

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

PRINTED: 10/21/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2010
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207	
(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 A standard survey was conducted 08/30/10 through 09/02/10 and a Life Safety Code survey was 09/02/10. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 253 SS=D	An abbreviated survey investigating KY00014625 was initiated on 08/30/10 and concluded on 09/02/10. KY00014625 was unsubstantiated. 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined the facility failed to ensure three (3) pieces of equipment maintained by the Therapy Department had current inspections. The findings include: Observation in the Therapy Department on 09/01/10 at 11:00am revealed two (2) Nerve Stimulators and one (1) Auto-therm 390 had no inspection documentation or tags. A Pressure Vest had an inspection sticker with the date of 07/29/10 Record review on 09/01/10 at 12:10pm revealed that Medical Equipment Services, Inc. did not	F 253	F 253 Housekeeping & Maintenance Services 1. No specific Resident identified 2. All residents have the potential to be affected 3. Facility had all therapy equipment check and calibration on 9-09-10 4. Facility will monitor Therapy equipment calibration by having Maintenance Director or designee keep tickler file on equipment and services needed. Issue will be addressed and followed with during QA monthly Completion Date: 10-01-2010	

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

TITLE

(X6) DATE

X Joshua E. Schumler

X Executive Director

11/2/10

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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F 253	Continued From page 1 have the Nerve Stimulator, Auto-therm Vest, or the Pressure Vest listed on the safety check and calibration form for an inspection conducted on 02/17/10.	F 253		
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure trash containers for refuse had lids. Bags of trash with exposed used disposable briefs were on the ground next to and under the dumpster. The findings include: Observations on 09/01/10 at 10:00am revealed three (3) rubber trash containers with bags of trash in two (2) of the containers that did not have lids on them and were in the trash dumpster area. There was also a bag of trash with exposed disposable briefs partially under the dumpster. Interview with the Director of Maintenance on 09/01/10 at 15:15am revealed trash is picked up two (2) times a week. The rubber trash containers were for yard waste. The Director confirmed that it was dietary waste in the cans.	F 372	F 372 Dispose Garbage & Refuse Properly 1. No specific Resident identified 2. All residents have the potential to be affected 3. Facility has removed the 3 rubber trash cans. All trash has been disposed properly Facility will contact Waste Management for evaluation of new dumpster or recommendations. 4. Facility will monitor all affected areas by completing room rounds. All issues will be reported to building engines that will be checked daily All issues and progress will be reported in the morning meetings. Completion Date. 10-1-2010	

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F 463 SS=D	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined the facility failed to have an emergency call system in two (2) bathrooms used by residents. One bathroom was located on the locked unit in the kitchen and the other was located in the Therapy Department.</p> <p>The findings include:</p> <p>Observations on 08/31/10 at 9:15am revealed a resident bathroom on the locked unit with an emergency call pull cord on the wall outside of the bathroom, but no pull cord in the bathroom.</p> <p>Interview with Licensed Practical Nurse (LPN) #7 on 09/01/10 at 9:30am revealed she was aware of an emergency call light not being present in the resident bathroom. She stated residents are never left alone in the bathroom because a staff member stays with them. She further confirmed the possibility of a resident entering the bathroom alone without a staff member.</p> <p>Interview with the Director of Maintenance on 09/01/10 at 11:30am revealed he/she was not aware there was no emergency call light inside the bathroom on the locked unit.</p> <p>Observations on 09/01/10 at 11:00am revealed</p>	F 463	<p>F 463 Resident Call System-Rooms/Toilet/Bath</p> <ol style="list-style-type: none"> 1. No specific Resident identified 2. All residents have the potential to be affected 3. Call lights have been installed in Alzheimer's care bathroom and in Therapy gym restroom. 4. Call light was installed 9-2-10 in Alzheimer's care bathroom and 9-16-10 installation was completed in the Therapy gym restroom. <p>Completion Date, 10-1-10</p>	

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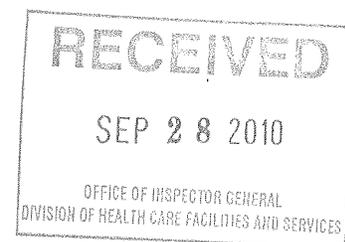
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F 463	Continued From page 3 there was no emergency call system available in the resident bathroom in the Therapy Department. The bathroom located in the Occupational Therapy area of the therapy department is utilized by ambulatory and non-ambulatory residents. An interview on 09/01/10 at 11:50am with the Director of Maintenance revealed he/she was unaware there was no emergency call system in the resident bathroom in the Therapy department.	F 463			

