

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

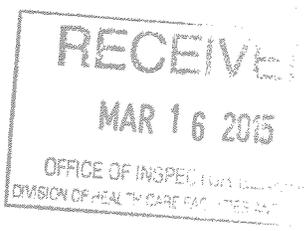
PRINTED: 02/25/2015
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 02/12/2015 |
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| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS | STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207 |
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| F 000 | INITIAL COMMENTS A Recertification Survey was initiated on 02/10/15 and concluded on 02/12/15 with deficiencies cited at the highest scope and severity of an "E". An Abbreviated Survey was initiated on 02/10/15 and concluded on 02/12/15 to investigate KY22826 and KY22838. The Division of Health Care unsubstantiated the allegations with no deficiencies cited. | F 000 | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility policy review, it was determined the facility failed to ensure the environment was safe and free from accident hazards related to leaving the central supply room door unlocked and the contents inside accessible to residents for one (1) of one (1) supply rooms on the 100 Unit. The facility staff failed to secure the central supply room that contained box cutters; instant hand sanitizer; bottles of no rinse perineal wash spray; bottles of dermal wound cleanser; safety lancets; insulin syringes; tuberculin syringes; and, | F 323 | | |



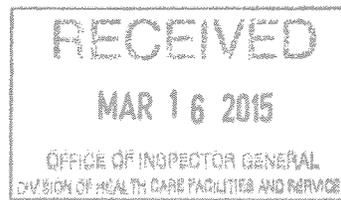
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X *Christi Noah* TITLE: X *Executive Director* (X6) DATE: 3/16/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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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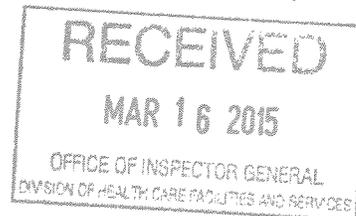
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| F 323 | <p>Continued From page 1 commercial spray cleaner.</p> <p>The findings include:</p> <p>Interview with the Administrator, on 02/12/14 at 3:52 PM, revealed the facility had a policy related to resident accidents and hazards, but did not have a policy specific to keeping the supply room door locked.</p> <p>Observation, on 02/10/15 at 9:26 AM, during initial tour revealed the central supply room located at the end of the 100 Unit hall had a sign on the door that indicated the door should be locked at all times. Continued observation revealed the door was unlocked and easily accessible to the residents.</p> <p>Observation, on 02/10/15 at 3:14 PM, revealed the sign on the door was absent and the door was unlocked. Continued observation revealed insulin syringes and tuberculin syringes were present in open boxes on a shelf.</p> <p>Observation, on 02/12/15 at 10:41 AM, revealed the central supply room door was unlocked with two (2) box cutters lying on a computer desk just inside the door. Further observation revealed eleven (11) bottles of instant hand sanitizer, twenty-one (21) bottles of no rinse perineal wash spray, twelve (12) bottles of dermal wound cleanser, safety lancets, insulin syringes, tuberculin testing syringes, and one (1) bottle of a commercial spray cleaner all accessible to the residents.</p> <p>Interview with State Registered Nurse Aide (SRNA) #6, on 02/12/15 at 10:57 AM, revealed he had been working three (3) days a week as the</p> | F 323 | <p>F323</p> <p>The Central Supply Room was locked immediately. A sign was placed on the door to notify staff that the doors to be kept locked at all times. No residents were found to be affected by the alleged deficient practice.</p> <p>Facility Maintenance Director installed a keypad lock and door closure on the central supply door on February 25, 2015. Staff were educated on 2/12/15 to ensure the door is locked at all times.</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> | |



