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

PRINTED: 04/13/2011
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
	185095		03/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HILLCREEK	3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted 03/29/11 through 03/31/11 and a Life Safety Code survey on 03/30/11. 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. An abbreviated survey investigating KY00015786, KY00015813, KY00015812, KY00016084, KY00015844, KY00016064 and KY00015910 was initiated on 03/29/11 and concluded on 03/31/11. KY00015786 was unsubstantiated. KY00015813, KY00015812, KY00016084, KY00015844, KY00016064 and KY00015910 were substantiated with no deficiencies cited.	F 000	**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.**	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain services necessary to maintain a sanitary, orderly, and comfortable interior. Five (5) resident rooms had stained ceiling tiles in rooms and/or bathrooms. Two (2) resident beds had broken headboards or footboards. Two (2) resident rooms did not have string cords attached to lights over head of beds. The findings include:	F 253	**F 253 E** **Corrective Actions for Targeted Residents:** All resident rooms that were identified as not having strings on their over bed lights were corrected. The identified footboards/headboards were repaired or replaced. The door knob with the identified sharp edge was repaired. The identified stained ceiling tiles were replaced. **Identification of Other Residents with Potential to Be Affected:** All residents have a potential to be effected by this practice. **Systemic Changes:** Associates were in serviced on how to enter maintenance requests in the maintenance computer log. The over bed lights missing strings has been added to the Non-clinical rounds form that is completed weekly by the Department managers. Maintenance will conduct weekly rounds to identify stained ceiling tiles.	May 9, 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X [signature] | TITLE: X Executive Director X | (X6) DATE: 4/22/11

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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NAME OF PROVIDER OR SUPPLIER: GOLDEN LIVINGCENTER - HILLCREEK

STREET ADDRESS, CITY, STATE, ZIP CODE: 3116 BRECKINRIDGE LANE, LOUISVILLE, KY 40220

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F 253	Continued From page 1 Observations made on intial tour on 03/29/11 revealed brown-rust colored stains on ceiling tiles in resident bathrooms in rooms 406, 409, 410, 412, a broken footboard on a resident's bed in room 408, strings missing from over bed lights in rooms 231 and 234. A door knob on the interior of the bathroom in room 202 was observed with a sharp edge protruding, which jabbed surveryor in the back during the tour. Observation on tour with the Maintenance Director on 03/31/11 at 10:45am revealed brown-rust colored stains on ceiling tiles in resident rooms 405 and 412, brown-rust colored stains on ceiling tiles in bathrooms in resident rooms 406, 408, 410, 412 and an unattached headboard in room 234. A door knob was observed on the inside of the bathroom door in room 202 with a piece missing from the center of the door knob exposing a sharp shaft. Interview with the Maintenance Director on 03/31/11 at 10:50am revealed that the he was not aware that the that strings had been missing on two over the bed lights. He was unaware of the sharp edge on the bathroom door knob. The Maintence Director said he did not consider the protruding edge on the door knob a problem when. He did reveal that the problem with the stained ceiling tiles in the 400 Unit was an on going problem for the facility because sinks and toilets were always running over in the rooms on the floor above and leaking into the ceilings on the floor below. He revealed even though the facility has a computerized system in place to track repairs needed, staff was not utilizing the system correctly or he would have caught these repairs He stated he reviews and prints out the work order list each day and deletes the issues as	F 253	**Monitoring:** Results from the Non-clinical rounds and audits will be reviewed daily (M-F) during the AM start-up meeting led by the Administrator or his designee. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.	

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F 253	Continued From page 2 the work is completed. In addition, he assesses resident rooms monthly. Review of the work order print out for 03/31/11 revealed that a work order request for Room 410 and 412 to repair moldy, wet, ceiling tiles was initiated on 03/24/11, but not yet completed. There was no work order request initiated for repairs needed in rooms 202, 231, 234, 406, and 409.	F 253	1) **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #10 was screened by therapy to ensure resident's restorative program was valid for the resident's current condition. 2) **How will the facility identify other residents having the potential to be affected by the same deficient practice?** Documentation records of residents currently receiving restorative services were reviewed for April 2011. Residents identified as having missing documentation, missing restorative services or refusing restorative were screened by therapy to ensure the restorative program ordered was still valid. Any issues identified were corrected. 3) **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** Restorative staff was trained by the ADNS to ensure all programs are completed as ordered or Nursing Administration must be notified so alternate staff may be assigned. 4) **How will the facility monitor its performance to ensure that solutions are sustained?** Weekly a review of the Restorative documentation will be completed by the Restorative Nurse team leader and submitted to the ADNS. These findings will be reported monthly to the facility QAA committee by the ADNS for review for 3 months, then quarterly for 3 quarters.	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide treatment and services to maintain or improve abilities for one (1) of thirty-two (32) sampled residents (Resident #10). Resident #10 did not receive Restorative Therapy for ten (10) of fourteen (14) scheduled days, with eight (8) of the ten (10) days consecutive. The findings include: Review of the facility policy, Clinical Guideline: Restorative, undated, revealed the facility provides a Restorative Nursing Program that promotes the residents' ability to adapt and adjust as independently and safely as possible. Resident selection may include but not be limited to: Recent completion of therapy program, restriction of activity, and/or a diagnosis that is likely to	F 311		May 9, 2011

