

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

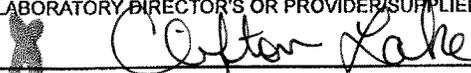
PRINTED: 04/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/11/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222
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F 000	INITIAL COMMENTS A recertification survey was initiated on 04/09/13 and concluded on 04/11/13 and a Life Safety Code survey was conducted on 04/09/13 with deficiencies cited at the highest scope and severity of an "E" level. The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition. An abbreviated survey, initiated on 04/09/13 and concluded on 04/11/13 to investigate KY 00020034. The Division of Health Care found the allegation unsubstantiated with no regulatory violation.	F 000	<u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or 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.</u>	
F 252 SS=D	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 the facility failed to provide a safe, clean, comfortable environment as evidenced by an odor of cigarette smoke from 04/09/13 to 04/11/13 in the hallways adjacent to the resident's designated indoor smoking room. Resident rooms were on this same hallway directly across from the smoking room. The findings include:	F 252	F 252 Safe/Clean/Comfortable/Homelike Environment This facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The designated smoking area inside the facility is being moved to the courtyard on the east wing on 5/08/13. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 5/8/13
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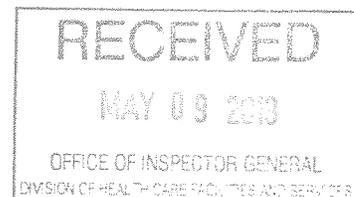
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

MAY 09 2013
OFFICE OF INSPECTION AND COMPLIANCE
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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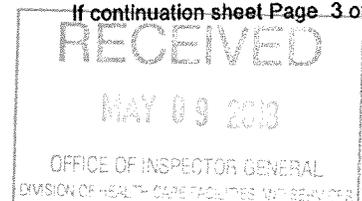
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F 252	<p>Continued From page 1</p> <p>Observation, on 04/09/13 at 8:30 AM during the initial tour, revealed cigarette smoke odor on the East Hallway between the resident's designated indoor smoking room and resident rooms 126, 127, and 128. The smoking room door was closed to the corridor, windows were open in the smoking room, and one (1) resident was smoking in the room.</p> <p>Observation, on 04/11/13 at 9:45 AM, revealed cigarette smoke odor in the hallway between the resident's designated indoor smoking room and resident rooms 126-128.</p> <p>Observation, on 04/11/13 at 11:20 AM, of the designated smoking room, revealed one open window with a screen that was not secured to the window sill allowing approximately a one (1) to two (2) inch opening to the outside.</p> <p>Interview, on 04/11/13 at 9:50 AM, with Unsampled Resident A who resided on the hall, revealed he/she did smell the cigarette smoke odor in his/her room and found it offensive. Resident A stated the smoking odor did go away temporarily when the housekeeping staff cleaned the smoking room. Resident A had recently reported the odor to a nurse on the unit.</p> <p>Record review of the facility's Deep Clean Schedule for April 2013, revealed the smoking room was scheduled for deep cleaning on 04/23/13.</p> <p>Interview, on 04/11/13 at 2:00 PM, with the Administrator revealed he was aware of the odor, had not received complaints from the residents, but a family member of a recently admitted</p>	F 252	<p>All residents have the potential to be affected. The designated smoking area inside the facility is being moved to the courtyard on the east wing on 5/08/13.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Smoking policy will be updated to reflect the change in the designated smoking area by 4/29/13. The Administrator (NHA) will train staff on the change in the designated smoking area by 5/07/13. A letter from the NHA is being sent to all residents POA's and families who smoke explaining the change in our smoking policy on 4/29/13. A meeting will be held with the NHA and the resident council and the residents who smoke (05/07/13) to explain the change. The new policy will be explained to new residents upon admission by the admission director or nursing house supervisor.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p>



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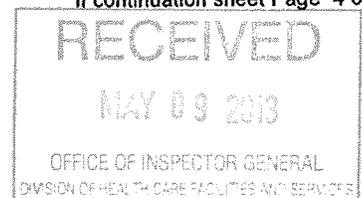
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F 252	Continued From page 2 resident had noticed the odor and requested the resident be admitted to a room on another hallway. The administrator stated it was the maintenance supervisor's responsibility to monitor the condition of the smoking room and secure the window screens whenever they were ajar. Interview, on 04/11/13 at 2:00 PM, with the Director of Maintenance, revealed the resident's designated smoking room was cleaned daily by housekeeping staff. Continued interview with the Administrator stated he made weekly rounds throughout the building to identify housekeeping and/or maintenance issues. He recorded the issues in a program titled Building Engines which also permitted him to track the timeliness of the necessary repairs. Within thirty (30) days the program issued an automatic alert if an issue was not resolved, and at that point the administrator stated he contacted maintenance or housekeeping personnel for an explanation as to why the issues were not resolved.	F 252	The east unit manager and the NHA will audit for smoking in designated area weekly for four weeks, then bi-weekly for four weeks, then monthly for four months with the results of the audit given to the NHA. The NHA will bring audit results to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule of additional audits if needed. Compliance Date: 05/08/13	5/8/13
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Care plan for resident #6 was revised 04/12/13 to include the diagnosis of leg fracture and osteoporosis. How will you identify other residents having the potential to be affected by	



