

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

PRINTED: 04/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/05/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484	
(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 MUST BE CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 164 SS=D	<p>A standard health survey was conducted on 04/03-05/12. Deficiencies were cited with the highest scope and severity at "E" level.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 164	<p>Division of Personal Care Southern Enforcement Branch</p>	

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

TITLE

(X6) DATE

[Signature] SEE Attached Executive Director 5/10/12

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

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F 164	<p>Continued From page 1</p> <p>Based on observation, interview, and policy review, it was determined the facility failed to provide personal privacy for one unsampled resident (Resident A). Observation on 04/03/12, at 12:40 PM, revealed Licensed Practical Nurse (LPN) #1 failed to close the privacy curtain and close the door after the resident stated he/she needed to use the bedside commode. Resident A was observed to be visible/exposed to anyone that passed by or entered the resident's room while using the bedside commode.</p> <p>The findings include:</p> <p>A review of a pamphlet given to all residents by the facility entitled "Residents Rights," (dated March 2010) revealed residents would be assured of at least visual privacy in multi-bed rooms and in the tub, shower, and toilet rooms. The facility had no policy/procedure related to ensuring resident privacy.</p> <p>Observation on 04/03/12, at 12:40 PM, revealed Resident A informed LPN #4 the resident needed to use the bedside commode. The LPN was observed to leave the room as the resident transferred his/her self to the bedside commode. The LPN failed to close the privacy curtain and the door. The resident was observed to then lower his/her clothes and sit on the bedside commode. The resident was exposed and visible to anyone that passed by or entered the resident's room.</p> <p>Resident A was cognitively impaired and could not be interviewed.</p> <p>An interview conducted with LPN #4 on 04/03/12,</p>	F 164			

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F 164	Continued From page 2 at 2:05 PM, revealed Resident A had asked to use the bedside commode and did not want the curtain closed. The LPN stated she was aware she should have closed the door and the privacy curtain. According to LPN #4, the resident had used the bedside commode before she could get back to close the privacy curtain. An interview conducted with the Director of Nursing (DON) on 04/04/12, at 3:30 PM, revealed staff was expected to close the door and to pull the privacy curtain anytime a resident used the bedside commode and/or when a resident would be exposed when care was provided. The DON stated all Department Managers monitored residents daily as part of the quality monitoring and monitored for resident privacy. The DON stated the facility had not identified any problems with privacy.	F 164			
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to ensure two of twenty-four sampled residents were free from physical restraints (Residents #9 and #12). Resident #9 and Resident #12 were observed to be in a reclined Geri-chair (chair that prevents rising), however, there was no evidence the facility had conducted	F 221			

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F 221	<p>Continued From page 3</p> <p>assessments prior to placing the residents in the reclined Geri-chairs. In addition, there was no evidence the facility had informed the resident's responsible parties of the risks/benefits related to the use of placing Residents #9 and #12 in the reclined Geri-chairs.</p> <p>The findings include:</p> <p>A review of the facility's Restraint Evaluation and Utilization Guideline policy/procedure (dated January 2011) revealed physical restraints included any manual method or mechanical device, material, or equipment attached or adjacent to the resident's body that the resident cannot remove easily, which restricted freedom of movement or normal access to one's own body. The policy revealed the interdisciplinary team (IDT) would be responsible to discuss the factors that resulted in the restraint use and evaluation. The policy further revealed a medical symptom was required to support the use of the restraint, the least restrictive device would be used, and a physician's order for the restraint would be documented.</p> <p>1. Observation of Resident #9 on 04/03/12, at 2:55 PM and 4:05 PM, revealed the resident was in a reclined Geri-chair in front of the 300 Wing nurses' station. Resident #9 was also observed on 04/04/12, at 9:40 AM, 10:30 AM, and 1:45 PM, in a reclined Geri-chair in front of the nurses' station.</p> <p>A review of the medical record for Resident #9 revealed the facility had admitted the resident on 01/03/12, with diagnoses that included Senile Dementia, Depression, and Anxiety.</p>	F 221			

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F 221	<p>Continued From page 4</p> <p>A review of the most recent significant change Minimum Data Set assessment for Resident #9, dated 02/17/12, revealed the resident had been assessed to have severely impaired cognition. The resident had also been assessed by the facility to require the extensive assistance of two staff persons for transfers and bed mobility.</p> <p>A review of the care area assessment (CAA) for falls dated 02/17/12, revealed the facility assessed Resident #9 as forgetful, often forgot to ask for assistance, and staff was required to offer frequent cues and reminders to encourage the resident to ask for assistance. Staff was to conduct frequent checks of the resident and offer assistance with transfers. The CAA also revealed the resident could assist with transfers.</p> <p>A review of the current comprehensive plan of care for Resident #9, dated 01/18/12, revealed no evidence the facility had developed an intervention to place the resident in a reclining Geri-chair.</p> <p>An interview conducted on 04/04/12, at 9:45 AM, with the Occupational Therapist (OT) revealed Resident #9 had been placed in a Geri-chair because it had been decided the resident ate better in a Geri-chair instead of a wheelchair. However, the OT also stated Resident #9 was unable to get out of the Geri-chair when the chair was reclined because the chair had a bar on the back that required another person to lift it up. The OT stated the resident could get out of the Geri-chair if the chair was not reclined.</p> <p>An interview conducted with Licensed Practical</p>	F 221			

