

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

PRINTED: 05/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/19/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

A standard health survey was conducted 04/17/12 through 04/19/12 and a Life Safety Code survey was conducted 04/17/12 through 04/18/12. Deficiencies were cited with the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.

F 252 483.15(h)(1)
SS=B SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

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.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to provide an environment free from odors in two (2) of four (4) wings (hallways). The 100 Wing and the 200 Wing, where residents reside, and the main upstairs entrance hallway, had unpleasant odors during the three days of the survey.

The findings include:
The facility did not have a policy related to odors.
Observation, on 04/17/12 at 10:30 AM, revealed when the facility was entered by the survey team, strong urine odors were noted in the hallway.
Observation, on 04/17/12 at 4:50 PM, revealed

F 000 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.

F 252

F 252 B

1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?
The area outside the elevator located next to the 200 wing Nurse's station and the area in the hallway in front of the 100 wing Nurse's station were sanitized using a product that will sanitize and neutralize odors by the housekeeping staff on 4/25/2012. Maintenance supervisor added a bioenzymatic treatment to assist with the degradation of organic waste.

2) How will the facility identify other residents having the potential to be affected by the same deficient practice?
All residents have the potential to be affected. An audit of resident rooms, hallways and resident common areas will be conducted

5/22/12

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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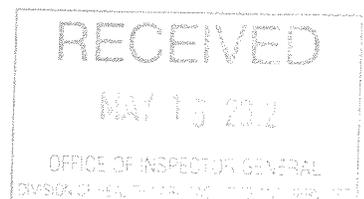
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F 252	Continued From page 1 strong urine odors outside the elevator located next to the 200 Wing nurses' station. Observation, on 04/19/12 at 10:00 AM, revealed strong urine odors on the 200 Wing located outside the elevator area. Observation, on 04/19/12 at 10:15 AM, revealed odors in the hallway in front of the 100 Wing nurses station. Interview, on 04/19/12 at 9:25 AM, with the Housekeeping Manager revealed he noted odors outside the elevator by the 200 Wing nurses' station. He stated problem areas with odors were identified and addressed. Deep cleaning schedules were modified to control odors. However, odors remained. Continued interview revealed the 100 Wing areas around the nurses' station had odors which he revealed were attributed to residents gathering there in the common area and the odor may be down in the carpet. He revealed there were more automated deodorizers located on the walls on the 100 Wing than in other areas of the facility, which he attributed to the fact that this was where most odors were noted. Interview, on 04/19/12 at 10:00 AM, with the Housekeeping Manager-In-Training revealed strong urine odors were present in the area of the 200 Wing nurses station. Interview, on 04/19/12 at 11:12 AM, with the Director of Nursing revealed the facility had a couple problem areas that were focused on to control odors. She revealed there were deodorizers in the hallway to help with the odors.	F 252	Housekeeping supervisor and Safety officer completed rounds on 04/20/2012 to determine the areas that need additional maintenance, cleaning or odor control. Issues identified during the audit were addressed by the Housekeeping Manager on 04/23/2012 and the Maintenance Director by 05/14/2012. <i>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i> Education was provided to housekeeping staff by the Housekeeping Manager on 05/14/2012 to provide necessary cleaning and odor control routinely, and to notify the Housekeeping Manager of problem areas. The Housekeeping Manager will provide education to the Housekeeping staff to report maintenance issues observed. The Director of Clinical Education will provide education to the Nursing staff (CNAs, LPNs, RNs) on requirements to provide a safe, clean, comfortable, and sanitary homelike environment including addressing Housekeeping or odor	
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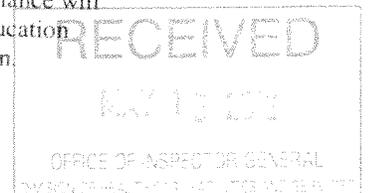