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F 280	<p>Continued From page 3</p> <p>physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to revise the comprehensive care plan for one (1) of twenty-five (25) sampled residents and one (1) unsampled resident (Resident #6). The facility failed to address Resident #6's new diagnoses of a Fractured Leg and Osteoporosis on the care plan.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care Plans revealed the facility followed the Resident Assessment Instrument (RAI).</p> <p>Interview with the Director of Nursing, on 04/11/13 at 3:30 PM, revealed the RAI Manual was the facility's policy and care plans were revised when changes to the resident's care occurred.</p> <p>Review of the RAI Manual, Section 4.7, page 4-8, Care Planning revealed The care plan must be</p>	F 280	<p>the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice. The Inter Disciplinary Team (IDT) will review and revise, as needed, care plans to include resident diagnosis by 5/07/13.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>The Director of Nursing (DNS) will re-educate the nursing staff on updating care plans by 5/07/13. The DNS will re-educate the care plan team on updating care plans by 5/07/13. All staff training will be validated thru competency evaluations upon completion of the training. Anyone not passing the competency evaluations will complete the training again until they do understand the subject matter.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p>	



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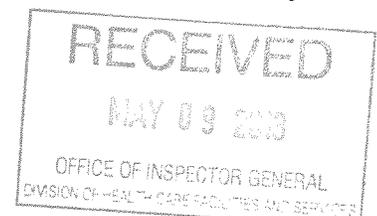
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F 280	<p>Continued From page 4</p> <p>reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. Page 4-12 #15, revealed the effectiveness of the care plan must be evaluated from its initiation and modified as necessary and #16 revealed changes to the care plan should occur as needed in accordance with professional standards or practice and documentation. The interdisciplinary team should communicate as needed about care plan changes.</p> <p>Observation of Resident #6, on 04/09/13 at 4:15 PM, revealed two (2) staff members repositioning Resident #6. The resident was pulled to the side of the bed with a sheet and turned to the side.</p> <p>Review of the clinical record for Resident #6 revealed the facility admitted the resident with diagnoses of Closed Head Trauma and Brain Injury and Vegetative State. The facility completed a Quarterly Minimum Data Set (MDS) assessment on the resident which revealed the resident required total assistance from staff and was severely impaired cognitively.</p> <p>Review of Nursing Notes, dated 01/26/13, revealed the resident's guardian reported signs of discomfort were present when the staff turned the resident. The resident's ankle was discolored and swollen. An X-Ray revealed the resident had a displaced fracture of the tibia. The extremity was casted until healed. Further testing revealed the resident had osteoporosis.</p> <p>Review of the Care Plan for Resident #6 revealed the fracture and the osteoporosis were not addressed and there were no interventions</p>	F 280	<p>The DNS or Assistant Director of Nursing (ADNS) will audit the care plans of 12 residents for diagnosis weekly for four weeks, then bi-weekly for four weeks, then monthly for four months. Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The DNS will bring audit results to the QAPI committee for two quarterly meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits.</p> <p>Compliance Date: 05/08/13</p>	5/8/13

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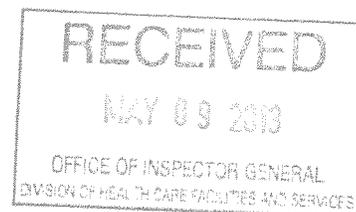
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F 280	Continued From page 5 implemented to ensure another fracture did not occur. Review of the Investigation regarding the fracture of Resident #6's leg revealed the facility was not able to identify the cause of the fracture. Interview with CNA #1, on 04/09/13 at 4:30 PM, revealed she knew the resident had a fractured leg; however, she was not aware of any precautions needed to prevent a future fracture related to osteoporosis. Interview with the Unit Manager, on 04/11/13 at 2:05 PM, revealed the nurses were responsible to update care plans when there were changes in a resident's care. She stated the care plan should have been updated; however, she was unable to locate the update.	F 280			
F 431 SS=E	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 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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.	F 431	F 431 Drug Records, Label/Store Drugs & Biological's This facility will store all resident medications safely, securely and properly, following the manufacturer's recommendations or those of the supplier. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The loose medications were removed on 04/11/13 from the four medication carts identified. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All medication carts have been checked and cleaned on 04/11/13. What measures will be put into place or what systemic changes you will		



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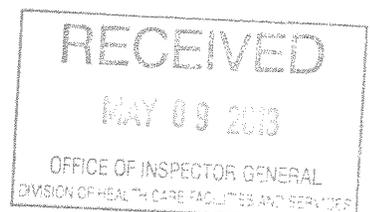
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F 431	<p>Continued From page 6</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the 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, interview, and review of the facility's policy, it was determined the facility failed to appropriately store resident medications in four (4) of the seven (7) facility medication carts. A total of seventy-six (76) pills were found lying on the bottom of the medication cart drawers, loose and not labeled to indicate the name, dosage, and to whom the medication belonged.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Storage of Medications, dated 05/2012, revealed all medications are stored safely, securely and properly, following the manufacturer's recommendations or those of the supplier. All medications dispensed by the pharmacy are</p>	F 431	<p>make to ensure that the deficient practice does not recur?</p> <p>The DNS will re-educate the staff nurses on the storage of medication policy by 5/07/13. All staff training will be validated thru competency evaluations upon completion of the training. Anyone not passing the competency evaluations will complete the training again until they do understand the subject matter. The nurses will check the medication carts each shift and remove loose medications. The medication carts will be cleaned weekly on third shift and any loose medications will be removed.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The Director of Clinical Education (DCE) will audit three medication carts for loose medications weekly for four weeks, then bi-weekly for four weeks, then monthly for four months. Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The DCE will bring audit results to the QAPI committee for two quarterly meetings.</p>		