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F 311	Continued From page 3 produce a functional decline. Observation on 03/29/11 at 11:20am of Resident #10 revealed a well groomed appearing resident lying in bed. Both of the resident's forearms were wrapped in Kerlix, and a compression glove was noted to the resident's left hand. Resident #10 was alert and oriented to person, place and time. Interview on 03/30/11 at 9:30am with Resident #10 revealed the resident asking what Restorative Therapy was and stated that it had not been getting done. Resident #10 stated he/she was not receiving Physical Therapy and Restorative Therapy was to be working with the resident. Review of the medical record for Resident #10 revealed an admission date of 12/29/10. The resident was re-admitted to the facility from a hospitalization on 03/01/11. Diagnoses for Resident #10 included: End Stage Renal Disease with a Kidney Transplant in 1998, History of Breast Cancer, Pneumonia, Diabetes, Cerebral Vascular Accident with late effects, and nontraumatic hematoma of soft tissue. Review of the Minimum Data Set (MDS) 3.0 Comprehensive Admission Assessment dated 01/24/11 revealed the facility assessed Resident #10 with a score of thirteen (13) on cognition (a score of 13-15 indicates a person is cognitively intact). Continued review of the MDS assessment completed by the facility revealed limited assistance with staff assist of one with bed mobility, transfers, and dressing. Range of Motion was coded as having impairment of lower extremities on both sides.	F 311		

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F 311	Continued From page 4 Review of the Restorative Function Maintenance program for Resident #10 revealed the resident was initiated on the program on 03/14/11. Resident #10 was to receive: Active Range of Motion (AROM) to bilateral upper extremities (BUE) and Passive Range of Motion (PROM) to Bilateral Lower Extremities (BLE) with 10 repititions for15 minutes, seven (7) days a week, Transfer Training from bed to chair and Bed Mobility training from side to side was to be completed for 15 minutes, seven (7) days a week. The treatment goals for Resident #10 were to maintain current level of Range of Motion to BLE's and BUE's, and to maintain current ability to assist with transfer, and bed mobility. Review of the Restorative Worksheet Record on 03/30/11 revealed eight (8) dates, March 15th, 16th, 17th, 18th, 20th, 22th, 26th, and 27th with zero (0) marked under minutes for all four (4) Restorative Therapy activities, and the dates were signed off with staff initials. Two (2) dates, Saturday, March 19th and Monday, March 21 were not marked with initials or minutes. Interview with the Restorative Licensed Practical Nurse (LPN) on 03/31/11 at 10:45am revealed she had been assigned to do Restorative for Resident #10 on occasion. She stated there is a zero (0) marked, indicating the resident did not receive Restorative Therapy that day. The Restorative LPN stated if they are not able to get to the residents they are to report to the Restorative Program Director. She went on to say that we may not necessarily report the resident did not get restorative therapy unless it is consistently missed. The Restorative LPN stated Resident #10 was at the bottom of the list and that sometimes they don't get to the resident.	F 311		

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F 311	Continued From page 5 When ask how this could affect the resident, she stated if the resident does not get restorative the resident could decline or develop contractures, or contractures can worsen. Interview with the Restorative Certified Nursing Aide (RCNA) on 03/31/11 at 11:20am revealed she stated if Restorative can not get to the Resident that day they will report it to the Restorative Program Director and to the charge nurse, which she stated she had done for Resident #10. She stated they will try to get to the resident the next day. Interview with LPN #4 and LPN #7 on 03/31/11 at 11:30am, the nurses primarily responsible for Resident #10 during the day, denied that they had been told that Resident #10 had not been receiving Restorative Therapy. Interview with the Restorative Program Director on 03/31/11 at 11:15pm revealed he was not aware that Resident #10 had not been receiving Restorative Therapy. He stated if he had been told he would have completed therapy himself or assigned them to another staff member. Interview with Physical Therapist (PT) #1 on 03/31/11 at 12:45pm revealed the facility had discontinued Physical Therapy for Resident #10 because the resident was not progressing and was refusing therapy. The Physical Therapist did re-evaluate Resident #10 for ROM while surveyor was observing and after reviewing the resident's previous measurements, the PT stated Resident #10 had a slight decline of left hip flexion strength from 2/5 to 2-/5. Interview with the Director of Nursing on 03/31/11	F 311		