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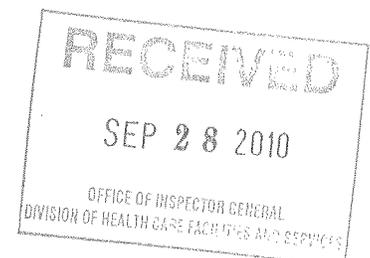
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F 156	Continued From page 4 Medicare Part A on 06/09/10; however, the notice was not provided to the resident until 06/14/10. Interview with the Billing Manager on 09/01/10 at 2:00pm revealed the notice provided to Resident #15 should have been a technical demand. The Admission Coordinator completes the demand bill notice and did not know the difference between a technical or coverage demand. Social Services completes the notice when removed from Part A when the resident no longer requires Part A. The Billing Manager never sees the denials or does anything with them, they go to corporate office. Technically this should not have been a demand bill.	F 156		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined the facility failed to ensure three (3) pieces of equipment maintained by the Therapy Department had current inspections. The findings include: Observation in the Therapy Department on 09/01/10 at 11:00am revealed two (2) Nerve Stimulators and one (1) Auto-therm 390 had no inspection documentation or tags. A Pressure Vest had an inspection sticker with the date of 07/29/10.	F 253	F 253 Housekeeping & Maintenance Services 1. No specific Resident identified 2. All residents have the potential to be affected 3. Facility had all therapy equipment check and calibration on 9-09-10 4. Facility will monitor Therapy equipment calibration by having Maintenance Director or designee keep tickler file on equipment and services needed. Issue will be addressed and followed with during QA monthly. Completion Date: 10-01-2010	



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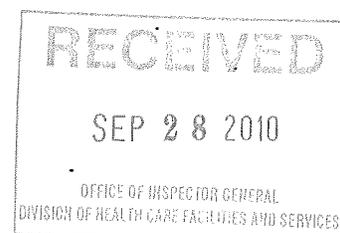
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F 253	Continued From page 5	F 253		
F 372 SS=D	<p>Record review on 09/01/10 at 12:10pm revealed that Medical Equipment Services, Inc. did not have the Nerve Stimulator, Auto-therm Vest, or the Pressure Vest listed on the safety check and calibration form for an inspection conducted on 02/17/10.</p> <p>An interview with the Director of Maintenance on 09/01/10 at 12:15pm revealed he/she had no records that the Nerve Stimulators, Auto-therm Vest, or Pressure Vest equipment had up to date safety checks.</p> <p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY</p> <p>The facility must dispose of garbage and refuse properly.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure trash containers for refuse had lids. Bags of trash with exposed used disposable briefs were on the ground next to and under the dumpster.</p> <p>The findings include: Observations on 09/01/10 at 10:00am revealed three (3) rubber trash containers with bags of trash in two (2) of the containers that did not have lids on them and were in the trash dumpster area. There was also a bag of trash with exposed disposable briefs partially under the dumpster.</p> <p>Interview with the Director of Maintenance on 09/01/10 at 15:15am revealed trash is picked up</p>	F 372	<p>F 372 Dispose Garbage & Refuse Properly</p> <ol style="list-style-type: none"> 1. No specific Resident identified 2. All residents have the potential to be affected 3. Facility has removed the 3 rubber trash cans. All trash has been disposed properly. Facility will contact Waste Management for evaluation of new dumpster or recommendations. 4. Facility Maintenance Director⁴ will monitor all affected areas by completing room rounds. All issues will be reported to building engines that will be checked daily. All issues and progress will be reported in the morning meetings. <p>Completion Date: 10-1-2010</p>	