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F 221	<p>Continued From page 5</p> <p>Nurse (LPN) #3 on 04/04/12, at 10:45 AM, revealed Resident #9 required staff assistance to the bathroom. The LPN also revealed Resident #9 believed he/she could walk by his/herself. The LPN stated Resident #9 tried to get out of the Geri-chair, however, if the chair was reclined the resident was unable to lower the feet, thereby decreasing the resident's ability to get out of the chair.</p> <p>An interview conducted with Certified Nursing Assistant (CNA) #4 on 04/04/12, at 10:50 AM, revealed the CNA had observed Resident #9 trying to get up out of the Geri-chair and if the chair was not reclined the resident could get out of the chair. CNA #4 stated the resident was unable to lower the feet of the Geri-chair because the bar on the back of the chair required the assistance of one other person to raise the chair to release the foot of the chair. The CNA stated the reclined Geri-chair prevented the resident from rising.</p> <p>An interview conducted with the Unit Manager (UM) of the 300 Wing of the facility on 04/04/12, at 10:55 AM, revealed Resident #9 sits in a Geri-chair, which is reclined except when eating, in front of the nurses' station on the 300 Wing during the day because the resident tries to get up unassisted. The UM also stated the resident was unable to lower the feet of the Geri-chair when it was reclined due to the bar on the back of the chair and required the assistance of another person to raise the bar to lower the feet. The UM stated she had never considered a Geri-chair to be a restraint and had not assessed the Geri-chair as a restraint for Resident #9.</p>	F 221			

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F 221	<p>Continued From page 6</p> <p>An interview conducted with the Director of Nursing (DON) on 04/04/12, at 3:30 PM, revealed if a resident had been assessed to require a restraint, the facility was required to use the least restrictive device. The DON stated the facility was also required to do a restraint assessment, inform the resident's responsible party, obtain physician consent, and place the restraint intervention on the resident's care plan. In addition, the DON stated the use of restraints was reviewed at the Interdisciplinary Team (IDT) meeting. The DON stated she had not considered a Geri-chair a restraint and that the reclined Geri-chair for Resident #9 had not been assessed as a restraint.</p> <p>2. A review of the medical record for Resident #12 revealed the facility admitted the resident on 03/07/11, with diagnoses that included a Closed Femur Fracture, Hypertension, Alzheimer's Disease, Cardiac Pacemaker, and Diabetes Mellitus.</p> <p>A review of the annual comprehensive assessment with a reference date of 02/03/12, revealed Resident #12 required extensive assistance of two staff persons for bed mobility, transfers, and toileting. The resident's ambulation status was assessed as "did not occur," and the resident was assessed to have no limitation in range of motion. Resident #12 was also noted to be receiving therapy services for therapeutic exercises. Continued review of the assessment revealed restraints were not utilized for Resident #12.</p> <p>Resident #12 was observed on 04/03/12, at 10:30 AM, to be sitting in a reclined Geri-chair with both lower extremities elevated. On 04/04/12,</p>	F 221			

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F 221	<p>Continued From page 7</p> <p>Resident #12 was observed at 8:35 AM and 1:45 PM, to be sitting in the reclined Geri-chair with the foot of the chair in a raised position. However, a review of documentation in the medical record revealed no evidence the facility had conducted an assessment of Resident #12 that included a medical symptom for the use of the reclined Geri-chair.</p> <p>Interview conducted with Certified Nurse Aide (CNA) #2 on 04/04/12, revealed Resident #12 was nonambulatory. CNA #2 stated the Geri-chair was reclined when Resident #12 was in the chair due to the resident's attempts to scoot/slide from the chair.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 04/04/12, revealed an assessment was required to be conducted when a Geri-chair was used for a resident. The LPN stated she believed the assessment would be documented in the nurse's notes; however, the LPN was unable to provide the documentation. LPN #2 further stated the Geri-chair was in a reclined position due to Resident #12's weakness and tendency to slide down while sitting upright in a chair.</p> <p>An interview conducted with the Unit Manager (UM) on 04/04/12, revealed a therapist would "screen" a resident for use of a restraint device and stated the Interdisciplinary Team (IDT) would make the final decision for the restraint use. In addition, the UM stated she was responsible to complete a restraint assessment when a restraint device was used for a resident. The UM stated she did not consider the reclined Geri-chair to be a restraint for Resident #12 and did not complete the required assessment.</p>	F 221			

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F 252 SS=E	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, it was determined the facility failed to provide a clean, comfortable, and homelike environment. During the environmental tour conducted on 04/03/12, combination closet/drawers and nightstands on the 100 and 200 Halls were damaged and marred.</p> <p>The findings include:</p> <p>The Administrator was asked for a policy related to maintenance repairs on 04/05/12, at 1:00 PM; however, a policy was not provided.</p> <p>Observation during the initial environmental tour on 04/04/12, revealed combination closet/drawers in rooms 101-B, 104-B, 111-A, and 115-B. Attempts were made to open the closet doors, however, the closet drawers also opened. Further observation revealed the closet doors and drawers could not be opened individually. The closet doors on the combination closet/drawers in rooms 107-B and 200-A did not latch shut when closed. Observations also revealed the outer finish of the closet/drawers was loose and peeling off from the surface. In addition, the finish on the</p>	F 252		

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F 252	Continued From page 9 nightstand in room 100-A was also observed to be loose and peeling from the surface. An interview with the Maintenance Supervisor (MS) on 04/05/12, at 11:40 AM, revealed any staff may submit repair requisitions to the Maintenance Department when needs are identified. However, the Supervisor stated he had not received requisitions for concerns identified during the environmental tour conducted on 04/04/12. An interview with the Administrator on 04/05/12, at 1:00 PM, revealed he was aware that some of the closet/drawer combination sets were old and in need of replacement, and that he had submitted a request for new furnishings from the facility's corporate office on 03/13/12, and was still awaiting approval to purchase the items.	F 252			
F 323 SS=D	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 observation, interview, record review, and review of facility policy/procedures, it was determined the facility failed to ensure one of twenty-four sampled residents (Residents #5) received adequate supervision and assistive	F 323			