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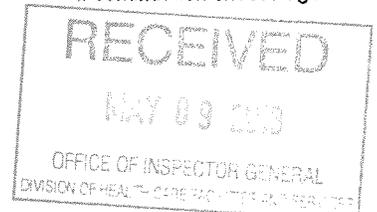
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F 431	<p>Continued From page 7</p> <p>stored in the container with the pharmacy label. Outdated, contaminated, deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, and disposed of according to procedures. Medication storage conditions are monitored on a monthly basis by the consultant pharmacist or pharmacy designee and corrective action taken if problems are identified.</p> <p>Observation of the West Unit medication cart, on 04/11/13 at 8:00 AM, revealed twenty-one (21) pills of various type lying loose on the bottom of the medication cart drawers.</p> <p>Interview with the West Unit Manager, on 04/11/13 at 8:00 AM, revealed she was also the floor nurse utilizing the medication cart. The West Unit Manager revealed the pills fall out of the bubble pack in which they are supplied, stating the bubble packs are easily compromised when the extra packs are stored in the cart. The West Unit Manager revealed cleaning of the medication carts was listed on the weekly cleaning schedule to be done on the night shift, every Saturday. The West Unit Manager stated she and all nurses were responsible to ensure the proper storage of medication and revealed she had not been monitoring for loose pills or compromised packaging. The West Unit Manager revealed a pharmacy representative had just inspected the carts on 04/10/13 and did not mention seeing the loose pills in the cart, but she was not aware if this was part of their inspection.</p> <p>Observation of the Alzheimer's Care Unit</p>	F 431	<p>The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits.</p> <p>Compliance Date: 05/08/13</p>	5/8/13



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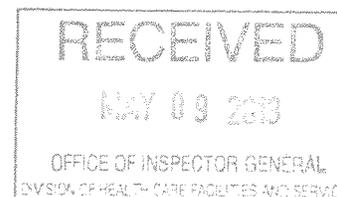
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F 431	<p>Continued From page 8</p> <p>medication cart, on 04/11/13 at 8:15 AM, revealed two (2) pills lying loose on the bottom of the medication cart drawers.</p> <p>Observation of the Advanced Alzheimer's Care Unit medication cart, on 04/11/13 at 8:17 AM, revealed seven (7) pills were found lying loose on the bottom of the medication cart drawers.</p> <p>Interview with the Alzheimer Care Unit Manager, on 04/11/13 at 3:10 PM, revealed there was a set cleaning schedule of the medication carts, but they should be inspected on a shift by shift basis and remove any medication that was loose or unlabeled. The Manager revealed she did monitor the carts and noticed a problem with pills falling out. The Manager revealed they started to remove empty cards to help with spacing.</p> <p>Observation of the East Unit A hall medication cart, on 04/11/13 at 8:45 AM, revealed forty-six (46) pills of various type lying loose on the bottom of the medication cart drawers.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 04/11/13 at 8:45 AM, revealed there was no one assigned specifically to monitor for loose pills in the medication carts. The LPN revealed the facility had recently switched pharmacies and medications were supplied in a bubble pack. The LPN revealed the medication drawers were so full it was difficult to see the bottom of the drawers and medications were easily popped free from their packaging.</p> <p>Interview with the East Unit Manager, on 04/11/13 at 2:17 PM, revealed cleaning of the medication carts are assigned for weekly cleaning on night</p>	F 431	



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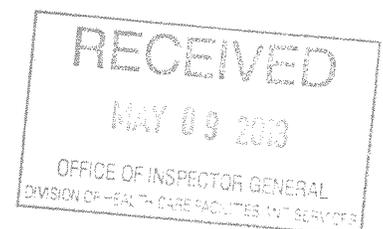
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/11/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
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F 431	Continued From page 9 shift and should be monitored by the night supervisor to ensure it was being done. The Unit Manager revealed she had noticed pills easily pop out of the dispensing packs but had not been looking at the bottom of the drawers. The Unit Manager revealed a pharmacy tech goes through the medication carts two (2) to three (3) times a week. Interview with the Pharmacy Supervisor, on 04/11/13 at 2:35 PM, revealed the pharmacy technicians do a spot check audit looking for expired medications and beyond usage dates of medication. The Supervisor revealed monitoring the drawers for fullness, arrangement, or loose unlabeled medication was not part of the regular duties and tasks. However, the Supervisor revealed a pharmacy representative was never in a medication cart without a nurse present, so any problems should have been identified by both the nurse and the representative at that time. Interview with the Director of Nursing (DON), in 04/11/13 at 4:00 PM, revealed the medication packs were tightly placed in the medication carts which contributed to the problem. The DON revealed she had not noticed a problem with the storage of medication. The DON revealed the nursing staff had revealed to her it was a tight fit with the new packaging, but no one had said the pills were popping free of the packaging. The DON revealed the night shift supervisor was supposed to be monitoring the medication carts after they are cleaned on night shift and ensure all medications were being stored appropriately. The DON revealed she had not monitored to ensure it was being done.	F 431			
F 441	483.65 INFECTION CONTROL, PREVENT	F 441			