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F 311	Continued From page 6 at 1:15pm revealed she was not aware residents were not receiving Restorative Therapy as ordered. She acknowledged there was a problem in the system of reporting, and ensuring residents are receiving Restorative Therapy. She stated if the residents did not receive therapy they could potentially lose there current level of function and have a decline in their Activities of Daily Living.	F 311	1) **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No specific residents were identified as being affected by the alleged deficient practice. The bottle of vanilla extract and food coloring were discarded.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined the facility failed to date open items in the dry storage area and wear beard coverings. The findings include: Review of the facility policy for storing dry food, (Chapter 5: Infection Control 5.43) stated label all open items with date opened. Review of the facility policy for hair guidelines, (Chapter 5: Infection Control 5.5) stated dietary associates must wear hair restraints such as beard restraints and must be worn to effectively keep hair from contacting exposed food. Observation during initial tour of the kitchen 03/29/11 at 8:30am revealed one (1) 32oz bottle	F 371	2) **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected. 3) **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** Staff was inserviced on the policy for storing/labeling of dry food and policy for infection control related to hair guidelines. Inservice was completed by the Dining Services Manager by 4/29/11. 4) **How will the facility monitor its performance to ensure that solutions are sustained?** Closing checklist will be completed daily by the PM cook to check for labeling and dating. Opening checklist will be completed daily by the Director of Dining Services, or designee to ensure closing checklist was completed correctly. DSM and Assistant DSM will also complete random rounds to ensure compliance in regards to both proper labeling and hair covering guidelines. Both items will be monitored through a weekly DSM checklist. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly for 3 quarters.	May 9, 2011

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F 371	Continued From page 7 of red food coloring and one (1) 32oz bottle of imitation vanilla extract were open and undated. Interview with the Assistant Dietary Director (ADD) on 03/29/11 at 8:35am revealed that the all dietary staff are trained to label and date any open food item. She further stated it is her responsibility to monitor if open food items are labeled and dated correctly. Interview with the Dietary Director (DD) on 03/31/11 at 1:30pm revealed all dietary staff are trained on proper labeling and dating open food items. She further stated the ADD along with herself are responsible to ensure open food items are properly labeled and dated. Observation of the tray line on 03/30/11 at 11:00am revealed the staff cook stirring a liquid substance over the stove without wearing a beard covering. Interview with the staff cook on 03/30/11 at 2:40pm revealed he had been trained on hair and beard coverings. He stated he knew better, but was rushing and nervous. He further stated uncovered hair was an infection control issue and could cause residents to become ill from the germs. Interview with the DD on 03/31/11 at 1:30pm revealed staff had been trained on infection control and hair covering guidelines. She stated hair coverings are used to keep hair from contact with exposed food. She further stated that a breech in infection control has a potential to make residents ill.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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	F 441		

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F 441	Continued From page 8 of disease and infection. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure proper infection control practices were	F 441	**F 441 E** 1) **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Identified foley catheter bags and tubing were replaced on March 31, 2011. 2) **How will the facility identify other residents having the potential to be affected by the same deficient practice?** An audit was conducted by the Director of Clinical Education of residents with foley catheters for proper placement of bags and tubing on April 20, 2011. Issues identified were corrected. 3) **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** Infection control training was conducted by the Director of Clinical Education to the nursing staff on Infection Control issues in Clinical Services, completed by April 29th, 2011. 4) **How will the facility monitor its performance to ensure that solutions are sustained?** An audit of infection control practices will be documented using the Monitoring Compliance with Infection Control Checklist completed by the Director of Clinical Education weekly for 4 weeks, then monthly thereafter. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly for 3 quarters.	May 9, 2011

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F 441	Continued From page 9 maintained by not ensuring proper placement of urinary drainage bags and/or tubing on four (4) of the twenty-five (25) sampled residents (# 1, 9, 18, and 20). The findings include: The facility could not provide a policy and procedure on catheter care which includes proper placement of urinary drainage bags and tubing. 1. Review of the clinical record for resident #1 revealed an admission date of 11/18/09 with the following diagnoses: Multiple Sclerosis, High Blood Pressure, Anxiety, Anemia, Hypothyroidism, Contractures, Colostomy placement, and Bladder Removal with an external urinary drainage system (Urostomy). Review of the Physician admission orders reveal routine urostomy care to be completed daily and urinary drainage bag to be changed every two (2) weeks. Observation on 03/29/11 at 11:20am revealed the resident lying in the bed. The urinary drainage bag was placed in a dignity bag hanging from the side of the bed, with the tubing exposed and lying on the floor. Observation on 03/29/11 at 12:10pm revealed the resident sitting up in the bed. The urinary drainage tubing was exposed and lying on the floor. Observation on 03/29/11 at 3:05pm revealed the resident in the bed with the urinary drainage tubing exposed and lying on the floor. Interview on 03/30/11 at 1:15pm with Certified Nursing Assistant (CNA) #2 revealed she was	F 441		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 10 aware the exposed tubing touching the floor. The CNA stated the tubing sometimes touches the floor when the bed is in the low position. The CNA also revealed she did not routinely check to see if the tubing was touching the floor during her rounds with the residents. She was not able to verbalize a potential problem for the resident when the tubing touched the floor. Interview on 03/30/11 at 1:20pm with Licensed Practical Nurse (LPN) #3 revealed potential risks to the resident would include issues with infection control and potentially stepping on the urinary drainage tubing, which could cause urostomy device to become dislodged. The LPN also stated that everyone is responsible for ensuring proper placement of catheter tubing. 2. Review of the clinical record for Resident #18 revealed an admission date of 12/24/08 with the following diagnoses: High Blood Pressure, Neurogenic Bladder, Depression, Dementia Anemia, Hydronephrosis, Diabetes, Renal Insufficiency, and a Suprapubic Catheter. Review of the physician admission orders revealed orders to perform routine suprapubic catheter care, to place catheter to a leg bag during the day, and to change indwelling catheter every eight (8) weeks. Observation on 03/29/11 at 9:15am revealed the resident sitting up on the side of bed eating breakfast. The urinary drainage bag and exposed tubing were lying on the floor. Observation on 03/31/11 at 9:05am revealed the resident sitting up on the side of the bed watching television. The urinary drainage bag and exposed tubing were lying on the floor.	F 441		