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F 323	<p>Continued From page 10 devices to prevent accidents.</p> <p>Resident #5 was assessed by the facility to be at risk for falls. On 11/16/11, staff implemented the use of a safety alarm on the wheelchair and the bed. Staff was required to check proper function of the safety alarm during each shift. Observations on 04/03/12, revealed the resident in the wheelchair with the alarm pad in the seat of the wheelchair; however, the alarm mechanism was not attached to the alarm pad but was attached to the bedside commode in the resident's room.</p> <p>The findings include:</p> <p>The facility had no policy/procedure related to the use of safety alarms. This was confirmed by the Director of Nursing (DON) on 04/03/12, at 5:15 PM.</p> <p>Review of the medical record of Resident #5 revealed the facility admitted the resident on 10/05/11, with diagnoses that included Congestive Heart Failure, Anxiety, Subdural Hemorrhage, and Cerebrovascular Accident. Review of the comprehensive assessment for Resident #5, with a completion date of 11/14/11, revealed the resident had been assessed as at risk for falls and had sustained a fall since the last prior assessment. Review of the comprehensive care plan for Resident #5, dated 11/23/10, revealed the resident was at risk for falls due to side effects from medication, unsteady balance, and a history of falls. Further review of the comprehensive care plan revealed the facility had added an intervention on 11/16/11, for the resident to have a safety alarm in the chair and</p>	F 323			

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F 323	<p>Continued From page 11</p> <p>the bed. The alarm was to be checked by staff every shift for proper functioning. An additional intervention was added on 11/30/11, after Resident #5 sustained a non-injury fall and indicated staff was to place the bed alarm out of the resident's reach as the resident would unplug the bed/chair alarm.</p> <p>Observations on 04/03/12, at 11:45 AM, 12:15 PM, 2:10 PM, 3:00 PM, 4:00 PM, and 5:00 PM, revealed the resident was in a wheelchair with a seat alarm pad in the chair and a cord from the pad wrapped around the right handle of the wheelchair. The alarm mechanism was observed attached to the resident's bedside commode during each observation and not to the pad in the wheelchair. Without the alarm mechanism the pad alarm was not operational.</p> <p>Interview with Registered Nurse (RN) #1 on 04/03/12, at 5:20 PM, revealed the resident's alarm should have a "box" attached but there was no box attached. RN #1 confirmed the alarm would not work without the box. According to RN #1, the resident needed the alarm to alert staff if the resident attempted to rise from the chair in an effort to prevent further falls.</p> <p>Interview on 04/03/12, at 5:30 PM, with Certified Nursing Assistant (CNA) #1 revealed the CNA was responsible for the care of Resident #5 on 04/03/12. CNA #1 stated the resident had a pad alarm in place in the seat of the resident's wheelchair. The CNA had transported the resident to the dining room and was unaware the resident's alarm mechanism was not attached to the wheelchair. The CNA stated he had observed the cord and assumed the alarm was intact.</p>	F 323		

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

PRINTED: 04/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/05/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484		
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F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility policy, observation, interview, and record review, it was determined the facility failed to ensure one of twenty-four sampled residents received the proper treatment and care related to respiratory care. Resident #2 was observed at 10:10 AM on 04/03/12, to receive oxygen at two liters per minute (2 L/m) via nasal cannula. However, the facility did not have a physician's order for the oxygen use.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure (dated 2006) for oxygen administration revealed a licensed nurse was responsible to check the physician's order for liter flow and method of administration for oxygen use.</p> <p>Review of the medical record for Resident #2</p>	F 328		

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

PRINTED: 04/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/05/2012
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F 328	<p>Continued From page 13</p> <p>revealed the facility initially admitted the resident on 02/17/12, and readmitted the resident on 03/15/12, with diagnoses that included History of Recurrent Pneumonia, Congestive Heart Failure, and Dementia. Review of the Admission Clinical Health Status for Resident #2 dated 02/17/12 and 03/15/12, revealed the resident required the use of oxygen. A review of the Minimum Data Set (MDS) assessments dated 02/24/12 and 03/22/12, also revealed Resident #2 required the use of oxygen.</p> <p>A review of the physician's admission orders dated 02/17/12 and 03/15/12, for Resident #2 revealed no evidence the physician ordered the use of oxygen for Resident #2 on the 02/17/12 or the 03/15/12 admission. A review the physician's telephone orders revealed oxygen was ordered on 04/03/12, after the lack of an order was brought to the facility's attention.</p> <p>Observation of Resident #2 at 10:10 AM, 11:25 AM, 12:15 AM, 2:10 PM, 3:30 PM, 4:45 PM, and 6:07 PM on 04/03/12, confirmed the resident had oxygen infusing at 2 L/m via nasal cannula.</p> <p>An interview was conducted with Registered Nurse (RN) #2 at 8:50 PM on 04/04/12. The RN was unable to find a physician's order for oxygen use for Resident #2 prior to 04/03/12, when a telephone order was received from the resident's physician.</p> <p>An interview was conducted at 10:30 AM on 04/04/12, with the Director of Nursing (DON). The DON stated that according to the nurses notes Resident #2 had oxygen in use at the time of admission on 02/17/12 and 03/18/12.</p>	F 328		