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F 372	Continued From page 6	F 372		
F 463 SS=D	<p>two (2) times a week. The rubber trash containers were for yard waste. The Director confirmed that it was dietary waste in the cans.</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined the facility failed to have an emergency call system in two (2) bathrooms used by residents. One bathroom was located on the locked unit in the kitchen and the other was located in the Therapy Department.</p> <p>The findings include:</p> <p>Observations on 08/31/10 at 9:15am revealed a resident bathroom on the locked unit with an emergency call pull cord on the wall outside of the bathroom, but no pull cord in the bathroom.</p> <p>Interview with Licensed Practical Nurse (LPN) #7 on 09/01/10 at 9:30am revealed she was aware of an emergency call light not being present in the resident bathroom. She stated residents are never left alone in the bathroom because a staff member stays with them. She further confirmed the possibility of a resident entering the bathroom alone without a staff member.</p> <p>Interview with the Director of Maintenance on 09/01/10 at 11:30am revealed he/she was not</p>	F 463	<p>F 463 Resident Call System-Rooms/Toilet/Bath</p> <ol style="list-style-type: none"> 1. No specific Resident identified 2. All residents have the potential to be affected 3. Call lights have been installed in Alzheimer's care bathroom and in Therapy gym restroom. 4. Call light was installed 9-2-10 in Alzheimer's care bathroom and 9-16-10 installation was completed in the Therapy gym restroom. <p>Completion Date: 10-1-10</p>	



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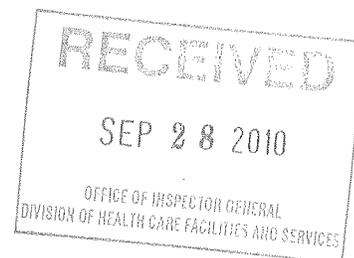
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F 463	<p>Continued From page 7</p> <p>aware there was no emergency call light inside the bathroom on the locked unit.</p> <p>Observations on 09/01/10 at 11:00am revealed there was no emergency call system available in the resident bathroom in the Therapy Department. The bathroom located in the Occupational Therapy area of the therapy department is utilized by ambulatory and non-ambulatory residents.</p> <p>An interview on 09/01/10 at 11:50am with the Director of Maintenance revealed he/she was unaware there was no emergency call system in the resident bathroom in the Therapy department.</p>	F 463		
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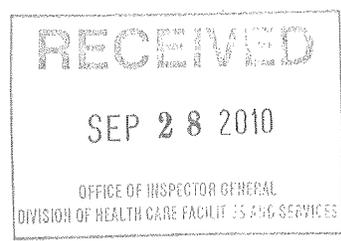
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 09/02/10. The facility was found to not meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was an "E".	K 000		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¼-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure smoke doors would resist the passage of smoke, according to NFPA standards. The findings include: Observation on 09/02/10 at 8:53am revealed the Blue Fire Zone smoke doors had a gap of approximately ¼ of an inch at the bottom of the doors when tested. The observation was confirmed with the Maintenance Director. Further interview revealed he tested the doors monthly but was unaware of the Blue Fire Zone smoke doors having a gap at the bottom of the doors.	K 027	K027 NFPA Life Safety Code Standard (Door openings in smoke barriers have at least a 20- minute fire protection rating or at least 13/4- inch thick solid bonded wood core). 1. No specific Resident identified 2. All residents have the potential to be affected 3. Facility will purchase strip to cover gap 1/4 in gap on fire doors. All other doors will be audited. 4. Facility Maintenance Director or designee will make sure all fire doors do not exceed the 1/4 inch gap by checking all fire door for gaps during monthly fire drills. All issues will be recorded in monthly fire drill report and tracked in QA. Completion Date: 10-01-2010	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>John Lee Schaefer</i>	TITLE <i>Executive Director</i>	(X6) DATE 9-24-10
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 027	Continued From page 1	K 027		
K 038 SS=D	<p>Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit doors, according to NFPA standards. Exit doors must be maintained to ensure residents, staff and visitors have a means to exit the building during an emergency.</p> <p>The findings include:</p> <p>Observation on 09/02/10 at 8:56am revealed the Red Fire Zone exit doors had the marking for delayed egress (Push until alarm sounds Door can be opened in 15 seconds) blocked by curtains on the door. Further observation revealed the same for the Blue Zone exit doors. The observations were confirmed with the Maintenance Director.</p>	K 038	<p>K 038 NPFA 101 Life Safety Code Standard (Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1 19.2.1)</p> <ol style="list-style-type: none"> 1. No specific Resident identified 2. All residents have the potential to be affected 3. Facility has removed curtains from all doors so that all signage on doors can be viewed by visitors, staff and residents. 4. Facility Maintenance Director or Designee will monitor this weekly during room and environment rounds. Maintenance Director or designee will track and trend in QA. <p>Completion Date: 10-01-2010</p>	

