

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185159	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/16/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - FRANKFORT		STREET ADDRESS, CITY, STATE, ZIP CODE 117 OLD SOLDIERS LANE FRANKFORT, KY 40601	

(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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<p>F 000 INITIAL COMMENTS</p> <p>A standard health survey was conducted from 02/14/12 through 02/16/12 and a Life Safety Code survey was conducted on 02/15/12. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>F 253 SS=D 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Deep Clean Calendar, it was determined the facility failed to provide effective housekeeping and maintenance services to maintain a sanitary and comfortable interior for one (1) of the twenty-five (25) resident bathrooms (room 116), which effected two (2) residents.</p> <p>The findings include: Review of the Deep Clean Calendar, dated February 2012, revealed room 116 was deep cleaned on 2/15/12.</p> <p>Observation of room 116's bathroom during initial tour, on 2/14/12 at 9:30 AM, revealed a strong urine odor and a thick yellow and brown substance around the base of the commode.</p>	<p>F 000</p> <p>Preparation and submission of this plan Of correction does not constitute an Admission of agreement of any kind by The facility or the correctness of any Conclusions set forth in this allegation by The survey agency. Accordingly, the Facility has prepared and submitted this Plan of correction prior to the resolution Of any appeal which may be filed solely Because of the requirements under state And federal law that mandate submission Of a plan of correction within (10) days of The survey as a condition to participate in Title 18 and Title 19 programs. The Submission of the plan of correction Within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. The plan of correction is submitted as the facilities credible allegation of compliance.</p> <p>F 253</p> <p><u>Corrective Action:</u> The 2 residents identified in this tag resulted in no negative or adverse effects Immediate action to deep clean the identified bathroom room 116 2/16/2012 by Housekeeping supervisor.</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *X [Signature]* TITLE: *X Executive Director X* (X6) DATE: *3/9/12*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	<p>Continued From page 1</p> <p>Yellow colored splatters were noted on the floor.</p> <p>Observation of room 116's bathroom, on 2/15/12 at 8:30 AM, revealed a strong urine odor and a heavy buildup of yellow and brown colored substances around the base of the commode.</p> <p>Interview with Resident #8, who resides in room 116, on 2/15/12 at 10:00 AM revealed he/she had noticed odors to the bathroom, however, the problem was not reported. When asked if they felt the bathroom was clean, the resident shook his/her head back and forth to indicate no and cast his/her eyes downward.</p> <p>Continued observation of the bathroom in room 116, on 2/15/12 at 3:40 PM, 2/15/12 at 5:00 PM, and 2/16/12 at 10:05 AM revealed the bathroom with a strong pungent urine odor, the floor was sticky, there was thick yellow and brown buildup around the base of the commode, and dark yellow splatters on several areas of the floor.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 2/16/12 at 2:15 PM, revealed she thought the bathroom smelled of urine, and the yellow splatters on the floor and around the base of the commode appeared to be urine. The CNA revealed she did not think the bathroom was clean</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 2/16/12 at 2:20 PM, revealed she thought the bathroom had a strong urine odor.</p> <p>Interview with Housekeeper #1, on 2/16/12 at 2:30 PM, revealed she deep cleaned room 116, including the bathroom, on 2/15/12. The</p>	F 253	<p><u>Identification of other residents with potential for similar concern:</u></p> <p>2/20/2012 thru 2/22/2012 the Housekeeping department assessed all resident bathrooms, cleaned and scrubbed including every toilet, corners and edges - old caulking was removed as needed and replaced by maint director.</p> <p>Room #116 floor was stripped and waxed by housekeeping department 2/21/2012.</p> <p>Maint supervisor raised the toilet and replaced the seal around the base of the commode and recaulked closed on 2/21/2012.</p> <p>No other locations identified to have urine stains or odors.</p> <p>In-service education conducted to Housekeeping employees by Housekeeping supervisor 2/22/2012 on proper daily cleaning / deep cleaning procedures for bathrooms</p> <p><u>Systemic changes:</u></p> <p>On 2/16/2012 Room #116 was placed on the target observation listing and checked every 2 hours by the assigned housekeeper.</p> <p>In-service education conducted to Housekeeping employees by Housekeeping supervisor 2/22/2012 on proper daily cleaning / deep cleaning procedures for bathrooms</p>