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

PRINTED: 04/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/05/2012
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F 328	Continued From page 14 However, the DON had no explanation why the oxygen for Resident #2 was not on the physician's admission or readmission orders.	F 328			
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding	F 334			

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

PRINTED: 04/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/05/2012
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F 334	<p>Continued From page 15</p> <p>the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(v) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and review of facility policy/procedure, it was determined the facility failed to ensure influenza and pneumococcal vaccines were provided to residents. Additionally, the facility had not</p>	F 334			

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

PRINTED: 04/20/2012
FORM APPROVED
OMB NO. 0938-0391

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F 334	<p>Continued From page 16</p> <p>developed policies/procedures to ensure residents were offered and received influenza and pneumococcal vaccines. Six of twenty-four sampled residents (Residents #7, #8, #12, #16, #17, and #18) had no evidence the pneumococcal vaccine had been offered and/or administered. One of twenty-four sampled residents (Resident #10) had no evidence the resident had been offered or received the influenza vaccine.</p> <p>The findings include:</p> <p>The facility had no policy/procedure related to pneumococcal and influenza immunization of residents. The Administrator confirmed on 04/04/12, at 3:20 PM, that the facility had no policy/procedure but followed the Minimum Data Set (MDS) guidelines for influenza and pneumococcal vaccination.</p> <p>1. Review of the medical record of Resident #10 revealed the facility admitted the resident on 02/12/10, with diagnoses that included Diabetes Mellitus Type II, End Stage Renal Disease, Coronary Artery Disease, and Gastroparesis. Further review of the medical record revealed an immunization record for the resident that indicated the resident had received an influenza vaccine prior to the resident's admission to the facility on 02/12/10. There was no evidence the resident had been offered/received the influenza vaccine during the fall of 2010 or 2011.</p> <p>Interview on 04/04/12, at 3:20 PM, with the Director of Nursing (DON) revealed the DON could find no evidence the resident had been offered and/or declined the influenza vaccination.</p>	F 334		

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

PRINTED: 04/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/05/2012
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F 334	<p>Continued From page 17</p> <p>According to the DON, it was facility practice to obtain a consent/declination for the influenza vaccination and the form was to remain in the resident's record; however, no form could be found for Resident #10.</p> <p>2. Review of the medical record of Resident #7 revealed the facility admitted the resident on 03/21/06, with diagnoses that included Dementia, Hypertension, Depressive Disorder, and Cellulitis. Further review of the medical record revealed an Immunization Record in the resident's record that documented the influenza vaccine had been administered but there was no evidence the pneumococcal vaccine had been offered and/or administered. Review of the electronic record for Resident #7 revealed on 03/17/11, the resident had not been offered/administered the pneumococcal vaccine because the resident had received the vaccine previously; however, there was no evidence the resident had received the vaccine.</p> <p>3. A review of the medical record for Resident #16 revealed the facility had admitted the resident on 02/05/09, with diagnoses that included Alzheimer's Disease, Congestive Heart Failure, and Atrial Fibrillation. A review of the immunization record for Resident #16 revealed the responsible party had signed a consent form on 02/05/09, for the administration of the pneumococcal vaccine; however, there was no evidence the pneumococcal vaccine had been administered to the resident.</p> <p>An interview conducted with the Director of Nursing (DON) on 04/05/12, at 2:25 PM, revealed it was the responsibility of the Unit Manager (UM)</p>	F 334			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 334	<p>Continued From page 18</p> <p>to ensure immunizations were up to date and administered. The DON confirmed the pneumococcal vaccine had not been administered to Resident #16 but should have been administered. The DON also revealed the facility did not have a policy related to the pneumococcal vaccine.</p> <p>An interview conducted with the UM of the 100 Wing on 04/05/12, at 2:30 PM, revealed she was responsible for ensuring residents received their immunizations. The UM revealed Resident #16 had not had a pneumococcal immunization and should have received the vaccine.</p> <p>4. A review of the medical record for Resident #18 revealed the resident had been admitted by the facility on 01/14/2000, with diagnoses that included Cerebral Palsy and Cerebral Vascular Disease. A review of the immunization record for Resident #18 revealed the resident had received a pneumococcal immunization on 12/03/04, and had been due another pneumococcal immunization in 2009. A review of a consent by the responsible party for Resident #18, dated 10/11/11, revealed the responsible party had provided consent for the resident to receive a pneumococcal immunization. There was no evidence provided that the pneumococcal immunization had been administered to the resident.</p> <p>An interview conducted with the DON on 04/05/12, at 2:25 PM, revealed it was the UM's responsibility to ensure immunizations were up to date and administered. The DON revealed the pneumococcal vaccine had not been administered to Resident #18 and the</p>	F 334		

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

PRINTED: 04/20/2012
FORM APPROVED
OMB NO. 0938-0391

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F 334	<p>Continued From page 19</p> <p>immunization should have been administered to the resident.</p> <p>An interview conducted with the UM of the 100 Wing on 04/05/12, at 2:30 PM, revealed she was responsible for ensuring the residents received their immunizations. The UM revealed Resident #18 had not had a pneumococcal immunization and the immunization should have been provided.</p> <p>5. Review of the medical record for Resident #8 revealed the facility admitted the resident on 11/03/11, with diagnoses to include Dementia, Psychosis, Diabetes Mellitus, Protein Calorie Malnutrition, Hypertension, Alcohol Dependence, Peripheral Vascular Disease, and gastrostomy Status. A review of the Immunization Record for Resident #8 revealed the responsible party had signed a consent form on 11/03/11, for the administration of the pneumococcal vaccine for the resident. However, there was no documented evidence the pneumococcal vaccine had been administered to Resident #8.</p> <p>An interview conducted with the DON on 04/05/12, at 2:25 PM, revealed it was the UM's responsibility to ensure immunizations were up to date and administered. The DON revealed the pneumococcal vaccine had not been administered to Resident #8 and the immunization should have been administered to the resident.</p> <p>6. Review of the medical record revealed the facility admitted Resident #12 on 03/07/11, with diagnoses to include Closed Femur Fracture, Hypertension, Alzheimer's Disease, Cardiac Pacemaker, and Diabetes Mellitus.</p>	F 334			