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F 441	Continued From page 11 Interview on 03/31/11 at 1:10pm with CNA # 3 revealed she had not gone into the Resident's room to ensure proper placement of the catheter bag and tubing. She stated the Resident did not want to be bothered. She did state the resident could be at risk for infection due to the catheter bag and tubing lying on the floor. Interview on 03/31/11 at 1:35pm with LPN #2 revealed the facility is responsible for ensuring proper infection control practices. She stated improper placement of the catheter bags and tubing could place the residents at risk for infection. Interview on 03/31/11 at 1:45pm with the Director of Clinical Education revealed placing the catheter bag and/or tubing on the floor could potentially place the resident at risk for an infection. She also revealed 01/11/11 she discovered a residents catheter bag on the floor on the 200 Unit, however she did not provide an in-service to all of the staff in the facility. She stated she did not feel that improper placement of catheter bags and tubing were a problem that required facility wide in-service. She indicated after the interview the facility did need further education of proper catheter care and infection control practice. Interview on 03/31/11 at 2:25pm with the Director of Nursing (DON) revealed she was not aware that the infection control in-services regarding catheter care were not done throughout the entire facility. She also revealed that improper catheter care could place the residents at risk for infection and that there could be a possible correlation between improper catheter care and Urinary Tract Infections. She confirmed that she is ultimately	F 441		

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F 441	Continued From page 12 responsible for ensuring safe and proper infection control practices in the facility. 3. The facility admitted Resident #9 on 03/24/11 with the following diagnoses of Cerebral Vascular Accident (Stroke), Congestive Heart Failure, Vitamin D Deficiency, Type I Diabetes, Hypertension, Hyperlipidemia, and Depression. The was an doctor's order for foley catheter (for urinary drainage) to bedside drainage with catheter care every shift. Observation on 03/29/11 at 11:21, 12:15pm, and 12:45pm am revealed Resident #9 sitting on the side of the bed or in a wheelchair with an indwelling catheter bag in a dignity bag and the catheter tubing lying on the floor. Record review on 03/29/11 revealed Resident #9 had a urinalysis performed on 03/26/11. The results revealed the following abnormal results: Clarity was cloudy (normal is clear), Blood was 3+ (normal is negative), Leukocytes were 1+ (normal is negative) and white blood cells were 3-5 (normal is 0-2). Observation on 03/30/11 at 8:25am revealed Resident #9 sitting in a wheelchair in his/her room with the indwelling catheter bag and tubing lying on the floor. At 9:10am and 12:40pm the catheter bag was in a dignity bag but the tubing was lying on the floor. Observation on 03/30/11 at 2:45pm for Resident #9 revealed urine in the indwelling catheter tubing to be pale yellow, cloudy and with sediment.	F 441		

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F 441	Continued From page 13 Record review on 03/31/11 revealed Resident #9 had a repeat urinalysis performed on 03/29/11. The results revealed the following abnormal results: Clarity was Turbid (normal is clear), Blood was 3+ (normal is negative), Nitrite was positive (normal is negative), Leukocytes 2+ (normal is negative), Red Blood Cells 3-5 (normal is 0-2), White Blood Cells 6-20 (normal is 0-2), Epithelial Cell -few (normal is negative), Uric Acid Crystals - present (normal is absent), and Budding Yeast - present (normal is absent). Observation on 03/31/11 at 8:47am revealed Resident #9 up in a wheelchair with the indwelling catheter bag in a dignity bag and the catheter tubing lying on the floor. Interview with CNA #1 on 03/31/11 at 10:18am revealed the indwelling catheter bag should be in a dignity bag and the catheter tubing should be off the floor. Interview with RN #1 on 03/31/11 at 10:25am revealed the indwelling catheter bag should be placed in a dignity bag below the level of the bladder and the tubing should be coiled in the dignity bag to keep tubing off the floor in order to prevent infections. Interview with LPN #1 on 03/31/11 at 10:45am the indwelling catheter bag should be kept in a dignity bag and the bag should be off the floor. She stated the catheter tubing should never be on the floor. LPN #1 acknowledged that catheter bags and tubings left on the floor could play a role in a resident developing a urinary tract infection. 4. The facility admitted Resident #20 on 03/09/11	F 441		