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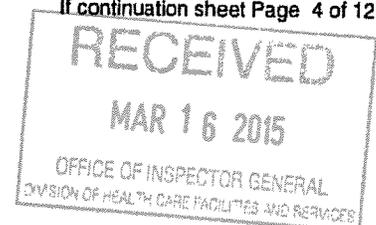
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| F 323 | <p>Continued From page 2</p> <p>Central Supply Clerk and two (2) days a week as an SRNA on the floor for approximately one (1) month. SRNA #6 had been working as the Central Supply Clerk on this day and stated he usually locked the supply room door when he left the room and he locked the door the last time he had left the supply room on this date. SRNA #6 further stated all nurses in the facility had a key to the central supply room and should know to keep the door to the supply room locked at all times.</p> <p>Interview with the Administrator, on 02/12/15 at 10:59 AM, revealed she was not aware the central supply room door was being left unlocked and stated that staff should know to keep the door locked at all times.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 02/12/15 at 3:39 PM, revealed if she needed any supplies from the central supply room she had a key to the room. LPN #4 stated she had never noticed the door to the central supply room to be unlocked and the door was always locked. LPN #4 stated all nurses in the facility had a key to the central supply room and she had been trained to make sure the door was locked at all times.</p> <p>Interview with SRNA #7, on 02/12/15 at 3:46 PM, revealed if she needed to get supplies she goes to a nurse who had a key to the central supply room. SRNA #7 stated she had not noticed the door to the central supply room being unlocked and she had been trained to make sure the door to the central supply room was locked at all times.</p> <p>Interview with the Administrator, on 02/12/15 at 3:52 PM, revealed she made daily rounds to check all areas of the facility and the Quality</p> | F 323 | <p>Audits will be conducted by the Executive Director to ensure door is locked at all times. Audits will be completed 5 times a week for 2 weeks then twice a week for 2 weeks then weekly for 2 weeks. The central supply door keypad and automatic closure will be added to building engines preventative maintenance program and will be checked monthly to ensure they are operating properly.</p> <p>Audit results will be reviewed at the monthly QAPI meeting to determine if further monitoring is necessary.</p> <p>Completion Date: 3/16/15</p> | | |



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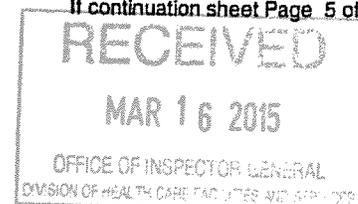
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| F 323 | Continued From page 3 Assurance (QA) Committee addressed any environmental concerns on a monthly basis. The Administrator stated on the weekends the Weekend Manager completed checks to ensure the doors were locked. | F 323 | F441 | | |
| 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 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. | F 441 | No Residents were found to be affected by the alleged deficient practice. The blood glucose monitor was cleaned on February 11, 2015 by an RN, with the appropriate bleach wipes. All residents receiving blood glucose monitoring have the potential to be affected by the alleged deficient practice. Nursing staff were re-educated on the blood glucose decontamination policy on March 9-11, 2015. Education was completed by the Regional Clinical Educator. Return demonstration was required. | | |



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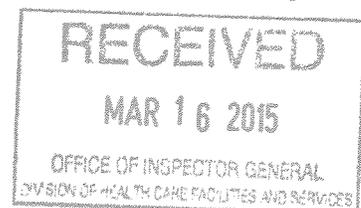
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| F 441 | <p>Continued From page 4</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review it was determined the facility failed to ensure Registered Nurse (RN) #1 cleaned a blood glucose monitor with bleach wipes as stipulated in the facility's policy for one (1) of one (1) glucose monitors used. In addition, the facility failed to provide employees with adequate supplies of soap, disposable paper towels or toilet paper for two (2) of eight (8) staff restrooms that did not have soap, disposable paper towels or toilet paper available for use by staff.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the facility's policy regarding Blood Glucose Monitor Decontamination, dated 12/01/14, revealed a wipe that was Environmental Protection Agency (EPA) registered as a tuberculocidal; effective against Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and a broad spectrum of bacteria would be utilized to clean the glucose monitors. The wipe would be the equivalent to a 1:10 bleach solution. <p>Observations, on 02/11/15 at 8:10 AM and 10:30 AM, revealed RN #1 failed to properly clean the blood glucose monitors. RN #1 used alcohol wipes to clean the blood glucose monitor after</p> | F 441 | <p>ADNS will observe 5 nurses each week X 4 weeks to ensure appropriate blood glucose monitor cleaning is occurring.</p> <p>Audit results will be reviewed at monthly QAPI Committee Meeting for review and further actions are deemed necessary.</p> <p>No Resident was identified as being affected by this alleged deficient practice.</p> <p>The paper towel dispensers were replaced by Housekeeping Services Supervisor on February 13, 2015 in the 100 Hall Nurse Station restroom and the 100 Hall Women's restroom. The soap dispensers were replaced by Housekeeping Services Supervisor on March 13, 2015 in the 100 Hall Nurse Station Restroom and the 100 Hall Women's Restroom.</p> | | |