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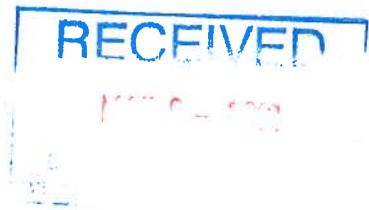
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F 253	Continued From page 2 Housekeeper revealed she did clean around the commode but could not remove the substance around the commode. When asked by the housekeeping supervisor if the housekeeper had used a bleach solution and a scraper, the housekeeper replied she did not know the items could be used to clean around the commode. Observation of the bathroom for room 116 being cleaned, on 2/16/12 at 2:35 PM, revealed yellow and brown substance around the commode easily removed with the floor scraper and cleaning solution. Interview with the Housekeeping Supervisor, on 2/16/12 at 2:40 PM, revealed the odor, buildup and splatters should have been resolved during the deep clean. The supervisor revealed she normally checked the residents' rooms multiple times a day to monitor for cleanliness. However, the housekeeping supervisor revealed she did not check room 116 due to it being scheduled for a deep clean and did not check after it was completed. The Housekeeping Supervisor revealed she kept a list of bathrooms that required more frequent cleaning and monitoring, however, room 116 was not on the list. Interview with the Executive Director, on 2/16/12 at 4:00 PM, revealed he did make daily rounds, as well as monthly rounds with the Housekeeping supervisor. The Executive Director revealed he did monitor all the rooms that were deep cleaned, however he did not monitor the bathrooms.	F 253	<u>Monitoring:</u> All resident bathrooms cleaned daily by assigned housekeeper and House keeping supervisor will check each on a daily basis and indicated any corrections necessary and validate observation by signing worksheet x 30 days, then weekly audit and pm Results of the audit will be reported in QA and A monthly till cleared <u>Completion Date:</u> 3/ 15/ /2012	3/15/12	
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides	F 364	<u>F 364</u> <u>Corrective Action:</u> No residents were identified to have resulted in negative or adverse effects from this cited deficiency The facility recognizes that all residents of the facility have the potential to be affected by the alleged deficient practice		



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F 364	<p>Continued From page 3</p> <p>food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review it was determined the facility failed to maintain proper food temperatures on the tray line as evidence by, not re-tempting reheated foods. In addition, the facility failed to take the temperature of new food items introduced to the tray line before serving.</p> <p>The findings include:</p> <p>Review of the facility's policy on Holding and Serving Food dated 2011, revealed foods are held and served at acceptable temperatures and in methods to prevent the spread of food borne illness and reduce those practices that result in food contamination or compromise food safety. Mechanically altering foods (including puree foods) increases the potential hazard and must be held at 140 degrees Fahrenheit (F) or above for hot food and 41 degrees or below for potentially hazardous cold foods. The policy stated to monitor temperatures shortly before the start of meal service to assure food is being served at correct and safe temperatures.</p> <p>Observation of the Tray line, on 02/15/12 at 5:00 PM, revealed a puree beef stew at 120 degrees F and chopped pork roast at 130 degrees (F), these two items were reheated, placed on the Tray line and not re-tempted. Continued observation of the</p>	F 364	<p><u>Identification of other residents with potential for similar concern:</u> The facility recognizes that all residents of the facility have the potential to be affected by the alleged deficient practice 3/1/2012 Registered Dietitian In-serviced all active dietary staff on procedures and actions to ensure holding temps of food items was maintained within the requirements of hot foods at a minimum of 140 degrees F and cold foods 41 degrees F or below for proper management and holding as well as procedure of temp completion of food items prior to start of tray line for every hot and cold item each meal each day. In-service education contained information on process for foods not meeting criteria and reheating and repeat tempting process.</p> <p><u>Systemic changes:</u> 3/1/2012 Registered Dietitian In-serviced all active dietary staff on procedures and actions to ensure holding temps of food items was maintained within the requirements of hot foods at a minimum of 140 degrees F and cold foods 41 degrees F or below for proper management and holding as well as procedure of temp completion of food items prior to start of tray line for every hot and cold item each meal each day. In-service education contained information on process for foods not meeting criteria and reheating and repeat tempting process.</p>



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F 364	<p>Continued From page 4</p> <p>tray line revealed the cook placed pureed salad, pureed green beans and pureed pork on the tray line, all items were not tempted. Observations made of the Tray line, on 02/15/12 at 5:36 PM, revealed a new pan of chopped pork placed on the steam table, not tempted. Observation of the Tray line, on 02/16/12 at 5:50 PM, revealed a new pan of pureed beef stew placed on the steam table and not tempted.</p> <p>Observation of a Test Tray, on 02/15/12 at 6:54 PM, revealed milk at 30 degrees (F), regular beef stew at 139 degrees (F), puree pork at 90 degrees (F), mechanical pork at 92 degrees (F), yams at 100 degrees (F) and puree beef stew at 100 degrees (F). Of the four surveyors who tasted the food, three of the surveyors observed the puree items as cold to the palette.</p> <p>Interview with an un-sampled, interviewable resident who ate a mechanical soft diet, Resident A, on 02/16/12 at 1:30 PM, revealed the food had been cold on occasion especially when there was no hot plate available. He/she further stated he/she did not like cold food.</p> <p>Interview with an un-sampled, interviewable resident who ate a mechanical soft diet, Resident B, on 02/16/12 at 1:34 PM, revealed sometimes the food was cold.</p> <p>Interview with Resident #3, on 02/16/12 at 1:45 PM, revealed ninety percent (90%) of the time his/her food was cold. He/she stated he/she did not inform staff because they figured the staff would not do anything about it.</p> <p>Interview with Certified Nursing Assistant (CNA)</p>	F 364	<p><u>Monitoring:</u> Assigned cook for each meal with temp food items daily and record. Registered Dietitian, Director of Dietary Services or ED will assess temp process, holding temps and compliance 3 x week and alternate meals. Registered Dietitian will assess point of service tray temps weekly. Resident A, B and #3 identified in cited deficiency were re-interviewed by DNS 3/4/2012 and 3/7/2012 assessed satisfaction with meal temp - reports x 3 with improvement in temp of food items at meals Guardian Angel rounds by Department Directors to assess weekly customer satisfaction of food temps as assigned Food temps satisfaction to be monitored monthly in Resident council Results will be presented to QA and A monthly till resolved</p> <p><u>Completion Date:</u> March 15, 2012</p>
FORM CMS-2567(02-99) Previous Versions Obsolete		Event ID: PA4511	Facility ID: 100512