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	185095		03/31/2011

NAME OF PROVIDER OR SUPPLIER
GOLDEN LIVINGCENTER - HILLCREEK

STREET ADDRESS, CITY, STATE, ZIP CODE
3116 BRECKINRIDGE LANE
LOUISVILLE, KY 40220

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F 441	Continued From page 14 with the following diagnoses of: intracerebral hemorrhage, nausea/vomiting, senile dementia, depressive disorder, dysphagia, hypertension, convulsions, and chronic ischemic heart disease. The resident currently has a diagnosis of urinary retention and a history of urinary tract infection (UTI). Observation on 03/30/11 at 2:55pm revealed Resident #20 seated in his/her wheelchair in physical therapy performing exercises on the arm bike. His/Her indwelling catheter bag was secured and hanging under his/her wheelchair in a dignity bag. The catheter tubing was touching the floor. Observation on 03/31/11 at 11:05am revealed Resident #20 coming down the hallway in his/her wheelchair, from the beauty shop, being transported by a physical therapy assistant. The resident's indwelling catheter bag was in a dignity bag and was secured and hanging under his/her wheelchair. The catheter tubing was dragging along the floor from the beauty shop back to the resident's room. Interview with the physical therapy assistant on 03/31/11 at 11:10am revealed that she was trained to make sure a resident's indwelling catheter bag or tubing did not touch the floor. The catheter bag is to be in a dignity bag and the tubing should be hooked up with a clip when a resident is in a wheelchair. When told Resident #20 was observed with his/her catheter tubing dragging on the floor from the beauty shop back to his/her room while she was transporting him/her, she responded that it was hooked up with a clip before she started transporting him/her, but it must have come unhooked on the	F 441		

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F 441	Continued From page 15 way. She stated she was trained to keep the tubing off the floor so it would stay clean and sanitary. Otherwise, the resident could possibly get an infection. Interview with LPN #4, the unit manager for the 300 unit, stated all indwelling catheter bags should be in a dignity bag, and the bag and tubing should not be touching the floor. The bag should hang to bedside drainage below the resident's bladder. If the resident leaves the room in a wheelchair, the indwelling catheter bag should be in a dignity bag and the tubing adjusted so it does not touch the floor. If the tubing is observed to be touching the floor the staff person is trained to either fix it right away or get someone who can fix it right away. If tubing is allowed to be on the floor it could lead to infections. Record review on 03/31/11 revealed Resident #20 had a urinalysis performed on 03/13/11. The final results revealed the following abnormal results: positive nitrites (normal is negative), 2+ leukocytes (normal is negative), 3-5 white blood cells (normal is 0-2), and many bacteria (normal is negative). A physician's telephone order was taken on 03/16/11 for Augmentin 875-125mg, 1 tablet, by mouth, two times a day, for 10 days, for urinary tract infection. Refer to regulatory tag F498	F 441		
F 498 SS=E	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 498		

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	185095		03/31/2011

NAME OF PROVIDER OR SUPPLIER: GOLDEN LIVINGCENTER - HILLCREEK

STREET ADDRESS, CITY, STATE, ZIP CODE: 3116 BRECKINRIDGE LANE, LOUISVILLE, KY 40220

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F 498	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on interview and policy review, it was determined the facility failed to ensure CNAs demonstrated competency in catheter care related to catheter tubing and bag placement for three (3) of twenty-five (25) sampled residents. Residents #1, #9 and #18 were observed to have catheter tubing and/or bags lying on the floor. The findings include: The facility could not provide a policy on CNA training regarding the placement of catheter bags and tubing to prevent infection. Review of the facility's policy entitled Catheter Care, Indwelling Catheter - Procedure 245 revealed there is no mention of placing the catheter bag in privacy bag or of keeping the tubing and bags off the floor to prevent infections. Review of the facility's Infection Control Policy revealed a Monitoring Compliance/ Infection Control Checklist. Included under the section on Foley Catheters were the following; Is bag anchored?, Is bag off the floor? Review of the facility's policy entitled Employee Training on Infection Control dated 10/2009 revealed the facility shall provide staff with appropriate information and instruction about infection control through various means, including initial orientation and ongoing training programs. Interview on 03/30/11 at 1:15pm with Certified Nursing Assistant (CNA) #2 revealed that she had	F 498	**F 498 E** **1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Identified foley catheter bags and tubing were replaced on March 31st, 2011. **2) How will the facility identify other residents having the potential to be affected by the same deficient practice?** An audit was conducted by the Director of Clinical Education of residents with foley catheters for proper placement of bags and tubing on April 20, 2011. **3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** The foley catheter care guideline was updated to include using privacy bags and to keep tubing and bags off the floor to prevent infections. The nursing assistants were retrained on proper placement of foley catheter bags and tubing by the Director of Clinical Education by April 29th, 2011. **4) How will the facility monitor its performance to ensure that solutions are sustained?** Foley catheter bag and tubing placement will be audited weekly by the Director of Clinical Education for 4 weeks, then monthly thereafter. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly for 3 quarters.	May 9, 2011