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

PRINTED: 04/20/2012
FORM APPROVED
OMB NO. 0938-0391

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F 334	Continued From page 20 A review of the Resident Immunization Consent or Refusal Form dated 03/07/11, revealed the Resident's Power of Attorney (POA) signed the document to authorize consent for Resident #12 to receive the influenza and pneumococcal vaccines. The document noted the influenza vaccine had been administered to Resident #12 on 10/05/11. However, there was no evidence the facility had administered the pneumococcal vaccine as requested by the Resident's POA. An interview conducted with the Admissions Director (AD) on 04/05/12, revealed the AD was responsible for obtaining the consent/refusal for the immunizations from either the resident or the family member upon admission to the facility. The AD stated a copy of the immunization consent/refusal form was sent to the Director of Nurses (DON) and the MDS nurse, and a copy was also placed in the resident's medical record. The AD stated she also verbally communicated this information to the nursing staff. Interview conducted with the DON on 04/05/12, at 3:20 PM, revealed there was no documented evidence the pneumococcal vaccine had been administered to Resident #12. The DON also stated a staff person had been responsible to conduct an audit to ensure residents' immunizations had been administered as directed; however, the audit had not been conducted as believed by the facility Administration. The DON stated the employee responsible was no longer employed at the facility. The DON also stated the facility followed the MDS guidelines regarding immunizations and did not have a policy/procedure.	F 334			

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

PRINTED: 04/20/2012
FORM APPROVED
OMB NO. 0938-0391

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F 334	<p>Continued From page 21</p> <p>7. A review of the medical record revealed Resident #17 was admitted to the facility on 11/28/97, with diagnoses to include Congenital Heart Stenosis, Hypertension, Dementia with Agitation, and Non-Organic Psychosis.</p> <p>A review of the immunization consent/refusal form revealed there was no evidence the facility had offered Resident #17 the pneumococcal vaccine. The form was not checked to indicate the consent or refusal of the pneumococcal vaccine.</p> <p>The DON stated in an interview conducted on 04/05/12, at 3:30 PM, there was no documented evidence the facility had offered the pneumococcal vaccine to Resident #17.</p>	F 334			

This Plan of Correction is the provider's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F 164 Privacy/Confidentiality of Records

1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?

There is no corrective action to be implemented for the affected resident(s) found to have been affected by the deficient practice.

2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken

All residents have the potential to be affected by the deficient practice.

3. What action did the provider take to assure that the alleged deficient practice does not recur?

Staff, which will include all nursing staff, dietary staff, therapy staff, and administrative staff will be in-serviced by the Director of Clinical Education starting 4/23/12 and must be completed 5/9/12 on detailed aspects of privacy and the resident rights as applies to privacy of residents. Additionally, weekly "huddles" will be performed by the Director of Nursing and Director of Clinical Education, which

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involve all nursing staff members (CNA, LPN, and RN) will occur which will address aspects of privacy for one month.

Non-Clinical rounds are completed weekly by Dept Heads and will monitor for privacy of residents.

4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?

The Executive Director (ED) will complete 4 weekly surprise audits by observation during ED rounds to determine privacy practices for each of the three units. Additionally the Interdisciplinary Team-All Department Heads (IDT) audits will report any potential issues to the ED for corrective action. All findings related to the weekly audits will be brought to the QA&A meeting for one month or until compliant.

Expected date of completion:

5/9/12

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F221:Right to be free from physical restraints.

1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?

Res.# 9 and 12 are currently in reclining geri chairs. Res. #9 & #12 were re-assessed by Unit Manager on 4/4/12 utilizing the Restraint and Device Assessment for potential restraint related to use of the reclining geri chair. Based on this assessment the reclining geri chair did not meet the criteria of a restraint for residents #9 and # 12 due to the definitions of the Restraint and Device Assessment which noted extensive assistance with transfers, ambulation, and bed mobility for resident #9 and total assistance for all Activity of Daily Living for resident #12. The reclining geri chairs for resident #9 and #12 is used to enable the residents to be out of bed and provide the most appropriate positioning device as tolerated without restricting their normal activity.

2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken

All residents have the potential to be affected by this deficient practice.

There are no residents currently in reclining geri chairs that meets the criteria of a restraint.

An Audit determined no resident's were identified to be affected by the deficient practice with 28 residents identified to have the potential to be affected by the deficient practice. All residents in reclining geri chairs were reassessed using the Restraint and Device assessment as of 4/27/12 and completed 5/3/12 by the Unit Managers and/or DNS. As a result of this audit, no

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residents were identified using reclining geri chairs assessed as being restraints due to the chairs not restricting their ability for mobility. All other Residents that may require use of a reclining geri chair, and/or other assistive devices will have a Restraint and Device assessment completed prior to placing them into the reclining geri chair or other assistive devices to determine if meets criteria of a restraint. Based upon completion of this assessment the reclining geri chair will have documentation to support appropriate use based on the resident's need.