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F 364	Continued From page 5 #4, on 02/16/12 at 2:30 PM, revealed sometimes the residents complain about the food being cold and she just went to the kitchen to retrieve a new plate. Interview with Dietary Cook #2, on 02/16/12 at 2:30 PM, revealed the temperature of food should be between 140 degrees to 165 degrees (F). If the temperature is not within range, it is placed back in the steamer or oven for fifteen (15) seconds until it reaches 165 degrees (F). She further stated, when the food comes out of the steamer and is placed on the steam table, the food should be re-tempted. Further, interview with Dietary Cook #2 revealed it was the cooks responsibility to make sure food was re-tempted. They temp food to keep down the growth of bacteria. Interview with Dietary Aid #1, on 02/16/12 at 2:39 PM, revealed the Hold temp should be 140 degrees (F) or above and foods should be re-tempted to prevent food from growing bacteria. Interview with the Dietary Cook #1, on 02/16/12 at 2:43 PM, revealed food temperatures should be 140 degrees (F) or above so that residents do not get food poisoning. Interview with the Dietary Manager, on 02/16/12 at 3:05 PM, revealed staff were aware of the need to recheck temperatures of food items and to re-tempt foods. The holding temperature should be 140 degrees (F) or above. The Dietary Manager stated they want to make sure the bacteria was killed off because the elderly can not take that.	F 364		





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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, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is propane gas.</p> <p>A standard Life Safety Code survey was conducted on 02/15/12. Golden Livingcenter - Frankfort was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one-hundred (100) beds and the census was ninety-nine (99) on the day of the survey.</p> <p>The findings that follow demonstrate non-compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>Preparation and submission of this plan Of correction does not constitute an Admission of agreement of any kind by The facility or the correctness of any Conclusions set forth in this allegation by The survey agency. Accordingly, the Facility has prepared and submitted this Plan of correction prior to the resolution Of any appeal which may be filed solely Because of the requirements under state And federal law that mandate submission Of a plan of correction within (10) days of The survey as a condition to participate in Title 18 and Title 19 programs. The Submission of the plan of correction Within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. The plan of correction is submitted as the facilities credible allegation of compliance.</p>	

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

X [Signature]

TITLE

X Executive Director

(X6) DATE

X 3/19/12

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	K 000		
K 018 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, approximately forty-five (45) residents, staff and visitors. The facility is licensed for one-hundred (100) beds</p>	K 018	<p><u>Corrective Action</u> Four residents were noted to have been affected.</p> <p>The resident room doors to 116 and 210 have Been repaired by the maintenance director on February 15, 2012 to ensure they function properly to resist the passage of smoke and a means suitable for keeping the door closed.</p> <p><u>Identification of other residents with potential to have been affected by the same Practice.</u> There were no residents noted to have been affected.</p> <p>The maintenance director completed an audit of all resident room Doors on February 16, 2012 and again on March 6, 2012 and found all doors to be functioning properly To resist the passage of smoke.</p> <p><u>Systematic Changes:</u> The Maintenance Director and or Housekeeping Director will conduct Monthly inspections/audits of all resident room doors to ensure proper function and free of obstructions. Any identified Problems will be immediately addressed.</p> <p><u>Monitoring</u> Monthly inspections/audits results completed by the maintenance director will also be reviewed by the safety committee in its monthly meeting.</p> <p>Monthly Inspection/audit results will also be Discussed quarterly in the QA & A committee</p>	



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K 050 SS=F	<p>Continued From page 3</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect each of the five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for one-hundred (100) beds and the census was ninety-nine (99) on the day of the survey.</p> <p>The findings include:</p> <p>Record review, on 02/15/12 at 11:45 AM, with the Maintenance Director revealed the fire drills were not being conducted quarterly, on each shift at random times. There was no record of a fire drill being conducted during the first shift, in the third quarter of 2011.</p> <p>Interview, on 02/15/12 at 11:45 AM, with the</p>	K 050		



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K 050	Continued From page 4 Maintenance Director revealed he was not aware of the fire drill not being conducted during the first shift in the third quarter of 2011. Reference: NFPA 101 (2000 Edition) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050		