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F 498	Continued From page 17 been told to place the extra tubing from catheters in the dignity bag by the unit manager, but she had not done this during her rounds today. She also revealed that she could not recall having an in-service on catheter care and placement of catheter bags and tubing, or if this information is discussed in training modules. Interview on 03/31/11 at 1:10pm with CNA #3 revealed that in-services vary from unit to unit. She stated she the last in-service she received on infection control was over a year ago, and could not remember if it included catheter care and proper placement of catheter bags and tubing. Review of the CNA training records revealed the content of the infection control computerized training modules and CNA in-services did not include information on urinary drainage bag and/or tubing placement. Interview with the Director of Clinical Education (DCE) on 03/31/11 at 1:45pm revealed she did not use the Monitoring Compliance with Infection Control Checklist from the facility's Infection Control Policy. The DCE stated she used a monitoring tool she developed. She was not trained to use the facilities tool. She revealed the monitoring device she used did not have an area on catheter care. When asked if catheter care was important to monitor she stated yes, but not important enough to put on the monitoring sheet. She stated she monitored catheter care only if she happened to see it. The DCE stated that she did one on one in-servicing when problems were identified and tried to cover all staff with in-servicing on units where problems were identified. The DCE reported all new hire CNAs get training on catheter care in the new employee	F 498		

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F 498	Continued From page 18 training, however, there had been no ongoing training regarding catheter care had been done since she had been at facility (8 months). The DCE stated training for the twelve required in-services for CNAs is completed using computer self study modules. There is a module on infection control but that module does not include caring for catheter bags and tubing to prevent infection. She stated the facility is responsible for ensuring the residents are taken care of and with the conclusion of surveyor interview she now saw the need to educate on catheter care to prevent infection. Interview with the DON on 03/31/11 at 2:30pm revealed there could possibly be a correlation between poor catheter care and urinary tract infections. The DON was unaware that the CNA self study modules did not cover catheter care and that the catheter care policy did not cover catheter bag and tubing placement. Refer to Tag F441.	F 498		

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	185095	A. BUILDING 01 - GOLDEN LIVING CENTER B. WING	03/30/2011

NAME OF PROVIDER OR SUPPLIER: GOLDEN LIVINGCENTER - HILLCREEK

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K 000	INITIAL COMMENTS A Life Safety Code Survey was initiated and concluded on March 30, 2011. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F". Type Of Structure: 2000 Existing/Type III-Protected with complete sprinker system Plan Approval Date: 6/15/1970	K 000	**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.**	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ 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 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by:	K 018	**K 018 D** **Corrective Actions for Targeted Residents:** Doors for rooms 129, 131, and 139 were repaired so that the door will positively latch. **Identification of Other Residents with Potential to Be Affected:** All residents have a potential to be effected. **Systemic Changes:** Maintenance director and assistant completed audits of living center resident rooms. Any doors found to be out of compliance were immediately repaired. **Monitoring:** Maintenance director will complete a door audit monthly. He will audit one unit per month. Results from the Non-clinical rounds and audits will be reviewed daily (M-F) during the AM start-up meeting led by the Administrator or his designee. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.	05/09/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X [signature] CEO

TITLE: X Executive Director

(X6) DATE: X 4/22/11

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 018	Continued From page 1 Based on observation and interview, it was determined the facility failed to maintain doors located in the corridor, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of six smoke compartments, six (6) residents, staff, and visitors. The findings include: Observation on 03/30/2011 at 11:00 AM, with the Maintenance Director, revealed resident room doors 129, 131, and 139 would not latch when closed. Interview on 03/30/2011 at 11:00 AM, with the Maintenance Director, revealed he agreed the doors needed to be worked on to ensure the doors would latch and keep smoke/fire from entering the resident ' s rooms in the event of a fire. Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm)	K 018		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	

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K 018	Continued From page 2 shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in	K 018		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GOLDEN LIVING CENTER B. WING	(X3) DATE SURVEY COMPLETED 03/30/2011
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	