3. What action did the provider take to assure that the alleged deficient practice does not recur?

In-service provided by Director of Clinical Education to RN's ,LPN's and CNA's on the Restraint Evaluation and Utilization Guideline began 4/23/12 and will be completed by 5/9/12.

The care plan and consent will reflect the use of the restraint as well as include the Risk vs. Benefits explanation to the resident/family.

Residents who have physical restraints will be evaluated a minimum of Quarterly for potential reduction.

4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?

Residents will be assessed by the Interdisciplinary team for the need of restraint use upon admission and as needed with change of conditions.

Restraint orders, consent and care plan audits will be conducted monthly for one month then quarterly by the unit manager/designee.

Results of the audits will be taken to the monthly

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Quality Assurance Committee meetings X 3 months to discuss findings and develop action plans as indicated.

Date of Compliance 5/9/12

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F 252 Safe/Clean/Comfortable/Homelike Environment

1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?

New furniture was being ordered as of March 2012 for affected residents' rooms and a "priority ship" was placed on these items 4/5/12.

2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken

A facility wide audit by the Executive Director /designee is to be conducted by 5/9/12 to identify any other furnishings which may be a safety concern.

3. What action did the provider take to assure that the alleged deficient practice does not recur?

The maintenance department will inspect furnishings on a monthly basis for potential safety concerns and wear. Housekeeping will keep a log of damaged or worn furnishings and the housekeeping director will communicate logged information to the maintenance department

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4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?

Interdisciplinary Team (IDT) members will evaluate their rooms on a weekly basis for any damaged furnishings. The Executive Director will monitor the Building Engines system to ensure it is being used for repair tracking, and receive a copy of housekeeping logs used by that department to compare identified issues with corrective actions taken. The findings of these audits and plans will be taken to the Quality Assurance and Assessment (QA&A) meeting for evaluation monthly X 3 months. The QA&A team will determine when sufficient measures are in place and evaluate effectiveness of present plan and revise if needed.

Expected date of completion:

5/9/12

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F 323:Free of Accident Hazards/Supervision
/Devices.

1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?

Resident # 5's Alarm mechanism was attached to the alarm pad and checked to assure proper functioning. The care plan was reviewed and accurate.

2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken

All residents have the potential to be affected by the deficient practice. All residents utilizing assistive devices (13 alarms) were reassessed to ensure proper functioning and placement of alarms. Audits were conducted by the Unit Managers/designee utilizing the physician orders of residents with alarms and completed on 4/27/12. Based on completion of audits no other residents were found to be affected. All other residents not currently utilizing assistive devices (Alarms,etc.) were re-assessed by the Unit Managers and completed on 4/27/12 for the potential need of assistive devices. Based on completion of re-assessments no other residents were identified needing assistive devices at this time

3. What action did the provider take to assure that the alleged deficient practice does not recur?

The Unit Managers/DNS/ADNS/designee will conduct daily monitoring through observation, of all residents utilizing assistive devices to ensure proper

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functioning/placement. Other residents will be assessed by the Unit Managers at least quarterly/significant change by use of the clinical assessments to determine need for assistive devices.

The nursing staff (RNs, LPNs, CNAs) will be re-in-serviced by the Director of Clinical Educator on identifying potential hazards, supervision, and safety concerns related to the use of assistive devices/etc. The charge nurses will ensure the CNA's are checking alarms every shift and document on CNA record when assistive devices are used.

The in-servicing began on 4/23/12 and will be completed by 5/9/12.

4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?

The DNS/designee will randomly audit the documentation records of 5 residents requiring supervision and or assistive devices (alarms) per unit weekly X 4 weeks beginning on 5/9/12. The Unit Managers/Department Managers will document safety hazards on Non-Clinical Rounds sheet and the DNS/ADNS/Designee will review the results of the audits daily. Accident and Investigation reports are reviewed monthly by the DNS and ED for trends and analysis. Results of audits will be taken to monthly Quality Assurance Committee Meetings X 3 months, then Quarterly thereafter to discuss results of the audits for further action plans as indicated.

Date of Compliance: 5/9/12

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F 328 TREATMENT/CARE FOR SPECIAL NEEDS

1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?

Resident # 2 had a clarification to the physician order for oxygen to include the amount of oxygen to be used. No further corrective action was needed for this resident.

2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken

An Audit was conducted by Director of Nursing Services and Unit Managers on 4/3/12 for residents with Oxygen. A follow up audit was completed on 4/6/12 and no residents were noted to be affected.

An audit was conducted for residents with special needs, such as:

Injections, Parenteral and Enteral fluids, colostomy, ileostomy or urostomy care, trach. care, Trach, suctioning, respiratory care, foot care and prosthesis was completed 4/27/12. No other residents with the special needs were noted to be affected.

3. What action did the provider take to assure that the alleged deficient practice does not recur?

The Director of Clinical Education will conduct an in-service to RN's, and LPN's related to transcription of nursing orders and components of documentation. In-servicing began 4/23/12 and will

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be completed by 5/9/12.

Residents identified with special needs will have their orders reviewed during the clinical start up process by the interdisciplinary team and follow up will be completed as needed by the unit managers/designee. Audits will be conducted monthly for one month and then quarterly by the unit managers/designee.

4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?

The unit managers/designee will monitor new orders of residents during the clinical start up process for accuracy.

Monthly for 3 months a review audit of the physician orders for residents will be conducted by the unit manager/designee for accuracy.

The Director of clinical education will submit the results of the review to the QA&A committee. The results of the audits will be taken to the monthly QA&A committee for 3 months and action plans developed/revised as indicated.

