

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100511	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/02/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - VANCEBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 58 EASTHAM STREET VANCEBURG, KY 41179
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(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) COMPLETE DATE
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N 000 INITIAL COMMENTS

A Relicensure Survey was initiated on 03/31/15 and concluded on 04/02/15 with deficient practice cited.

N 000

N 303 902 KAR 20:300-13(1) Section 13. Dental Services

The facility shall assist residents in obtaining routine and twenty-four (24) hour emergency dental care. The facility shall provide or obtain from an outside resource, in accordance with Section 15(6)(a) and (b) of this administrative regulation following dental services to meet the needs of each resident:
(1) Routine dental services; and

This requirement is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to ensure residents received routine dental services to meet the needs of each resident for eight (8) of nineteen (19) sampled residents, Residents #2, #3, #4, #5, #9, #10, #14, and #15.

The findings include:

1. Review of Resident #9's medical record revealed the facility admitted Resident #9 on 08/21/09 with diagnoses which included Acute Respiratory Failure, Obstructive Sleep Apnea, and History of Tobacco Use. The facility assessed Resident #9, in a Quarterly Minimum Data Set (MDS), dated 02/05/15 as requiring extensive assistance with hygiene. Review of Resident #9's care plan revealed the facility assessed Resident #9 as at risk for dental problems and requiring assistance for oral care. However, review of the record revealed no documented evidence Resident #9 had been

N 303

N 303
1.
Resident were asked if they would like to consult with dental services annually or as needed. Resident number 9, 10, 3, 14, 5 was asked if they would like to have a annual consult with the dentist, they all declined services. Resident number 2, 15, and 4 next of kin was contacted and they also declined services at this time. Resident 9, 10, 3, 14, and 5 was informed that annual dental services was offered and they would be assessed bi-annual for change in decision. Resident number 2, 15, and 4. Families was informed that resident would be

APR 22 2015

-Cont

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

TITLE

E. D.

(X8) DATE

5-22-15

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N 303	<p>Continued From page 1</p> <p>seen by or given the opportunity to be seen by a dentist in the previous year.</p> <p>2. Review of Resident #10's medical record revealed the facility admitted Resident #10 on 08/15/11 with diagnoses which included Senile Dementia Uncomplicated, Enlargement of Lymph Nodes, and Acute Pain. The facility assessed Resident #10, in a Quarterly MDS, dated 01/06/15, as requiring extensive assistance with hygiene. Review of Resident #10's care plan revealed the facility assessed Resident #10 as at risk for chewing difficulty related to partial or complete edentulism, and also documented on 06/20/12 the resident refused of dental consult. However, review of Resident #10's medical record revealed no documented evidence of any offered dental consult in the previous year.</p> <p>3. Review of Resident #3's medical record revealed the facility admitted Resident #3 on 02/19/14 with diagnoses which included Chronic Obstructive Pulmonary Disease, Generalized Pain, Depressive Disorder and Ill Defined Cerebrovascular Disease.</p> <p>The facility assessed Resident #3, in an Annual MDS Assessment, dated 01/16/2015, as being moderately impaired with a Brief Interview for Mental Status (BIMS) score of (8) eight, as being edentulous and needing extensive assist of (1) one staff member for oral hygiene.</p> <p>Review of Physician orders dated 06/04/14, revealed Resident #3 could see a Dentist.</p> <p>Review of Resident #3's Comprehensive Plan of Care dated 01/29/15, revealed Resident #3 needed assistance with oral care and dental exams as necessary; however, there was no</p>	N 303	<p>assessed bi-annual for need of dental exam or at any time they could also request services.</p> <p>2. All resident and or their family member will be contacted via mail by May 15, 2015 to receive or decline dental service with risk verses benefits explained by the DNS, ANDS, Unit Manager and or Admission Nurse. Resident will be assessed upon admission by the Admitting nurse and consent or refusal will be obtained within 7 working days for the need for dental services. Education and training was completed with admission nurse on May 15, 2015, Resident or family</p>	
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N 303	<p>Continued From page 2</p> <p>documented evidence Resident #3 had been seen by or offered the opportunity to be examined on an annual basis by a dentist.</p> <p>4. Review of Resident #14's medical record revealed the facility admitted Resident #14 on 01/16/2012 with diagnoses which included Hepatic Encephalopathy, Generalized Pain, Depressive Disorder, Dementia and Alzheimer's Disease.</p> <p>The facility assessed Resident #14, on a Quarterly MDS Assessment, dated 01/23/15, as being cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen(15), as being edentulous and needing extensive assist of (1) one staff member for oral hygiene.</p> <p>Review of Resident #14's Comprehensive Plan of Care dated 01/27/12, revealed Resident #14 needed assist with oral care and dental exams as necessary; however, there was no documented evidence Resident #14 had been seen by or offered the opportunity to be examined on an annual basis by a dentist.</p> <p>5. Review of Resident #2's medical record revealed the facility re-admitted Resident #2 on 02/02/11 with diagnoses which included Hypertension, Anemia, Osteoarthritis, Altered Mental Status, Hypothyroidism. The facility assessed Resident #2, in a Quarterly MDS, dated 12/1/15 with a BIMS score of five (5), indicating cognitive impairment and as being edentulous at time of assessment. Further review of the medical record revealed no documented evidence of the resident receiving dental services or being offered a dental consult in the previous year.</p>	N 303	<p>member will be ask to consent or decline dental services awaiting response from mail. Resident if alert and oriented will be asked if they wish to consult with dentist and bi-annual after admission by the Interdisciplinary Team (which includes DNS, ADNS, Unit Manager, RNAC, or Staff nurse.) by May 15, 2015. All residents in the facility with a BIMS of 8 or greater will be asked if they wish to consult with dental services. Will be completed by May 15,</p>	
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N 303	<p>Continued From page 3</p> <p>6. Record review for Resident #5 revealed the facility admitted Resident #5 on 02/25/14 with diagnoses of Atrial Fibrillation, Iron Deficiency Anemia, Generalized Pain, Urine Retention, Chronic Kidney Disease, Hypertension and Diabetes Mellitus. The facility assessed Resident #5, in a Quarterly MDS dated 12/27/14 with a BIMS of (10). Further review of the assessment revealed the Resident was edentulous at this time. Continued record review revealed no documented evidence of any dental exam since admission.</p> <p>7. Record review for Resident #15 revealed the facility admitted the resident on 05/19/11 with diagnoses of Alzheimer's Disease, Aphasia, Depressive Disorder, Anxiety, Hypertension and Psychosis. Resident #15 was severely impaired and required assistance with hygiene including oral care. Further record review revealed no documented evidence of any dental exam since admission.</p> <p>8. Review of Resident #4's medical record revealed the facility admitted Resident #4 on 07/19/12 with diagnoses which included Cerebrovascular Disease, Obstetrical Blood Clot Embolism, Dementia, Anxiety, Aphasia, Cerebral Edema. The facility assessed Resident #4, in a Significant Change MDS, dated 02/28/15 as being severely cognitively impaired, total assistance with ADLs and as being edentulous. Further review of the medical record revealed no documented evidence of any offered dental consult in the previous year.</p> <p>Interview with the Director of Nursing (DON), on 04/01/15 at 4:30 PM, revealed the facility had no written policy regarding dental exams, and revealed the facility did not do routine dental</p>	N 303	<p>2015 Those with BIMS below 8 the responsible party will be contacted via mail on May 15, 2015 to see if they wish their family member have dental consult. A return envelope was also included. Risk verses benefits explained. All Residents will be assessed by Interdisciplinary Team (DNS, ADNS, RNAC, Unit Manager or Admission nurse) on a bi-annual basis. Finding will be documented.</p> <p style="text-align: right;"><i>Continue</i></p>