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K 018	Continued From page 3	K 018		
	service.			
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 025	**K 025 F**	
	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		**Corrective Actions for Targeted Residents:** Both identified penetrations were repaired.	05/09/11
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) out of six (6) smoke compartments, one hundred and six (106) residents, staff, and visitors.		**Identification of Other Residents with Potential to Be Affected:** All residents have a potential to be effected.	
	The findings include:		**Systemic Changes:** Maintenance director will follow up with all vendors that gain access to our attic space and ensure that all penetrations are closed properly once the work is performed.	
	Observation on 03/30/2011 at 10:30 AM, with the Maintenance Director, revealed a penetration in the smoke barrier located in the attic of the 100 Hall. The penetration was approximately eight (8) inches by eight (8) inches and had cables running through the opening. Interview on 03/30/2011 at 10:30 AM, with the Maintenance Director, revealed he is responsible for checking the smoke barriers twice a year and he had not identified the penetration in the smoke		**Monitoring:** Maintenance director or designee will complete an attic penetration audit monthly. He will audit one unit per month. Results from the Non-clinical rounds and audits will be reviewed daily (M-F) during the AM start-up meeting led by the Administrator or his designee. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.	

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K 025	Continued From page 4 barrier before the day of the survey. Observation on 03/30/2011 at 10:55 AM, with the Maintenance Director, revealed a penetration in the smoke barrier located in the attic of the 300 Hall. The penetration was approximately two (2) feet by two (2) feet. Interview on 03/30/2011 at 10:30 AM, with the Maintenance Director, revealed he is responsible for checking the smoke barriers twice a year and he had not identified the penetration in the smoke barrier before the day of the survey. Reference: NFPA 101 (2000 Edition). 8.2.3.2.4.2* Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) * Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one	K 025		

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K 025	Continued From page 5 of the following conditions is met: a. The material shall be capable of maintaining the fire resistance of the fire barrier. b. The material shall be protected by an approved device that is designed for the specific purpose. (4) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the fire barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 025		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access and exit doors were maintained to be clearly recognizable as a means of egress, per NFPA standards. The facility is licensed for (172) beds and the census on the day of the survey was (159) residents. The findings include: Observation on 3/30/2011 at 10:40 AM with the Safety Director and Maintenance Director,	K 038	**K 038 D** **Corrective Actions for Targeted Residents:** No residents were identified. **Identification of Other Residents with Potential to Be Affected:** No residents have the potential to be affected. **Systemic Changes:** Curtains on the 100 wing doors were removed immediately on tour with surveyors. **Monitoring:** Monitoring not necessary as there will be no curtains or hardware on the exit doors.	05/09/11

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K 038	Continued From page 6 revealed curtains on the exit doors to the outside on the (100 Wing) next to resident rooms 100 and 101. Interview with the Safety Director on 3/30/2011 at 10:40 AM, revealed they did not know they could not use curtains on exit doors. Reference: 7.5.2.2 Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit.	K 038		
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051	**K 051 F** **Corrective Actions for Targeted Residents:** No specific residents were identified. **Identification of Other Residents with Potential to Be Affected:** All residents have the potential to be affected. **Systemic Changes:** Contracted vendor was called to inspect the findings and lower any pull station that does not meet regulation. All pull stations that were identified as being too high were lowered to be in compliance with the regulation. **Monitoring:** Monitoring not necessary as there will be no pull station that will be out of regulation and no additional pull stations will be added.	05/09/11

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	

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K 051	Continued From page 7	K 051		

This STANDARD is not met as evidenced by:
Based on observation and interview it was determined the facility failed to maintain the building's fire alarm system as required by the National Fire Protection Association (NFPA) Standard 72. This deficiency has the potential to affect all (159) residents, staff and visitors. The facility is licensed for (172) beds and the census on the day of the survey was (159) residents.

The findings include:

Observation on 3/30/2011 at 2:00 PM with the Safety Director and Maintenance Director, revealed four (4) fire pull initiation devices were mounted higher than the 4 1/2 ft. maximum. The first pull device was located on the 100 Wing across from the nurses station. The second pull device was located across from front lobby at the main entrance. The third pull device was located on the 200 Wing across from the nurses station. The fourth pull device was located in the therapy gym in the basement.

Interview with the Maintenance Director on 3/30/2011 at 2:00 PM, indicated that he did not realize the pull initiation devices were mounted too high.