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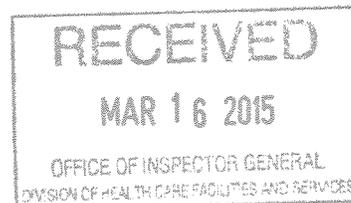
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| F 441 | <p>Continued From page 5 performing the blood glucose test on two separate residents.</p> <p>Interview with RN #1, on 02/11/15 at 10:38 AM, revealed she had been trained to use a bleach wipe to clean the blood glucose monitor between each use. The RN stated she thought the alcohol wipes were doing the same thing as the bleach wipes. The facility approved bleach wipes were found on the medication cart.</p> <p>Interview with the Director of Nursing (DON), on 02/12/15 at 10:00 AM, revealed she expected the nurses to follow the policies and procedures. The DON stated she expected the nurse to use bleach wipes to clean the blood glucose monitoring machine before and after each use.</p> <p>Interview with the Staff Development Nurse, on 02/11/15 at 10:05 AM, revealed she was responsible for educating the nursing staff. She further stated all nurses are in-serviced on hire and at least yearly regarding cleaning the blood glucose monitors. The in-service instructed staff to clean the blood glucose monitors with a bleach wipe before and after each use. The facility had not identified a problem with cleaning blood glucose monitors.</p> <p>2. Interview with the Regional Nursing Consultant, on 02/12/15 at 3:48 PM, revealed the facility had no written policy pertaining to staff contacting housekeeping with concerns.</p> <p>Review of the facility's Handwashing Policy, not dated, revealed handwashing was regarded as the single most important means of preventing the spread of infections. All associates would</p> | F 441 | <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>Staff were educated on 2/13/15 to inform Housekeeping Services Supervisor or housekeepers if supplies are not available.</p> <p>Housekeeping supervisor was educated by the Director of Nursing on infection control practices with emphasis on supplies being available at all times.</p> <p>Housekeeping supervisor educated his staff on infection control practices with emphasis on not leaving paper towel rolls on back of toilet.</p> | | |



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| F 441 | <p>Continued From page 6</p> <p>wash their hands and any other skin with antimicrobial soap. Handwashing facilities would be readily accessible to residents and associates.</p> <p>Observation of State Registered Nurse Aide (SRNA) #6, on 02/10/15 at 10:00 AM, in the women's public bathroom on the 100 Unit attempting to perform hand hygiene revealed she pumped the soap dispenser multiple times while it made a humming sound and then attempted to dispense paper towel from the paper towel dispenser, without success. She opened the door with her wet hands and exited the bathroom. Observation continued as she proceeded to the staff bathroom on the 100 Unit located in the nurses station. SRNA #6 stood inside the staff bathroom with the door propped open. Water was heard running while she proceeded with washing her hands. SRNA #6 left the bathroom and continued observation of the bathroom revealed the paper towel dispenser was open and the one and only roll of paper towel was placed on the toilet tank. The roll of paper towel had moist spots on the available roll of paper towel. The soap dispenser was missing the cover to assist in the dispensing of the soap. The soap dispenser required pushing on the bubble to dispense the soap. The bathroom did not contain any toilet paper.</p> <p>Observation, on 02/10/15 at 10:00 AM and at 3:00 PM, of a sign posted in the 100 Unit Nurses Station bathroom, dated January/2003 and titled Handwashing, revealed handwashing was the best way to prevent the spread of infection. Staff hands should be washed after using the bathroom by wetting their hands with warm running water and lathering with soap. Also, the</p> | F 441 | <p>Infection control coordinator or weekend nursing supervisor will monitor restrooms daily times two weeks then weekly times 4 weeks to ensure supplies are available.</p> <p>Housekeeping supervisor and Executive Director will make rounds weekly to ensure supplies are available in the restrooms.</p> <p>Results of inspections will be reviewed at the monthly QAPI meeting to determine further corrective action as deemed necessary.</p> <p>Completion Date: 3/16/15</p> | | |