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N 303	<p>Continued From page 4</p> <p>exams unless the saw a need for a dental exam.</p> <p>Interview with the facility Administrator, on 04/02/15 at 6:08 PM revealed the facility did not have a contract with a dentist, and she interpreted "routine dental services" to mean if any resident shows signs of having a dental problem.</p>	N 303	<p>call and schedule routine dental exams if the resident or responsible party/next of kin consents for treatment and exam. The ADNS/ DNS or designee will complete bi-annual audits to assure compliance. If any further issues regarding dental services is observed it will be forwarded to the QA_A committee for further opportunities or solutions.</p>	<p>May 16, 2015</p>

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

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OMB NO 0938-0391

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K 000 INITIAL COMMENTS K 000

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 story, Type III (unprotected)

Smoke Compartment: Five (5)

Fire Alarm: Complete fire alarm with smoke detectors installed in corridor, heat detectors in 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 a 2786S (Short Form) was conducted on 03/31/15. Golden Living Center Vanceburg was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was eighty nine (89). The facility is licensed for ninety four (94) beds.

The Highest Scope and Severity deficiency was

RECEIVED
 APR 22 2015
 86

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

[Signature] E. D. 5-22-15

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 000 Continued From page 1
"D" level.

K 000

K 029 NFFA 101 LIFE SAFETY CODE STANDARD SS=D
One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

K 029

K 029 SS=D
The Mechanical Room Door, door knob was replaced with a new door knob assembly as or April 1, 2015.

No resident was affected by this.

The facility will complete a total in-house audit of all door knobs to assure they are properly working this will be completed by the maintenance director on April 2, 2015 and will be audited every six months by the maintenance director. The staff will be re-educated on work orders if knobs is observed broken. In-service will be

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected according to National Fire Protection Association (NFFA). The deficiency had the potential to affect one (1) of five (5) smoke compartments, eight (8) residents, staff and visitors.