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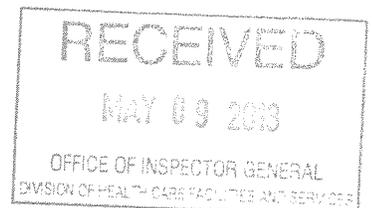
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F 441 SS=D	<p>Continued From page 10 SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F 441 Infection Control, Prevent, Spread, Linens</p> <p>This facility will provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Nurse with deficient practice was in-serviced 04/15/13 on hand hygiene and glove removal, maintaining a clean field and prevention of cross contamination. Resident's #6 tube feedings were labeled, dated and the feeding tube syringes were cleaned and dated on 04/12/13. Biohazard storage was cleaned and a lock was placed on the door on 4/10/13.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All resident's have the potential to be affected by the alleged deficient practice. The nurses taking care of residents #6 were re-educated on labeling and dating tube feeding and feeding tube syringes clean and dated and cross contamination on 5/07/13.</p>



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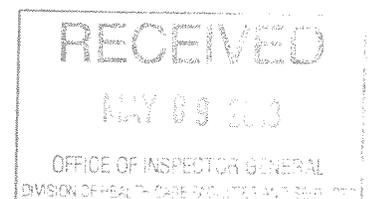
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F 441	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure the nursing staff utilized proper hand hygiene and glove removal after peri-care, failed to ensure nursing staff protected resident equipment from cross contamination, failed to ensure feeding tube tubing was dated when changed and failed to ensure feeding tube syringes were dated and clean for two (2) of twenty-five (25) sampled residents and one (1) unsampled resident (Residents #1 and #6) and failed to ensure bio-hazard materials were contained and secured until disposal. The findings include: 1. Review of the facility's policy titled Perineal Care, Procedure 525, dated 2006, revealed once perineal care was completed, gloves should be removed and staff should replace the top bed linen, make the resident comfortable, and place the call light in reach. Review of the clinical record for Resident #1 revealed the facility admitted the resident on 07/05/12 with diagnoses of Dementia, Congestive Heart Failure, Essential Hypertension, Hyperlipidemia, Atherosclerosis, Peripheral Vascular Disease, Anxiety and Unspecified Psychosis. The resident received a twice daily treatment for a Stage 4 pressure ulcer on his/her coccyx. Observation of a skin assessment for Resident #1 with Licensed Practical Nurse (LPN) #1, on 04/10/13 at 9:00 AM, revealed a wound dressing	F 441	What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur? On 5/07/13 the DNS will re-educated the nurses on hand hygiene and glove removal, maintaining a clean field and prevention of cross contamination, labeling and dating enteral tube feeding and syringes. The NHA re-educated the Maintenance and Housekeeping Director on the biohazard storage policy on 5/07/13. All staff training will be validated thru competency evaluations upon completion of the training. Anyone not passing the competency evaluations will complete the training again until they do understand the subject matter. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The second shift house supervisor will audit three enteral feeding three times a week times four weeks, then weekly times four weeks, and then monthly times four months for compliance with labeling and dating enteral feedings and syringes. The results of the audit		



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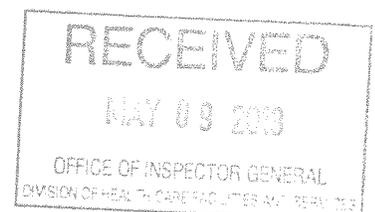
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F 441	<p>Continued From page 12</p> <p>in place to a pressure ulcer located on Resident #1's coccyx. The nurse did not create a clean field for the treatment supplies used for the wound care and dressing change. After treating the wound, the nurse secured the exterior dressing over the pressure ulcer with paper tape. During this process, the nurse placed the roll of paper tape directly on Resident #1's bed linens. This roll of paper tape was returned to a drawer on the treatment cart containing general supplies used for other residents.</p> <p>Continued observation revealed after completion of the dressing change, LPN #1 removed his gloves, washed his hands, and donned clean gloves to perform Resident #1's peri care. After completion of the peri care, LPN #1 did not remove his gloves and wash his hands before applying lotion to Resident #1's legs, back, and right hip.</p> <p>Interview, on 04/10/13 at 9:45 AM with LPN #1, revealed the roll of paper tape used to secure Resident #1's dressing was not dedicated to Resident #1, and could be used during procedures performed for other residents.</p> <p>Interview, on 04/11/13 at 2:55 PM, with Registered Nurse (RN) #2, revealed supplies used during dressing changes that would be used for more than one resident, such as a roll of paper tape, should be placed on a clean field and should not have direct contact with the resident's bed linens or other surfaces in the resident's room. In addition, RN #2 stated glove removal and hand hygiene should occur immediately after completing a resident's peri-care and before performing any additional direct care for that</p>	F 441	<p>will be given to the DNS. DNS will audit the care of four residents receiving treatments weekly for four weeks, then biweekly for four weeks, then monthly for four months. Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The DNS will bring audit results to the QAPI committee for two quarterly meetings. The NHA will check the biohazard storage room weekly for four weeks, then bi-weekly for four weeks, then monthly for four months to ensure the receptacle containers are closed and the door is locked. The audit results will be brought to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for additional audits.</p> <p>Compliance Date: 05/08/13</p>	5/8/13	