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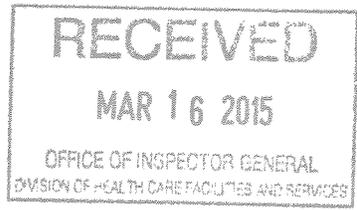
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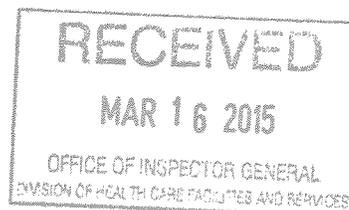
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| F 441 | <p>Continued From page 7</p> <p>staff should dry their hands using a single use paper towel and use a paper towel when they turned off the water faucet.</p> <p>Observation, on 02/10/15 at 10:15 AM, of the restroom at the nurses station on the 100 Unit, revealed the paper towel dispenser was not dispensing towels. A roll of paper towels were sitting on the back of the toilet for use and there was no toilet paper on the toilet paper dispenser.</p> <p>Observation, on 02/10/15 at 2:15 PM, of the restroom at the nurses station on the 100 unit, revealed there was no paper towels dispensed by the dispenser. A roll of paper towels were still sitting on the back of the toilet for use and there was still no toilet paper on the toilet paper dispenser for use.</p> <p>Observation, of the 100 Unit Nurses Station bathroom, on 02/10/15 at 3:00 PM, revealed the paper towel dispenser remained opened and without any paper towel in the dispenser. The roll of paper towel remained on the toilet tank. The soap dispenser was missing parts that facilitated the dispensing of the soap. The bathroom did not contain any toilet paper.</p> <p>Observation, on 02/11/15 at 9:10 AM, of the restroom at the nurses station on the 100 unit, revealed the paper towel dispenser was still not functioning and paper towels were not coming out of the dispenser at all. A roll of paper towels were still sitting on the back of the toilet for use.</p> <p>Observation, on 02/10/15 at 10:08 AM, of the women's public restroom on the 100 Unit, revealed the soap dispenser was not functioning and soap did not come out of the dispenser at all.</p> | F 441 | | |
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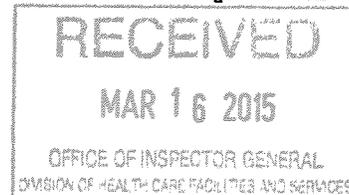
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| F 441 | <p>Continued From page 8</p> <p>The paper towel dispenser was also not functioning and paper towels were not coming out of the dispenser at all.</p> <p>Observation, on 02/10/15 at 2:00 PM, of the women's public restroom on the 100 Unit, revealed the soap dispenser was not functioning and soap did not come out of the dispenser at all. The paper towel dispenser was not functioning and paper towels were not coming out of the dispenser at all.</p> <p>Observation of the women's public bathroom, on 02/10/15 at 3:05 PM, revealed the soap dispenser was not dispensing soap. The paper towel dispenser did not dispense paper towels.</p> <p>Observation, on 02/11/15 at 9:00 AM, of the women's public restroom on the 100 Unit, revealed the soap dispenser was not functioning and soap did not come out of the dispenser at all. The paper towel dispenser was not functioning and paper towels were not coming out of the dispenser at all.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 02/12/15 at 5:20 PM, revealed the 100 Unit frequently ran out of soap and paper towels. She stated she did not like using the bathroom at the nurses station because of this. She stated the paper towel holder had not been working for several days. Cross contamination was a concern when staff could not wash and dry their hands.</p> <p>Telephonic interview with SRNA #6, on 02/12/15 at 5:30 PM, revealed there was not any soap in the soap dispenser or paper towels when she tried to wash and dry her hands in the women's</p> | F 441 | | | |



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| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207 | | |
| (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 | <p>Continued From page 9</p> <p>public bathroom, which was frustrating when trying to wash your hands after going to the bathroom. She stated, she went to the bathroom at the nurses station to wash her hands, only to find the paper towels on the tank of the commode. She stated they frequently ran out of paper towels in the bathrooms on the 100 Unit. She stated, housekeeping was the one that refilled the soap and the paper towels. She stated not being able to complete handwashing was a concern for spreading infections through out the unit when providing care to the residents.</p> <p>Interview with the Director of Nurses, on 02/12/15 at 5:40 PM, revealed housekeeping replenished the soap and paper towels in the bathrooms on the units. She was concerned for infection control and cross contamination on the units during the care of residents. She further stated the policy was not followed without soap and paper towels to complete the handwashing task.</p> <p>Review of facility's policy titled Housekeeping, not dated, revealed it was the policy of the facility that all places of work, passageways, store rooms, and service rooms were maintained in a clean, orderly, and sanitary condition.</p> <p>Review of facility's policy regarding Management Tools, Daily Management Routine, dated 01/01/00, revealed the daily management routine was designed to help the Account Manager structure their day and keep focused on the completion of all front line staff routines. The policy further stated the goal was to insure that all routines were completed correctly before the last</p> | F 441 | | |



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F 441 Continued From page 10
management person left for the day. Continued review revealed during the Account Manager's final walk through of the facility, if things are not right, the manager was to stay and correct them.