Date of Compliance: 5/9/12

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F 334:Influenza and Pneumococcal Immunizations:

1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?

Resident # 10 : was re-educated on risks and benefits of the flu vaccine and facility obtained the refusal for the Influenza vaccine.

Resident's # 7, 8, 12, 16, 17,and 18 were re-educated on risks and benefits, offered, and administered pneumococcal vaccine as applicable. Documentation completed on the consent/refusal immunization form and documentation in the medical record for immunization.

2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken

Audits were initiated on 4/6/12 by the Unit managers for other residents that are candidates for receiving the pneumococcal vaccine for consent and/or administration of immunizations. The RN or LPN will educate the family/resident of the risks and benefits of vaccine and administer vaccines accordingly. The RN or LPN will document on immunization record of refusal or consent to obtain the vaccine and placed on the medical record. The audit will be completed by 5/9/12.

3. What action did the provider take to assure that the alleged deficient practice does not recur?

The Director of Clinical Education will re-in-service

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RN's, and LPN's on education, eligibility, consent and administration of immunizations for all residents upon admission and annually as indicated. The in-service began on 4/26/12 and will be completed by 5/9/12.

Upon admission the Charge Nurse/Unit Manager/Designee will obtain the resident's past history of vaccinations to include specific dates of receiving the vaccination if received. If the resident/family is unaware of the date last received staff will obtain a consent to vaccinate and offer the vaccination and administer in accordance with the physician orders to include discussion of Risk vs. Benefits with the resident/family. Flu vaccines will be offered annually by the facility to residents. Documentation will occur for all residents receiving/refusal of vaccines on the consent form and/or in the electronic record.

4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?

The Unit Managers/designee will monitor daily during the clinical start up process of new admissions to ensure pneumococcal vaccine/flu vaccine has been offered/declined. Documentation will include consent to obtain/decline, date of consent to receive, and/or reason for refusal. Flu vaccines will be offered annually. The DCE will submit the results of the monitoring to the QA&A committee. Unit managers will audit immunizations on admission and monthly and submit to the QA&A committee monthly for one quarter. The committee will review and recommend any revisions to the process to assure continued compliance including the

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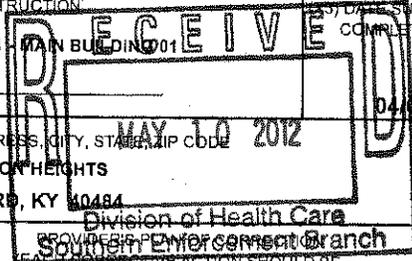
necessity for continued monitoring.

Date of completion: 5/9/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION: A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1988 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111(200) SMOKE COMPARTMENTS: Five FIRE ALARM: Complete automatic fire alarm system SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system GENERATOR: Type II natural gas generator A life safety code survey was initiated and concluded on 04/03/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000			
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in	K 025			



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Executive Director (X6) DATE: 5/10/12

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

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K 025	<p>Continued From page 1</p> <p>accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire/smoke wall assemblies in the attic area. This deficient practice affected four of five smoke compartments, staff, and approximately forty-five residents. The facility has the capacity for 128 beds with a census of 120 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 04/03/12, at 10:50 AM, with the Director of Maintenance (DOM), observation revealed gaps around sprinkler piping and wiring in the fire/smoke barrier wall in the attic area of the Zone 4 corridor. These penetrations must be sealed with an approved material to help prevent fire/smoke from spreading to other areas of the building in a fire situation. An interview with the DOM on 04/03/12, at 10:50 AM, revealed the DOM thought he had repaired all the fire/smoke barrier walls. During the survey, another fire/smoke barrier wall above the corridor fire doors in Zone 3 in the attic area was observed to have gaps around wiring</p>	K 025		

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K 025	<p>Continued From page 2</p> <p>passing beneath an access door. The facility was cited for this same deficient practice on 04/28/10 and 03/20/11.</p> <p>Observations conducted at 10:25 AM on 04/03/12, revealed the Zone 2 fire/smoke barrier wall was not reasonably accessible for maintenance and inspection purposes. An interview with the DOM on 04/03/12, at 10:50 AM, revealed this area of the attic was difficult to maintain due to the limited access.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose.</p>	K 025		
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K 025	Continued From page 3 (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) 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 smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 025			
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, the facility failed to maintain the fire sprinkler system by NFPA standards. This deficient practice affected eight of eight smoke compartments, staff, and all the residents. The facility has the capacity for 128 beds with a census of 120 on the day of the survey. The findings include:	K 062			

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K 062	<p>Continued From page 4</p> <p>During the Life Safety Code survey on 04/03/12, at 11:20 AM, with the Director of Maintenance (DOM), two covers were observed to be missing from the fire department connection on the exterior of the facility. These covers help ensure foreign material does not get into the facility's fire sprinkler system. An interview with the DOM on 04/03/12, at 11:20 AM, revealed the covers had been missing since he started working at the facility in July 2011. The DOM stated replacement covers were hard to find but he was unaware measures should have been taken to cover the connections temporarily until permanent covers were attained.</p> <p>A record review on 04/03/12, at 2:00 PM, revealed the facility had an interior pipe inspection completed on their sprinkler system in May 2011. The inspection report revealed the sprinkler system needed to be flushed due to the system being dirty with lots of organic matter in the pipe.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p>	K 062			