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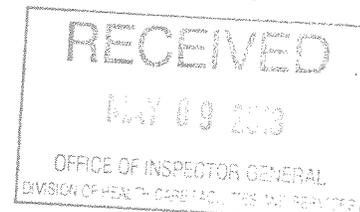
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F 441	<p>Continued From page 13</p> <p>resident. RN #2 stated the problem with both situations was a break in infection control procedures that could cause cross-contamination resulting in the spread of infection to the resident being cared for, other residents, and staff members.</p> <p>Interview, on 04/11/13 at 3:10 PM, with the facility's Health Educator revealed infection control in-services were offered every quarter for direct care staff, and whenever necessary if breaks in infection control were identified through tracking/trending processes, and as she identified concerns during daily rounds on each unit. Identified breaks in infection control were discussed in morning staff meetings, and direct care givers were in-serviced on infection control measures immediately.</p> <p>Interview, on 04/11/13 at 3:15 PM, with the DON revealed she monitored nursing care daily and as issues of concern were identified she met with the direct care givers during daily huddle meetings to discuss the observed breaks in infection control and she provided immediate education to correct the problem. The problem with not strictly observing proper hand hygiene and glove changes, and with contaminating supplies used for multiple residents would be the potential for cross-contamination and the spread of infection.</p> <p>2. Review of the facility's infection control policy and procedure manual, revised 08/2012, revealed containers or buildings used for storage of medical waste and sharps outdoors, would be locked at all times to prevent unauthorized access.</p>	F 441		



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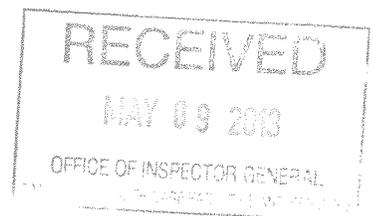
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F 441	<p>Continued From page 14</p> <p>Observation, on 04/10/13 8:10 AM, revealed an unlocked gray storage shed located out-of-doors at the back side of the facility, that contained overflow bio-hazardous waste. Open receptacles in the storage unit contained full sharps containers and red bag waste.</p> <p>Observation, on 04/10/13 at 3:50 PM, revealed the storage shed containing bio-hazardous materials remained unlocked.</p> <p>Interview, on 04/10/13 at 3:50 PM, with the Director of Maintenance revealed the receptacle had been locked in the past and should be locked at all times. He stated the housekeeping staff was responsible for moving red bag waste and sharps containers from inside the facility to this overflow shed when necessary. The maintenance director stated residents did not have direct access to the area where the shed was placed, but staff members did, and the storage shed should remain locked to prevent unauthorized access by anyone.</p> <p>Interview, on 04/11/13 at 11:00 AM, with the Administrator revealed the facility contracted with Beverly Enterprises Kentucky for bi-weekly pick-up/removal of bio-hazardous waste, and the company was supposed to remove all biohazardous waste with each pick-up.</p> <p>3. Review of the facility's guide titled Ross Ready-To-Hang set-up, undated, revealed staff were to mark the feeding set with the start time and date. Proper dating was essential for</p>	F 441		



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F 441	Continued From page 15 resident safety to prevent the transfer of microbes. Staff should use the container and tubing for twenty-four (24) hours Observation of Resident #6, on 04/09/13 at 8:30 AM, revealed the tube feeding tubing was dated 04/02/13 and the piston syringe stored in a bag was undated and contained a small amount of tan colored fluid. On 04/09/13 at 11:50 AM, the tube feeding tubing was noted to have a blank sticker with no date and the piston syringe continued to be undated and contained a small amount of tan colored fluid. On 04/10/13 at 8:15 AM, the tube feeding tubing continued to have no date as to when it was changed. Interview with Licensed Practical Nurse #2, on 04/11/13 at 10:00 AM, revealed tube feeding tubing and piston syringes used to deliver medications and flushes were to be changed and dated every day. She stated she had not noticed the tubing and piston syringe had no date. She stated bacteria could grow and cause harm to a resident if the items were not clean and replaced daily. She stated she had been trained to write the date on disposable equipment. Interview with the Director of Nursing, on 04/11/13 at 3:30 PM, revealed tube feeding tubing and piston syringes were to be replaced daily to avoid infection.	F 441			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514			