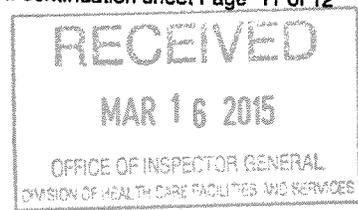
Review of the facility's policy regarding Job Routines, dated 01/01/00, revealed completion of the daily routines was the #1 responsibility of every Account Manager and that their work was not complete as a manager until the scheduled routines were completed up to quality standards.

Review of the facility's housekeeping in-service with the subject of 7-Step Daily Washroom Cleaning revealed the first thing that was to be done was to check supplies that included ensuring paper towels and soap dispensers were filled. Housekeeping staff were to be careful to stack paper towels in dispensers properly so they did not stick or jam.

Interview with the Housekeeping Account Manager, on 02/11/15 at 9:38 AM, revealed he expected his housekeeping staff to clean rooms daily and they were to check and fill the soap dispensers and paper towel dispenser as needed. The Housekeeping Account Manager stated he was the only one who had a key to the paper towel dispensers due to there being a waste of paper towels in the facility. The Housekeeping Account Manager stated there was a key to the paper towel dispensers in the laundry room for when he was not present in the facility.

Interview with Housekeeper #1, on 02/11/15 at 4:01 PM, revealed all rooms should be cleaned daily and she checked soap dispensers and paper towel dispensers daily. She stated she had access to any supplies that she needed.

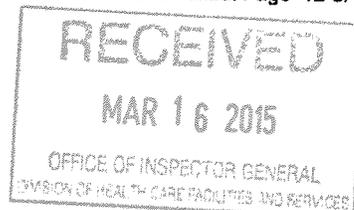
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| F 441 | <p>Continued From page 11</p> <p>Interview with the Housekeeping Account Manager, on 02/12/15 at 1:20 PM, revealed his job was to provide oversight to the entire building including laundry and housekeeping and that he did checks every forty-five (45) minutes to ensure that housekeeping staff were doing their jobs. He conducted housekeeping quality inspections daily to check three (3) predetermined rooms in the facility and would do some random rooms that he picked to check. Further interview revealed no one checked to ensure the housekeeping staff was doing their jobs on the weekends, except for his random weekend checks.</p> <p>Interview with the Housekeeping Manager, on 02/12/15 at 1:18 PM, revealed some paper towel dispensers and soap dispensers needed to be replaced.</p> <p>Interview with the Housekeeping Manager, on 02/12/15 at 4:08 PM, revealed he had found three (3) brand new paper towel dispensers in storage.</p> | F 441 | | |



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| {K 000} | <p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 03/13/15 as alleged.</p> | {K 000} | | |
|---------|--|---------|--|--|

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

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.

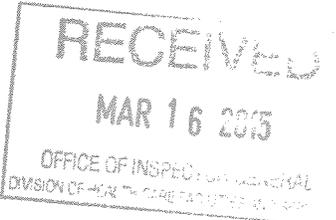
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| K 000 | <p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1965</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story with a partial basement, Type III Unprotected.</p> <p>SMOKE COMPARTMENTS: Nine (9) 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, 350 KW generator. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 02/10/15. The facility was found not in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p> <p>Deficiencies were cited with the highest</p> | K 000 |  | |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Anisic Noah</i> | TITLE <i>X Executive Director</i> | (X6) DATE 3-16-15 |
|---|--------------------------------------|----------------------|