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K 062	Continued From page 5 A-10-2.2 Obstruction Prevention Program (a) Dry Pipe and Preaction Systems - Scale. 1. Dry pipe and preaction systems using noncoated ferrous piping should be thoroughly investigated for obstruction from corrosion after they have been in service for 15 years, 25 years, and every 5 years thereafter. 1-8* Records. Records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to, valve inspections; flow, drain, and pump tests; and trip tests of dry pipe, deluge, and preaction valves. 1-8.1 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. 9-7.1 Fire department connections shall be inspected quarterly. The inspection shall verify the following: (a) The fire department connections are visible and accessible. (b) Couplings or swivels are not damaged and rotate smoothly. (c) Plugs or caps are in place and undamaged. (d) Gaskets are in place and in good condition. (e) Identification signs are in place. (f) The check valve is not leaking. (g) The automatic drain valve is in place and operating properly.	K 062		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 076		

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K 076	<p>Continued From page 6</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that oxygen cylinders were stored according to NFPA standards. This deficient practice affected one of five smoke compartments, staff and approximately ten residents. The facility has the capacity for 128 beds with a census of 120 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 04/03/12, at 12:15 PM, with the Director of Maintenance (DOM), 27 E-size oxygen cylinder tanks were observed to be stored in the oxygen storage room. These tanks were within five feet of combustible storage. Three of the tanks were unsecured. Oxygen cylinders while in storage and in quantities greater than 300 cubic feet must be kept five feet from combustibles. An interview</p>	K 076		
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K 076	<p>Continued From page 7</p> <p>with the DOM on 04/03/12, at 12:15 PM, revealed he was not aware of oxygen storage requirements. Quantities 300 cubic feet (12 E-sized cylinders) and less may follow the requirements of S&C-07-10.</p> <p>Reference: S&C-07-10.</p> <p>Up to 300 cu ft (12 E sized cylinders) of nonflammable medical gas can be located outside of an enclosure (per smoke compartment) at locations open to the corridor such as at a nurse's station or in a corridor of a healthcare facility.</p> <p>This amount of nonflammable medical gas per smoke compartment is not considered a hazard if the containers are properly secured, such as in a rack to prevent them from tipping over or being damaged. In this case, the medical gas is considered an "operational supply" and not storage. If the cylinders are placed in a corridor they should be placed so as not to obstruct the use of the corridor. This amount of medical gas is in addition to those cylinders contained in "crash carts" and in use on wheelchairs or gurneys.</p> <p>The term "PRN" means "as needed." An individual cylinder placed in a patient room for immediate use by a patient is not required to be stored in an enclosure and is considered in use. It should be secured to prevent tipping or damage to the cylinder. If the resident does not need the use of oxygen for an extended period of time, such as several days, then the medical gas container should be removed from the room and properly secured in an approved storage room.</p> <p>Reference: NFPA 99 (1999 Edition).</p>	K 076		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 076	Continued From page 8 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m ³ (300 ft ³) but less than 85 m ³ (3000 ft ³) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 076			

This Plan of Correction is the provider's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

K 025

1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?

There is no correction. No residents were identified as being affected by this deficient practice.

2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken

All residents have the potential to be affected by this deficient practice.

3. What action did the provider take to assure that the alleged deficient practice does not recur?

All penetrations in affected zones observed during survey will be sealed with an approved fire sealant material by 5/9/12. The Director of Maintenance (DOM) or Maintenance Assistant will perform attic and firewall inspections quarterly. A fire rated access panel/door will be installed in the main break room to help access to needed areas in the attic space. This access panel/door has been ordered and a contract has been procured for installation to be

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completed 5/9/12.

4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?

The DOM/designee will do a semiannual audit of the building zones which could be affected by the deficient practice. Both quarterly inspections and semiannual audits will be put into Building Engines, the facility work order software system. Audit results will be brought to the Quality Assurance and Assessment (QA&A) meeting on a semiannual bases for review ongoing for one year.

Expected date of completion:

5/9/12

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K 062

1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?

There is no correction. No residents were identified as being affected by this deficient practice.

2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken

All residents have the potential to be affected by this deficient practice.

3. What action did the provider take to assure that the alleged deficient practice does not recur?

Covers were replaced 4/26/12 to ensure foreign material is kept out of the fire sprinkler system. A sprinkler flush quote has been obtained as of 4/9/12 and is scheduled to be completed May 4, 2012.

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4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?

The Director of Maintenance/designee will perform semiannual checks of the building fire system/sprinkler mechanics and contract any needed work to be done by an approved agency/company. Any and all reports from sprinkler/fire maintenance company will be reviewed by the DOM and the Executive Director consecutively. The DOM will bring findings of building fire/sprinkler systems and any concerns to the Quality Assurance and Assessment meeting for review and discussion.

Expected date of completion:

5/5/12

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K 076

1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?

There is no correction. No residents were identified as being affected by this deficient practice.

2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken

All residents have the potential to be affected by this deficient practice.

3. What action did the provider take to assure that the alleged deficient practice does not recur?

Oxygen cylinders were relocated on 4/4/12 to ensure there were no more than 12 cylinders within one smoke compartment. Staff will be in serviced by 5/9/12 as to the regulation of 12 cylinders per smoke compartment and where the compartments are located. Signage will also be placed in oxygen cylinder storage areas by 4/26/12 as reminder to staff on the regulation regarding cylinder storage.

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4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?

Weekly checks will be performed by the maintenance department to ensure the proper storage and amount of cylinders per smoke compartment. This will be tracked by Building Engines, the facility work order software in order to prompt maintenance employees to complete the check. The Executive Director will complete weekly audits for a one month period to ensure compliance. Findings will be brought to the Quality Assurance and Assessment meeting for review and recommendations.

Expected date of completion:

5/9/12