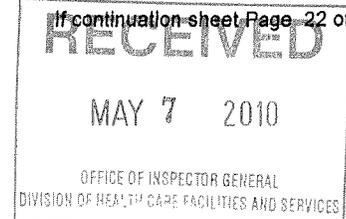
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F 371	Continued From page 20 4. Observation of the food line on 04/13/10 at 12:15pm revealed a gravy spoon had fallen into a bowl of turkey gravy, handle first. The Cook had been observed serving the gravy with her bare hands touching the ladle handle. Interview with the Cook on 04/15/10 at 1:35pm revealed that she should have taken the gravy off the tray line because it had become contaminated, and could harm the Residents. 5. Observation of the tray line on 04/13/10 at 12:20pm revealed the cook in the process of placing turkey gravy onto a resident's plate that had not had the temperature obtained. Interview with the Cook on 04/15/10 at 1:35pm revealed that food temperatures were supposed to be checked prior to serving foods to make sure they were not in the danger zone, or it could make a resident very sick. She continued to state she knew better, but felt rushed. Record review on 04/15/10 at 4:00pm of the Facility Infection Control Guidelines state staff should wash hands before and after procedures, wear sterile or clean gloves when appropriate. Observe standard precautions or other infection control standards as approved by the appropriate facility committee, medical director, or procedure.	F 371		
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 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431	F 431 Drug records, label/store drugs and bio-chemicals 1. No specific resident identified. No actual harm occurred. All expired drugs and bio-chemicals were properly disposed of on 4-14-10. 2. All residents have potential to be affected.	5.30.10



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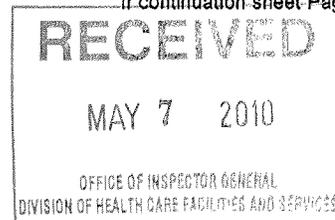
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F 431	<p>Continued From page 21</p> <p>records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted 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 and interview, it was determined the facility failed to ensure expired drugs and biologicals were not accessible to staff. The facility had twenty-two (22) vials of expired Pneumovax in the medication refrigerator on the Annex unit and seventy-one (71) expired lab tubes in a drawer at the East/West/Main nurse station. Both the lab tubes and the Pneumovax</p>	F 431	<p>3. Nurses will receive instruction on procedure by DCE for expired drug and bio-chemical disposal. DNS or designee to do weekly cart/medication room audits in addition to the nightly audits completed by night shift supervisor.</p> <p>4. All audit results will be reviewed monthly by the QAA committee with additional plans developed as indicated by audit results.</p> <p>Compliance Date of 5-30-10</p>	5.30-10



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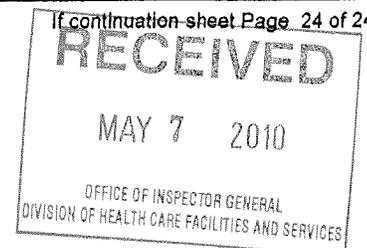
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F 431	<p>Continued From page 22 were accessible to staff.</p> <p>The findings include:</p> <p>Observation on 04/14/10 at 11:30am revealed, there were expired lab tubes in a drawer stack on the counter top in the medication room. Seventy-one (71) lab tubes revealed expiration dates between 12/2009 through 02/2010.</p> <p>Observation on 04/14/10 at 11:00am revealed, there were twenty-two (22) expired Pneumovax vials in the refrigerator on the Annex unit. The expiration date was 03/03/10.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 04/14/10 at 11:30am revealed Med-Lab brings their own lab tubes for blood draws.</p> <p>Interview with LPN #2 on 04/14/10 at 12:30pm revealed Med-Lab supplies their own lab tubes for routine and emergency blood draws. Occasionally the facility nurse has to draw blood and use the facility lab tubes.</p> <p>Interview with the Director of Nursing (DON) on 04/15/10 at 9:20am revealed the night shift nurse should pull expired lab tubes. Occasionally the nurses are required to draw blood and use a facility lab tube. She acknowledged that using expired lab tubes could cause inaccurate results and the potential for a second blood draw.</p> <p>Interview with LPN #2 on 04/15/10 at 9:20am revealed the night shift nurse is responsible for checking for expired medications. She further stated Pharmacy checked for expired medications.</p>	F 431		5.30-10



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F 431	Continued From page 23 Interview with the DON on 04/15/10 at 9:20am revealed the nurse should check the expiration date prior to giving a medication. She was unsure who was responsible for disposing of expired medications. Interview with the Pharmacist on 04/15/10 at 9:45am revealed the Pharmacy does not check the refrigerators or medication carts for expired medications. The Pharmacist stated it is the nurses' responsibility to remove expired medications.	F 431	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or an agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the Quality of Care and to comply with all applicable State and Federal regulatory requirements. Date of Compliance: May 30, 2010 <i>Mary Jo Cavanaugh</i> Mary Jo Cavanaugh Administrator/Executive Director Date: May 7, 2010	5.30.10



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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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K 062	Continued From page 1 Reference to: NFPA 25 1999 Edition 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	<p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or an agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the Quality of Care and to comply with all applicable State and Federal regulatory requirements.</p> <p>Date of Compliance: June 10, 2010</p> <p><i>Mary Jo Cavanaugh</i> Mary Jo Cavanaugh Administrator/Executive Director Date: May 7, 2010</p>	6-6-10
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