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

PRINTED: 03/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185238		02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - VANCEBURG	58 EASTHAM STREET VANCEBURG, KY 41179

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey and an Abbreviated Survey investigating AROs KY00015524 and KY00015624 was conducted 02/14-17/11; and, a Life Safety Code Survey was conducted 02/15/11. Deficiencies were cited, with the highest Scope and Severity of a "F". ARO KY00015524 was unsubstantiated with no deficiencies cited. ARO #KY00015624 was substantiated with no deficiencies.	F 000		
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; accurately documented; readily accessible; and systematically organized. 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to maintain accurate clinical record information for one (1) of nineteen (19) sampled residents (Resident #9). Resident #9 had an indwelling catheter ("Foley") removed on 01/01/11; however, on three (3) occurrences staff documented drainage and/or care of the resident's "Foley" catheter after that	F 514	RECEIVED MAR 15 2011 BY:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Berkley
TITLE: Executive Director
(X6) DATE: 3-8-11

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 514	Continued From page 1 date. The findings include: Review of the medical record for Resident #9, revealed diagnoses which included Infantile Cerebral Palsy, Parkinson's Disease and Urinary Retention. Review of Resident #9's Physician Orders dated 01/01/11, revealed orders to remove and leave out the "Foley" catheter for urinary retention secondary to Cerebral Palsy and discontinue catheter care. Further review revealed the order to straight catheterize the resident for urinary retention when necessary. Review of Progress Notes dated 01/01/11, revealed documentation the "Foley" catheter was removed without incident. Interview with Resident #9 on 02/16/11 at 4:20 PM, revealed the "Foley" catheter was removed on 01/01/11, and he/she did not have another catheter inserted. Interview with the Director of Nursing on 02/17/11 at 10:05 AM, revealed Resident #9 had not had a "Foley" catheter since his/her catheter was discontinued on 01/01/11. Review of the Progress Notes signed by Registered Nurse (RN) #5 dated 01/18/11, and 02/01/11 revealed documentation that Resident #9 had a catheter that was noted to be patent and draining dark amber urine. The Notes also revealed catheter care was performed. Review of the Progress Notes dated 02/08/11,	F 514	1) **Corrective action for those residents found to have been affected by the deficient practice:** A late-entry nursing note correction to be completed for Resident #9 by Nurse #5 for the original 1/18/11 progress note, and by Nurse #6 for the original 2/8/11 progress note by 3/15/11. 2) **How the facility will identify other residents having the potential to be affected by the same deficient practice-** The facility will identify other residents with the potential to be affected through the daily clinical start-up process. The Director of Nursing Services and/or Asst. Director of Nursing and the Resident Assessment RN will review the prior 24-hour nursing notes for accuracy. Any identified discrepancies or errors will be addressed at that time. 3) **Measures put into place or systemic changes made to ensure that the deficient practice will not recur-** 1:1 education provided by the Director of Nursing Services to both nurse #5 and nurse #6 regarding assessment and documentation. General nursing education in-service in regards to assessment and documentation practices implemented by Director of Nursing Services on 3/8/11, to be completed by 3/15/11. 4) **How the facility plans to monitor performance to ensure solutions are sustained-** Review of documentation errors identified in the clinical start-up will be tracked through the facility QA for 3 months to determine effectiveness of actions and need for continued QA monitoring.	3-15-11

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F 514	Continued From page 2 revealed documentation by RN #6 that the catheter was patent and draining dark amber urine. Interview with RN #5 on 02/17/11 at 12:30 PM, revealed she had probably been tired and thought the resident still had his/her catheter and made a mistake and charted incorrect information.	F 514		

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K 000	INITIAL COMMENTS A Life Safety Code Survey was initiated and concluded on 02/15/2011 for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility not in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at an "F".	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure smoke/fire dampers were inspected and maintained, according to NFPA standards. The deficiency had the potential to affect five (5) smoke compartments, ninety four (94) residents, staff and visitors. The findings include: Review of the building plans for the facility on 02/15/2011 at 3:30 PM, with the Maintenance	K 025	RECEIVED MAR 9 - 2011 BY:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Beasley
TITLE: Executive Director
(X6) DATE: 3-8-11

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 025	Continued From page 1 Director, revealed two (2) fire dampers located on the 100 Hall; two (2) smoke dampers located on the 200 Hall; and, two (2) fire dampers on the 300 Hall. Fire/smoke dampers prevent the spread of fire and smoke through duct work in a building and must be maintained to ensure reliable operation in a fire. Interview on 02/15/2011 at 3:30 PM, with the Maintenance Director, revealed the facility had no documented evidence the fire/smoke dampers had been inspected and maintained. Further interview revealed the Maintenance Director was unsure when the last time the fire/smoke dampers were inspected and maintenance had been provided for the fire/smoke dampers. Reference: NFPA 90A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 025	K025- Fire damper inspection has been scheduled with vendor to be completed by 3/11/11. The facility will include this inspection in the Life Safety preparedness manual with documentation alerting as to when next inspection due to prepare for timely completion. The Executive Director will maintain the Life Safety preparedness book and discuss audits that are needed or approaching due date in the monthly Safety Meeting.	3-15-11
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper	K 056		

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K 056	Continued From page 2 switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a complete sprinkler system. The deficiency had the potent to affect one (1) smoke compartment, four (4) residents, staff and visitors. The findings include: Observation on 02/15/2011 at 2:10 PM, revealed that an overhang (approximately 30' x 11') with combustible construction located at the front entrance of the building did not have sprinkler coverage. The observation was confirmed with the Maintenance Director. Interview on 02/15/2011 at 2:10 PM, with the Maintenance Director, the canopy had never been sprinklered. Reference: NFPA 13 1999 edition 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056	K056- The fire system/sprinkler vendor was contacted on 3/7/11 in regards to the need of sprinkler installation for the front porch of the facility. Vendor to be on-site to evaluate and schedule for installation on 3/10/11. The system shall continue to be maintained and inspected as indicated.	3-15-11
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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K 147	Continued From page 3	K 147		
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was installed/maintained according to NFPA standards. The deficiency had the potential to affect two (2) smoke compartments and staff. The findings include: Observation on 02/15/2011 at 4:15 PM, revealed one (1) electrical plug in the kitchen area when tested with a circuit tester had been wired in reversed polarity. Reversed polarity creates a possible shock hazard to anyone using the electrical plug. Further observation revealed electrical plugs located in the dining room, 100 Hall and 300 Hall when tested with a circuit testing indicated the plugs were wired in reversed polarity. The observation was confirmed with the Maintenance Director. Interview on 02/15/2011 at 4:15 PM, with the Maintenance Director, revealed he was not aware of the electrical plugs being wired in reversed polarity. Reference: NFPA 70 (1999 edition) 200-11. Polarity of Connections. No grounded conductor shall be attached to any terminal or lead so as to reverse the designated polarity.		K147- Each of the electrical plugs identified being in reverse polarity (kitchen, dining room, 100 and 300 Hall) have been changed out by maintenance by 3/8/11. Maintenance will audit the remainder of outlets throughout the facility on preventative maintenance round schedule, and will timely change out any identified to be defective. Preventative maintenance concerns will continue to be followed in the monthly Safety Meeting. 3-15-11	