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F 252	Continued From page 2 Interview, on 04/19/12 at 2:40 PM, the facility Ombudsman revealed she had noted objectionable odors within the facility.	F 252	issues and reporting problem areas to the Housekeeping Manager/Maintenance Director through the electronic reporting system (Building engines). Education will be provided by the Executive Director by 05/15/2012 to the Management Staff on their non-clinical rounds assignments and items on the form. Education included the addition of resident common areas, hallways, laundry department, and therapy departments for needed maintenance issues (including ceiling and ceiling tiles) and or housekeeping issues (including odors). Maintenance supervisor or assistant will treat open floor drain lines weekly for 4 weeks and monthly thereafter.		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's invoice records from the vendor Advanced Mechanical, record review of Non Clinical Rounds, review of receipts for ceiling panel purchases and the Work Order List, it was determined the facility failed to maintain a sanitary environment. Stained ceiling tiles were present in seven (7) of seventeen (17) resident bathrooms on the 400 Wing, Rooms 400, 401, 402, 405, 409, 410 and 411 and in two (2) of seventeen (17) resident bedrooms on the 400 Wing, Room 402 and 405. The findings include: Review of the Non-Clinical Rounds records for the 400 Wing revealed the rooms were to be monitored for cleanliness, which included the ceilings. The rounds on Rooms 400, 401, 402 and 405 dated 04/06/12 listed no concerns with the ceilings. The rounds on Rooms 409, 410 and 411 dated 04/05/12 revealed no concerns with the		4) How will the facility monitor its performance to ensure that solutions are sustained? Non-clinical rounds will be completed weekly by Management staff for resident rooms, resident common areas, hallways, laundry department and therapy departments. Areas of concern will be reported to maintenance or housekeeping and documented on the Non-clinical round form then discussed in the Executive Director AM meeting (M-F). Results from these rounds will be presented weekly to the QAA committee for review for 4 weeks starting 05/14/2012, then monthly to QAA.		

Any areas of non-compliance will be addressed with re-education and or disciplinary action.



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F 253 Continued From page 3
ceilings. However, on 04/17/12 during the tour of the facility, dried brown stains were noted on the ceilings in Rooms 400, 401, 402, 405, 409, 410 and 411.

Review of the invoice records from Advanced Mechanical, the company that addressed plumbing and water issues for the facility, revealed twice in the last six (6) months, on 11/09/11 and 01/19/12, Advanced Mechanical serviced the facility for clogged restrooms/toilets. The rooms which were serviced were not identified. The water was shut down in the facility on 10/11/11 and "bad piping" was removed. Also, on 10/18/11, the 400 Wing sewer main was unclogged by Advanced Mechanical.

Review of receipts from Home Depot over the last six (6) months, ending 04/16/12, the day before the survey, revealed the facility had purchased on 02/13/12 seven (7) ceiling tiles, on 02/08/12 two (2) ceiling tiles and on 01/19/12 three (3) ceiling tiles.

Review of the Work Order List, dated 04/17/12, revealed no ceiling tiles were noted as needing replacement, indicating there were no stained ceiling tiles. However, seven (7) rooms had existing stained ceiling tiles.

Observation, on 04/17/12, during the tour of the facility, revealed stained ceiling tiles were present in resident bathrooms on the 400 Wing in Rooms 400, 401, 402, 405, 409, 410 and 411 and in two (2) resident bedrooms on the 400 Wing, Room 402 and 405.

Interview, on 04/17/12 at 4:50 PM, with the

F 253

1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

Ceiling tiles were replaced in resident bathrooms in rooms 400, 401, 402, 405, 409, 410, 411 and in resident bedrooms in 402 and 405 by the Maintenance Director and Maintenance Assistant on 04/18/2012.

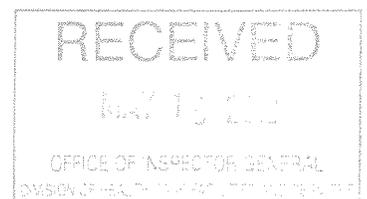
2) How will the facility identify other residents having the potential to be affected by the same deficient practice?