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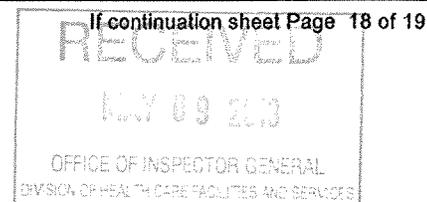
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F 514	<p>Continued From page 16 accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to have current physician orders for Advance Directives for one (1) of twenty-five (25) sampled residents and one (1) unsampled resident (Resident #6). The facility failed to ensure Advance Directive orders were carried forward and signed by the physician.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Advance Directives, dated October 2009, revealed the resident had the right to self-determination regarding their medical care. An Advance Directive was defined as a written instruction regarding care when the resident was incapacitated.</p> <p>Observation of Resident #6, on 04/09/13 at 8:30 AM, revealed the resident was in bed. The resident had contractures of arms and legs and a tube feeding was in place for nutrition. The resident gave no response to greetings.</p>	F 514	<p>F 514 Resident Records - Complete/Accurate/Accessible</p> <p>This facility will maintain clinical records on each resident in accordance with accepted professional standards and practice.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #6 received a physician order to match the advanced directive on 04/11/13.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All resident's have the potential to be affected by the alleged deficient practice. The resident charts were reviewed to ensure advanced directives had corresponding physician orders on 4/26/13.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p>	

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F 514	<p>Continued From page 17</p> <p>Review of the clinical record for Resident #6 revealed the facility admitted the resident with diagnoses of Closed Traumatic Brain Injury, Vegetative State and Aphasic. Review of the Quarterly Minimum Data Set (MDS) assessment completed by the facility on 02/27/13 revealed the resident was severely impaired cognitively and required total assistance with all areas of care. The resident was unable to eat and utilized a feeding tube for all nutrition.</p> <p>The clinical record continued to revealed the resident had a court ordered guardian, which was the resident's mother. In addition, the resident had Advanced Directives which included No Cardiopulmonary Resuscitation, No Hospitalization and No Intravenous Fluids.</p> <p>Review of the Physician's Orders for Resident #6 revealed no orders for No Hospitalization or No Intravenous Fluids.</p> <p>Interview with the Unit Manager, on 04/11/13 at 1:30 PM, revealed Advance Directives should be on the monthly renewal physician's orders and signed by the physician. She stated a nurse reviewed these orders monthly to ensure the orders were accurate and complete. She stated the orders for No Hospitalization and No Intravenous Fluids were not located. She revealed the facility honored residents' Advance Directives and she could not explain how these orders were left off the chart or how long the orders had not been renewed. The missing orders could result in the resident receiving unwanted care in case of an emergency.</p> <p>Interview with the Director of Nursing, on 04/11/13</p>	F 514	<p>The DNS will re-educate the nurses on obtaining physician orders corresponding with the resident's advance directives on 5/07/13. All staff training will be validated thru competency evaluations upon completion of the training. Anyone not passing the competency evaluations will complete the training again until they do understand the subject matter. Social services to convey updates in advanced directives to the nurse managers when obtained.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The social service director will audit twelve charts weekly for four weeks, then bi-weekly for four weeks, then monthly for four months to ensure residents with advanced directives have corresponding physician orders. The audit findings will be brought to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits.</p> <p>Compliance Date: 05/08/13</p> <p style="text-align: right;">5/8/13</p>



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F 514	Continued From page 18 at 3:35 PM, revealed all Advance Directives were on the physician's orders and signed monthly. She stated someone missed these orders when reviewing the orders and the error was passed on from month to month. She stated staff needed to know what the resident's wishes were to prevent unwanted care.	F 514		

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1973 for the original building and 1983 for the East Wing expansion.</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) Story, Type III Unprotected ordinary construction.</p> <p>SMOKE COMPARTMENTS: Eleven (11) smoke compartments.</p> <p>FIRE ALARM SYSTEM: Complete fire alarm system with heat and smoke detectors, originally installed in 1973 and 1983, upgraded in 2008.</p> <p>SPRINKLER SYSTEM: Complete automatic, dry sprinkler system, originally installed in 1973 and 1983.</p> <p>EMERGENCY POWER: One (1) Type II, 100KW Natural Gas Generator originally installed in 1973 and one (1) Type II, 275KW Diesel installed in 2008.</p> <p>A standard Life Safety Code survey was conducted on 04/09/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire). Golden Livingcenter - Camelot</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Walter Lake</i>	TITLE NHA	(X6) DATE 5/8/13
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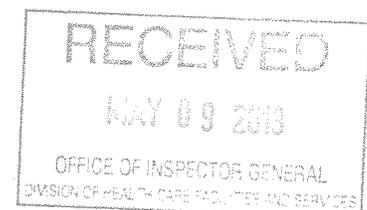
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE SERVICES AND SERVICES

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222	
(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
K 000	Continued From page 1 was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has for one-hundred and forty-five (145) certified beds and the census was one-hundred and forty (140) on the day of the survey.	K 000	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or 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.</u></p> <p>K 25 NFPA Life Safety Code</p> <p>This facility will ensure that all smoke barriers will be sealed to ensure a safe environment.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The two holes identified where conduit was installed have been repaired 04/29/13 to resist the passage of smoke.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Audit of all smoke barriers has been completed and any area in need of</p>	
K 025 SS=D	<p>Deficiencies were cited with the highest deficiency identified at E level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eleven (11) smoke compartments, approximately forty-five (45) residents, staff and visitors. The facility has one-hundred and forty-five (145) certified beds and the census was one-hundred and forty (140) on the day of the survey.</p>	K 025		