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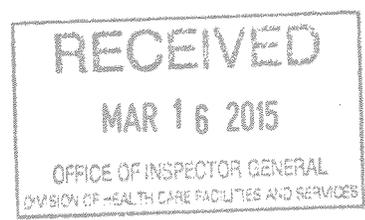
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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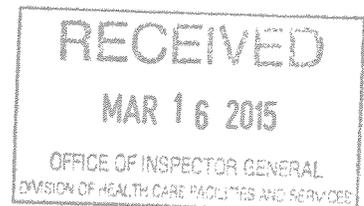
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| K 000 K 038 SS=E | <p>Continued From page 1 deficiency identified at a F level</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress was maintained from smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of nine (9) smoke compartments, approximately forty (40) residents, staff and visitors. The facility has one-hundred and twenty-five (125) certified beds and the census was one-hundred and twenty-two (122) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/10/15 at 1:42 PM, with the Executive Director and the Maintenance Director revealed the cross corridor doors located in the 400 Wing would not reopen when the magnetically held open doors were released and tested in the closed position. The closed doors would not readily reopen in accordance with</p> | K 000 K 038 | <p>K038</p> <p>No resident was found to be affected by the alleged deficient practice.</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>Dave Muller with Enterprise Technical Solutions removed the 15 second delayed egress hardware and the coded key pad mounted on the wall. The doors will reopen after they have closed in the event of an emergency.</p> <p>Facility Safety Committee designee will monitor door closures during the monthly fire drills and report findings to the QAPI committee monthly to ensure compliance.</p> | 2/20/15 |



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| K 038 | <p>Continued From page 2</p> <p>NFPA standards. Cross corridor doors should be able to reopen for access from one smoke compartment to another smoke compartment in the event of an emergency. The doors should be able to readily reopen for egress in the event of an emergency.</p> <p>Interview, on 02/10/15 at 1:44 PM, with the Executive Director and the Maintenance Director revealed they were not aware the cross corridor doors were not able to readily reopen when in the closed position. The cross corridor doors had previously been used for special locking requirements for a dementia wing of the facility. The wing was no longer used for dementia residents and special locking requirements were no longer applicable. The doors were equipped with fifteen (15) second delayed egress hardware and a coded key pad mounted on the wall in close proximity to the cross corridor doors. Both the Executive Director and the Maintenance Director acknowledged the cross corridor doors should readily reopen when in the closed position for egress in the event of an emergency.</p> <p>The census of one-hundred and twenty-two (122) was verified by the Executive Director on 02/10/15. The findings were acknowledged by the Executive Director and verified by the Maintenance Director at the exit interview on 02/10/15.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving</p> | K 038 | | |



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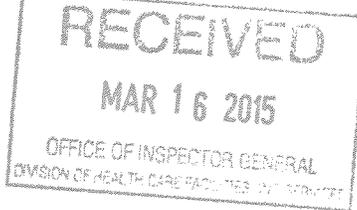
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| K 038 | <p>Continued From page 3</p> <p>low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of</p> | K 038 | | |
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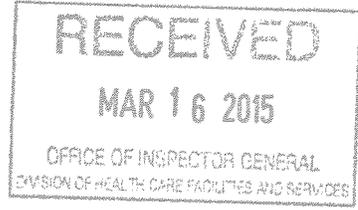
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| K 038 | <p>Continued From page 4</p> <p>force to the releasing device, relocating shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO</p> <p>EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.</p> <p>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. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any</p> | K 038 | | | |

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| K 038 | Continued From page 5 exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings. 19.7.2 Procedure in Case of Fire. 19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy 's fire safety plan. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area | K 038 | | | |