The findings included:

Observation on 03/31/15 at 12:51 PM, with the Maintenance Director, revealed the door leading into the Mechanical Room did not have automatic latching hardware. The door was kept closed with a dead bolt when staff was not using the room. Interview, with the Maintenance Director, revealed he thought the door was ok if staff locked the door when the room was unattended.

Continued

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K 029 Continued From page 2

The findings were acknowledged by the Administrator during the exit conference.

Reference: NFPA 101 (2000 Edition)

19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.

Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.

Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.

K 038 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1

K 029

completed by May 15, 2015. The work order will be placed in the facility internal system called Building Engines for maintenance to review and complete task. Any further issues will be address in the QA-A committee

May 16, 2015

K 038

K-038 SS=D

Maintenance has ordered new signage indicating proper

COH/MS/CP

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K 038 Continued From page 3

K 038

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors equipped with delayed egress hardware had signage that was readily visible, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, eight (8) residents, staff, and visitors.

background and color lettering. Was replace prior to completion of survey on 04-02-2015. All doors will be evaluated for proper signage and new signs to be displayed. To be completed by April 30, 2015.

The findings include:

Observation on 03/31/15 at 1:21 PM, with the Maintenance Director, reveled the exterior exit door for the Front Hall was equipped with delayed egress hardware and with red signage indicating the proper door operation. Further observation revealed the door was also red.
Interview on 03/31/15 at 1:21 PM, with the Maintenance Director, revealed the facility was unaware the signage did not meet Life Safety Code requirements.

The maintenance director will check doors 3x weekly for appropriate signage to assure the signage is still in place. If signage has removed it will be immediately replace.

The findings were confirmed with the Administrator during the exit conference on.

Reference: NFPA 101 (2000 Edition).

Any further issues or concerns will be addressed in QA-A.

7.2.1 6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.

5-1-15

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K 038 Continued From page 4 K 038

(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.

(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.

(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.

(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows:
PUSH UNTIL ALARM SOUNDS
DOOR CAN BE OPENED IN 15 SECONDS

7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows:
NO

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K 038 Continued From page 5
EXIT
Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.

K 038 K-064 SS=D

K 064 NFFA 101 LIFE SAFETY CODE STANDARD
SS=D
Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFFA 10

K 064
Maintenance contacted Ohio River Valley Fire Protection for update to Fire Extinguishers. A 5lb Fire Ext. Recharge/ six year was completed along with Hydrostatic test. This was completed April 21, 2015

This STANDARD is not met as evidenced by:
Based on observations and interview, it was determined the facility failed to ensure fire extinguishers were inspected according to National Fire Protection Association (NFFA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, eight (8) residents, staff, and visitors.

The maintained director will be monitoring the fire extinguish tags on monthly basis and

The findings include:

Observation on 03/31/15 at 12:56 PM, with the Maintenance Director, revealed the fire extinguisher near the Laundry Room did not have a verification of service collar indicating a hydrostatic test had been performed. The fire extinguisher had a manufacture date of 2008. Interview with the Maintenance Director revealed he was did not know why the fire extinguisher did not have a verification of service collar.

appropriate testing scheduled.

Observation on 03/31/15 at 1:01 PM, with the Maintenance Director, revealed the fire

Any further issues or concerns will be addressed in the QA-A meeting.

April 22 2015

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - VANCEBURG		STREET ADDRESS CITY STATE, ZIP CODE 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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extinguisher near the Rehabilitation Department did not have a verification of service collar indicating a hydrostatic test had been performed. The fire extinguisher had a manufacture date of 2007. Interview with the Maintenance Director revealed he was did not know why the fire extinguisher did not have a verification of service collar

The findings were acknowledged by the Administrator during the exit conference.

Reference: NFPA 10 (1998 Edition)

4-4.3* Six-Year Maintenance. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon closed recovery system. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall begin from that date.

Exception: Nonrechargeable fire extinguishers shall not be hydrostatically tested but shall be removed from service at a maximum interval of 12 years from the date of manufacture.

Nonrechargeable halon agent fire extinguishers shall be disposed of in accordance with 4-3.3.3.

4-4.4.1* Fire extinguishers that pass the applicable 6-year requirement of 4-4.3 shall have the maintenance information recorded on a suitable metallic label or equally durable material having a minimum size of 2 in. x 3 1/2 in (5.1 cm x 8.9 cm).

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

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The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self-destructive type when removal from a fire extinguisher is attempted. The label shall include the following information:

- (a) Month and year the maintenance was performed, indicated by a perforation such as is done by a hand punch
- (b) Name or initials of person performing the maintenance and name of agency performing the maintenance

4-4.4.2* Verification of Service (Maintenance or Recharging). Each extinguisher that has undergone maintenance that includes internal examination or that has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch.

Exception No. 1: Fire extinguishers undergoing maintenance before January 1, 1999.

Exception No. 2: Cartridge/cylinder-operated fire extinguishers do not require a "Verification of Service" collar.