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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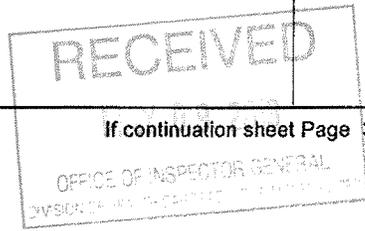
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222
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K 025	<p>Continued From page 2</p> <p>The findings include:</p> <p>Observation, on 04/09/13 at 11:55 AM, with the Director of Maintenance revealed the fire resistant, rated smoke barrier located in the East, A Hall, had been penetrated by two (2) electrical conduits above the ceilings. The space around the penetrations had not been filled with a material rated equal to the smoke barrier and could not resist the passage of smoke.</p> <p>Interview, on 04/09/13 at 11:55 AM, with the Director of Maintenance revealed he was unaware of the penetrations in the smoke barrier.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. 	K 025	<p>repair has been repaired to ensure a good seal is in place.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Monthly audits will be completed by the maintenance director to ensure no openings have occurred.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Fire barriers will be audited monthly by maintenance director and/or the administrator for any openings in the fire wall. Findings of audits will be brought to Quality Assessment & Performance Improvement (QAPI) monthly for three months and then quarterly for three quarters.</p> <p>Compliance Date: 05/08/13</p>	5/8/13
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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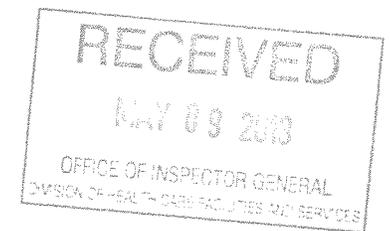
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222
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K 025 K 029 SS=E	<p>Continued From page 3</p> <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiencies had the potential to affect each of the (11) smoke compartments, residents, staff and visitors. The facility has one- hundred and forty-five (145) certified beds and the census was one- hundred and forty (140) on the day of the survey.</p> <p>The findings include:</p>	K 025 K 029	<p>K 29 NFPA 101 Life Safety Code</p> <p>This facility will ensure that all hazardous areas will be protected by smoke resistant partitions to ensure a safe environment.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The door to the janitor closet in the kitchen will be replaced by 05/21/13 and a self closing device installed by 05/21/13. The door to the dry storage room will have a self closing device installed on it 05/21/13. The drywall has been repaired in the wall next to the air handling unit 04/29/13. The activities storage room has had a self closing device installed on the door 05/21/13.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Audit of all doors to hazardous areas has been completed and any door needing a self closing device has had them added to ensure that all hazardous areas will be protected.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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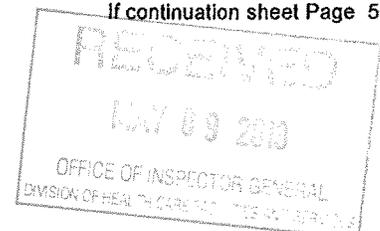
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222
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K 029	<p>Continued From page 4</p> <p>1. Observation, on 04/09/13 at 8:30 AM, with the Director of Maintenance revealed the door to the Janitor Closet within the Kitchen, did not completely close and latch. The door was equipped with a self-closing device; however, loose hinges prevented the door from completely closing.</p> <p>Interview, on 04/09/13 at 8:30 AM, with the Director of Maintenance, revealed he was not aware of the door to the Janitor Closet not being able to close completely.</p> <p>2. Observation, on 04/09/13 at 8:40 AM, with Director of Maintenance revealed the door to the Dry Storage Room located within the Kitchen, did not have a self-closing device installed on the door. There was a sign on the door advising the Staff to keep the door closed.</p> <p>Interview, on 04/09/13 at 8:40 AM, with the Director of Maintenance revealed he was not aware of the Dry Storage Room being categorized as a hazardous storage area and the requirement for the door to be equipped with a self-closing device.</p> <p>3. Observation, on 04/09/13 at 9:08 AM, with the Director of Maintenance revealed a twelve (12) inch by twelve (12) inch hole had been cut out of the drywall beside the air handling unit.</p> <p>Interview, on 04/09/13 at 9:08 AM, with the Director of Maintenance revealed he was not aware of the opening being cut out of the drywall and acknowledged the requirement that the room was required to be sealed smoketight.</p>	K 029	<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Monthly audits will be completed by the maintenance director and/or the administrator to ensure hazardous areas will be protected by smoke resistant partitions to ensure a safe environment.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Monthly audits will be completed by the maintenance director and/or the administrator to ensure hazardous areas will be protected by smoke resistant partitions to ensure a safe environment. Findings of audits will be brought to Quality Assessment & Performance Improvement (QAPI) monthly for three months and then quarterly for three quarters.</p> <p>Compliance Date: 05/22/13</p>	5/22/13
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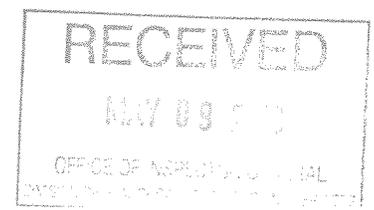
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K 029	<p>Continued From page 5</p> <p>4. Observation, on 04/09/13 at 10:45 AM, with the Director of Maintenance revealed the door to the Activities Storage Room located in the Rehab Hall, did not have a self-closing device installed on the door.</p> <p>Interview, on 04/09/13 at 10:45 AM, with the Director of Maintenance revealed he was not aware of the Activities Storage Room being categorized as a hazardous storage area, and the requirement for the door to be equipped with a self-closing device.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ul style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms 	K 029		
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K 029	Continued From page 6 (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029	K 46 NFPA 101 Life Safety Code This facility will ensure that emergency lighting is functioning for at least 1 1/2 hours of duration in the event of failure of normal lighting.	
K 046 SS=D	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eleven (11) smoke compartments, residents, staff and visitors. The facility has one-hundred and forty-five (145) certified beds and the census was one-hundred and forty (140) on the day of the survey. The findings include: Observation, on 04/09/13 at 8:45 AM, with the Director of Maintenance revealed the emergency battery light located at the exit from the Laundry, did not function when tested.	K 046	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The light has been repaired 04/25/13 to ensure that there is emergency lighting for at least 1 1/2 hours of duration in the event of failure of normal lighting. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Audit of all emergency lights has been completed and any light in need of repair has been repaired to ensure that there is emergency lighting for at least 1 1/2 hours of duration in the event of failure of normal lighting.	