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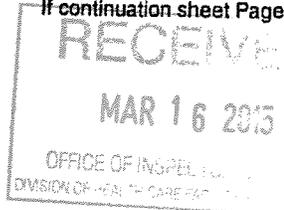
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|---------------|---|-------|--|--|
| K 038 | Continued From page 6 (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation | K 038 | K046 | |
| K 046 SS=F | NFFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide battery-powered emergency lighting at the generator transfer switch in accordance with the National Fire Protection Association (NFFPA) standards. The deficiency had the potential to affect each of the nine (9) smoke compartments, residents, staff and visitors. The facility has one-hundred and twenty-five (125) certified beds and the census was one-hundred and twenty-two (122) on the day of the survey. The findings include: Observation, on 02/10/15 at 9:56 AM, with the Maintenance Director revealed the facility did not have a battery-powered emergency light fixture located at the emergency generator transfer switch, located within the Main Electric Room in the Basement of the facility Interview, on 02/10/15 at 9:58 AM, with the Maintenance Director revealed he was not aware of the requirement of providing a battery-powered emergency light fixture at the generator transfer switch. He stated the facilities generator powers | K 046 | No resident was found to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. Reed Electric installed a battery-powered emergency light fixture at the emergency generator transfer switch on 3/13/15. A battery-powered emergency light test will be added to the Building Engines program and the fixture will be checked monthly to ensure it is operating properly. The Building Engines report will be reviewed at the safety committee meeting monthly to ensure all checks have been completed and equipment is in proper working order. Completion Date: 3/13/15 | |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____ | (X3) DATE SURVEY COMPLETED 02/10/2015 |
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| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS | STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207 |
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| K 046 | <p>Continued From page 7</p> <p>the entire facility in the event of a power failure and the room would illuminate with the ceiling mounted fluorescent light fixtures. The battery powered emergency light fixture was required in accordance with NFPA standards, in case the generator failed to start during a power failure.</p> <p>The census of one-hundred and twenty-two (122) was verified by the Executive Director, on 02/10/15. The findings were acknowledged by the Executive Director and verified by the Maintenance Director at the exit interview on 02/10/15.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on interview, record review of the automatic sprinkler system, it was determined the facility failed to maintain the sprinkler system in accordance with the National Fire Protection Association (NFPA) standards. The deficiency</p> | K 046 | | |
| K 062 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on interview, record review of the automatic sprinkler system, it was determined the facility failed to maintain the sprinkler system in accordance with the National Fire Protection Association (NFPA) standards. The deficiency</p> | K 062 | | |

If continuation sheet Page 8 of 16

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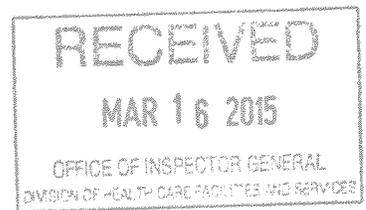
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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES SURVEILLANCE

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

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| K 062 | <p>Continued From page 8</p> <p>had the potential to affect each of the nine (9) smoke compartments, all residents, staff and visitors. The facility has one-hundred and twenty-five (125) certified beds and the census was one-hundred and twenty-two (122) on the day of the survey.</p> <p>The findings include:</p> <p>Review of the automatic sprinkler system, on 02/10/15 at 2:23 PM, with the Maintenance Director revealed the facility could not provide documentation that a five (5) year internal pipe inspection system had been conducted within the past five (5) year period. The date of the previous internal pipe inspection was unknown at the time of the automatic sprinkler system record review.</p> <p>Interview, on 02/10/15 at 2:25 PM, with the Maintenance Director revealed he relied on his Sprinkler Company to ensure the automatic sprinkler system was maintained and inspected properly in accordance with NFPA standards.</p> <p>The census of one-hundred and twenty-two (122) was verified by the Executive Director on 02/10/15. The findings were acknowledged by the Executive Director and verified by the Maintenance Director at the exit interview on 02/10/15</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to</p> | K 062 | |



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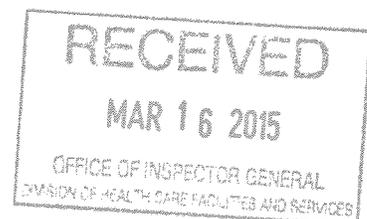
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| K 062 | <p>Continued From page 8</p> <p>had the potential to affect each of the nine (9) smoke compartments, all residents, staff and visitors. The facility has one-hundred and twenty-five (125) certified beds and the census was one-hundred and twenty-two (122) on the day of the survey.</p> <p>The findings include:</p> <p>Review of the automatic sprinkler system, on 02/10/15 at 2:23 PM, with the Maintenance Director revealed the facility could not provide documentation that a five (5) year internal pipe inspection system had been conducted within the past five (5) year period. The date of the previous internal pipe inspection was unknown at the time of the automatic sprinkler system record review.</p> <p>Interview, on 02/10/15 at 2:25 PM, with the Maintenance Director revealed he relied on his Sprinkler Company to ensure the automatic sprinkler system was maintained and inspected properly in accordance with NFPA standards.</p> <p>The census of one-hundred and twenty-two (122) was verified by the Executive Director on 02/10/15. The findings were acknowledged by the Executive Director and verified by the Maintenance Director at the exit interview on 02/10/15</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to</p> | K 062 | <p>K062</p> <p>No resident was found to be affected by the alleged deficient practice.</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>Brown Sprinkler conducted a five year internal pipe inspection on February 19, 2015.</p> <p>The 5 year internal pipe inspection date has been added to the online preventative maintenance program called Building Engines. This program will alert facility maintenance staff when the test is due to be conducted.</p> <p>The Building Engines report will be reviewed monthly at the safety committee to ensure all items have been completed.</p> <p>Completion Date: 3/13/15</p> | |