Reference: NFPA 72 (1999 Edition) 2-8.1 Mounting
Each manual fire alarm box shall be securely mounted. The operable part of each manuel fire alarm box shall be not less than 3 1/2 ft. (1.1 m)

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K 051	Continued From page 8 and not more than 4 1/2 ft. (1.37 m) above floor level.	K 051		
K 056 SS=F	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 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 ensure the building had a complete sprinkler system, according to NFPA standards. The defciency has the potential to affect all (159) residents, staff and visitors. The facility is licensed for (172) beds and the census on the day of the survey was (159) residents. The findings include: Observation on 3/30/2011 at 11:20 AM with the Safety Director and the Maintenance Director, revealed five overhangs with no sprinklers. The overhangs are located at the two exits on the (100 Wing) and the two exits on the (200 Wing). The basement exit next to the Therapy Gym also	K 056	**K 056 F** **Corrective Actions for Targeted Residents:** No specific residents were identified. **Identification of Other Residents with Potential to Be Affected:** All residents have the potential to be affected. **Systemic Changes:** Vendor contracted to install sprinklers on the egress identified on the tour. **Monitoring:** Monitoring not necessary as there will be no additional egress that requires a sprinkler head. Monitoring of all sprinkler heads is completed by the contracting on a routine basis.	05/09/11

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K 056	Continued From page 9 has a overhang. All five overhangs are over four (4) foot in width. Interview with the Maintenance director on 3/30/2011 at 11:20 AM, indicated that he was not aware that the overhangs needed to be sprinkled. 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		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the sprinkler system was maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one hundred and fifty nine (159) residents, staff and visitors. The findings include: Observation on 3/30/2011 at 10:48 AM, with the Maintenance Director, revealed the sprinkler piping located in the attic space on the 200 wing was being used to support various cables and wires. Further observation revealed the sprinkler	K 062	**K 062 F** **Corrective Actions for Targeted Residents:** No specific residents were identified. **Identification of Other Residents with Potential to Be Affected:** All residents have the potential to be affected. **Systemic Changes:** Vendor was contracted to come and remove any wire/conduit from the sprinkler piping and make sure that the piping was in good working condition. **Monitoring:** Maintenance director will follow up with vendors after work is performed in attic to ensure that no cables or conduit is in contact with the sprinkler piping.	05/09/11

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	185095	A. BUILDING 01 - GOLDEN LIVING CENTER B. WING	03/30/2011
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	

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K 062	Continued From page 10 piping was also being used to support metal conduit in which wiring was ran through. Interview on 03/30/2011 at 10:48 AM, with the Maintenance Director, revealed the facility uses an outside contractor for sprinkler inspection and repair. When questioned the, Maintenance Director, agree that the various wires and metal conduit attached to the sprinkler piping could overtime cause damage to the sprinkler system causing it to leak or not work. Reference: NFPA 13(1999 edition) 6-1.1.5 Sprinkler piping or hangers shall not be used to support nonsystem components.	K 062		
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency could affect all residents, staff, and visitors in (Zone 1). The facility is licensed for one-hundred seventy-two beds (172) and the census on the day of the survey was one-hundred fifty-nine residents (159). The findings include: Observation on 3/30/11 at 10:40 AM with the Safety Director, revealed a hanging decoration (wreath) on the resident's room door numbered 100.	K 073	**K 073 F** **Corrective Actions for Targeted Residents:** No specific residents were identified. The wreath was immediately removed from the identified door. **Identification of Other Residents with Potential to Be Affected:** All residents have the potential to be affected. No other rooms identified to have had a hanging decoration on the door. **Systemic Changes:** A letter has been drafted and sent to all families making them aware of the dangers of hanging decorations from the doors and having items that are not flame retardant. **Monitoring:** Inappropriate decorations have been added to the weekly non-clinical rounds form that is completed by the department managers. Results from the Non-clinical rounds and audits will be reviewed daily (M-F) during the AM start-up meeting led by the Administrator or his designee. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.	05/09/11

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K 073	Continued From page 11	K 073		
	Interview with the Safety Director on 3/30/11 at 10:40 AM, revealed the facility did not have a policy or system in place to ensure the decorations were treated with a flame retardant material. Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.		**K 147 D** **Corrective Actions for Targeted Residents:** No specific residents were identified. **Identification of Other Residents with Potential to Be Affected:** All residents have the potential to be affected. An audit of all rooms was completed by the Maintenance director and no other rooms were identified.	05/09/11
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	**Systemic Changes:** An inservice, for department managers and nursing staff, led by the Director of Education was completed by 4/29/11 to educate on the dangers of this alleged deficient practice. A letter has been drafted and sent to all families making them aware of the dangers of power strips and the living center's policies regarding power strips. **Monitoring:** Power strips have been added to the weekly non-clinical rounds form that is completed by the department managers. Results from the Non-clinical rounds and audits will be reviewed daily (M-F) during the AM start-up meeting led by the Administrator or his designee. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.	
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were enough electrical plugs to meet the needs of residents. The deficiency affected one (1) resident. The findings include: Observation on 03/30/2011 at 11:04 AM, with the Maintenance Director, revealed medical equipment (oxygen concentrator, medical bed) was plugged into a power strip. Interview on 03/30/2011 at 11:04 AM, with the Maintenance Director, revealed he agreed the medical equipment should not have been plugged into the power strip.			

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K 147	Continued From page 12 Reference: NFPA 99 Chapter 3 Electrical Systems 3-3.2.1.2 D 2. Minimum number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147		

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