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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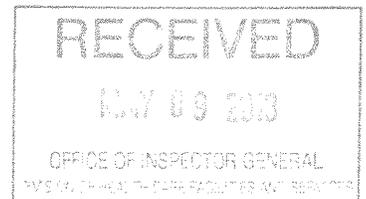
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K 046	<p>Continued From page 7</p> <p>Interview, on 04/09/13 at 8:45 AM, with the Director of Maintenance revealed he was not aware the battery light had stopped functioning.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less</p>	K 046	<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Monthly audits will be completed by the maintenance director for the next ninety days and audits will completed quarterly thereafter to ensure that emergency lighting is working.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Monthly audits will be completed by the maintenance director for the next ninety days and audits will completed quarterly thereafter to ensure that emergency lighting is working. Findings of audits will be brought to Quality Assessment & Performance Improvement (QAPI) monthly for three months and then quarterly for three quarters.</p> <p>Compliance Date: 05/08/13</p>	5/8/13
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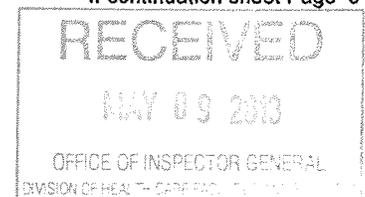
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K 046	Continued From page 8 than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals. NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress, in accordance with NFPA standards. The deficiency had the potential to affect each of the eleven (11) smoke compartments, residents, staff, and visitors. The facility has one-hundred and forty-five certified beds and the census was one-hundred and forty (140) on the day of the survey. The findings include: Observations, on 04/09/13 between 8:05 AM and 11:30 AM, with the Director of Maintenance revealed unapproved locks (slide bolt type) were installed on the egress side of the doors to the Men's and Women's public Toilet Rooms located in the Main Entrance Lobby. Further observations revealed the doors to the shared Toilet Rooms between opposite sex residents, located throughout the facility, had slide bolt locks installed on the egress side of the doors.	K 046		
K 130 SS=D		K 130	<p>K 130 NFPA 101 Miscellaneous</p> <p>This facility will maintain doors within a required means of egress in accordance with NFPA standards.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>All slide bolt locks have been removed from the facility 04/29/13. Doors identified- public bathrooms and bathrooms that are shared between resident rooms - have had the slide bolt locks removed 04/29/13.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Audit of all doors in the facility has been completed and any slide bolt identified has been removed. Bathroom locks that are in accordance with NFPA standards have been installed as needed or requested.</p>	



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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(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
K 130	<p>Continued From page 9</p> <p>Interviews, on 04/09/13 between 8:05 AM and 11:30 AM, with the Director of Maintenance revealed he was aware of the locks installed on the doors; however, he was not aware that slide bolt locks were prohibited by Code. He agreed that slide bolt locks could be a deterrent to exiting the rooms in the event of an emergency.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.</p>	K 130	<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Training with the maintenance director has been completed outlining the appropriate type of lock to use. All training will be validated thru competency evaluations upon completion of the training. Anyone not passing the competency evaluations will complete the training again until they do understand the subject matter. Door audits will be completed monthly for the next year by the administrator to ensure that only bathroom locks that are in accordance with NFPA standards are used.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Monthly audits will be completed by the administrator for one year. Findings of audits will be brought to Quality Assessment & Performance Improvement (QAPI) monthly for three months and then quarterly for three quarters.</p> <p>Compliance Date: 05/08/13</p>	5/8/13