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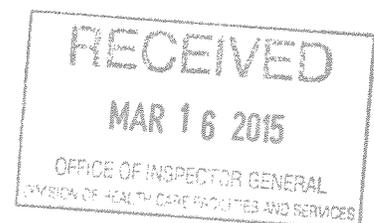
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| K 062 | Continued From page 9 determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 | K 062 | | | |



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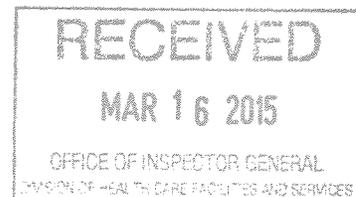
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| K 062 | Continued From page 10 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10 Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 | K 062 | | | |
| K 066 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. | K 066 | | | |



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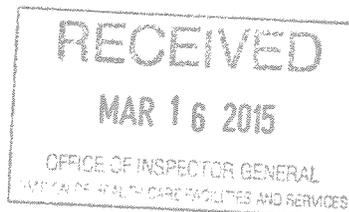
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| K 066 | <p>Continued From page 11</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure the facility was maintained as a smoke-free campus, in accordance with National Fire Protection Association (NFPA) standards. The deficient practice had the potential to affect each of the nine (9) smoke compartments, residents, staff and visitors. The facility has one-hundred and twenty-five (125) certified beds and the census was one-hundred and twenty-two (122) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/10/15 at 9:01 AM, with the Maintenance Director revealed the area outside of the facility's rear exit, in close proximity to the emergency generator, was being used as a smoking area. There were approximately fifty (50) cigarette butts on the ground directly outside of the exit doors. The facility was converted to a smoke-free campus in 2009 that required all smoking to be done outside of the facility's property.</p> <p>Interview, on 02/10/15 at 9:03 AM, with the Maintenance Director revealed the smoke-free campus policy was not being strictly followed by some staff members.</p> | K 066 | <p>K066</p> <p>No Resident was identified as being affected by the alleged deficient practice.</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>Staff were re-educated on the facility smoking policy by their Department Managers on 3/2/15.</p> <p>Additional signage will be placed at the rear employee entrance of the facility indicating that this is a smoke free campus.</p> <p>Maintenance Director or Staffing Coordinator will conduct audits to ensure staff are not smoking at the rear entrance of the facility.</p> <p>Audits will be presented to the QAPI committee monthly to determine if further actions and audits are needed</p> <p>Completion Date: 3/13/15</p> | |



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| K 066 | Continued From page 13 (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure portable space heaters used in the facility were in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, approximately twenty (20) residents, staff, and visitors. The facility has one-hundred and twenty-five (125) certified beds and the census was one-hundred and twenty-two (122) on the day of the survey. The findings include: Observation, on 02/10/15 at 9:39 AM, with the Maintenance Director revealed a portable space heater was located in Resident Room 100 and was plugged into an electrical receptacle and was in use. Interviews, on 02/10/15 at 9:41 AM, with the | K 066 | K070 The space heater was removed from room 100 on February 10, 2015. All residents have the potential to be affected by the alleged deficiency. Staff were educated and informed that portable space heaters are prohibited in the facility February 10, 2015. All space heaters were removed from facility and discarded on February 10, 2015. Maintenance Director or Assistant Director will tour the facility monthly to ensure no space heaters are in the facility. If found, they will be discarded immediately. Results from the audits will be reviewed at the monthly QAPI Committee meeting to determine if further actions are needed and continuance of auditing. Completion Date: 3/13/15 | |
| K 070 SS=D | | K 070 | | |



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| K 070 | Continued From page 15 Executive Director verified by the Maintenance Director at the exit interview on 2/10/15. Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). | K 070 | | |