All residents have the potential to be affected. An audit of resident rooms, hallways and resident common areas will be conducted by Executive Director and Safety officer by 05/14/2012 to determine the areas that needed additional maintenance, cleaning or odor control. Issues identified during the audit will be addressed by the Housekeeping Manager on 05/15/2012 and the Maintenance Director by 05/15/2012.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

Education was provided by the Housekeeping Manager on 05/14/2012 to the housekeeping staff to provide necessary cleaning and odor control

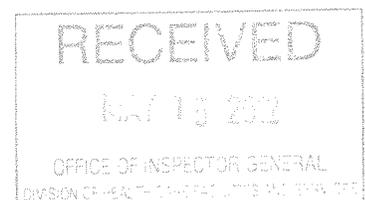
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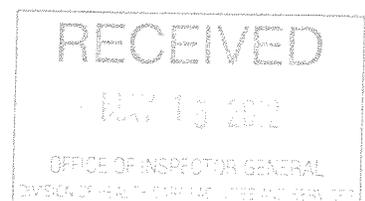
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F 253	<p>Continued From page 4</p> <p>Maintenance Director revealed requested work orders were retrieved from the computer every morning and not deleted from the computer until the work order was completed. No current work order existed to replace the ceiling tile in any room. Continued interview with the Maintenance Director revealed every time there was an overflow upstairs (above the 400 Wing) we (the facility) go through hundreds of dollars of tiles. He revealed the expense to the facility was a significant amount. However, the sum total, provided by the facility, spent on ceiling tiles for the last six (6) months was less than three hundred dollars (\$300).</p> <p>Interview, on 04/18/12 at 12:05 PM with Certified Nursing Assistant (CNA) #3 revealed stained or wet ceiling tile, would be reported to the Unit Manager. She stated she reported Room 408 for the ceiling leaking water in the bathroom and it was repaired. Room 408 was not observed to have stained ceiling tile.</p> <p>Interview, on 04/18/12 at 12:10 PM, with Licensed Practical Nurse (LPN) Unit Manager #3 revealed stained ceiling tiles are found at least two (2) to three (3) times a week. She stated "a lot of time they (the ceiling tile) will be moist and fall through". It seemed to be an ongoing issue she stated.</p> <p>Interview, on 04/18/12 at 12:15 PM, with Registered Nurse (RN) #2 revealed the ceiling tiles were an on-going problem. She stated the tiles were replaced quite frequently. A weekly inspection was done and the results turned into the Director of Nursing. She stated Rooms 410 and 416 had leaks. Rooms 400, 401 and 402</p>	F 253	<p>routinely, and to notify the Housekeeping Manager of problem areas. The Housekeeping Manager provided education on 05/14/2012 to the Housekeeping staff to report maintenance issues observed.</p> <p><i>The Director of Clinical Education will provide education to the Nursing staff (CNAs, LPNs, RNs) between 05/10/2012 & 05/15/2012 on requirements to provide a safe, clean, comfortable, and sanitary homelike environment including addressing Housekeeping or odor issues and reporting problem areas to the Housekeeping Manager and reporting maintenance issues through the electronic reporting system (Building engines). All staff will be educated by the Director of Clinical Education or the Housekeeping manager of the importance of not putting large items such as briefs, wash cloths, towels, or other non-biodegradable materials into the commode and if there is a toilet that overflows how to immediately turn the water off at the commode and to immediately put some towels down to get the water off of the floor. All commodes in the affected area will be caulked by Maintenance Supervisor or Assistant by 05/15/2012. Education will be</i></p>	



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F 253	Continued From page 5 have had problems for more than a year she revealed. She indicated the source of the water leak needed to be found. Interview, on 04/18/12 at 2:02 PM, with the Owner of Advanced Mechanical revealed when the toilets overflow, the seal (around the bottom of the commode) was not a pressed fit or a sealed fit, and water would run down the hole where the plumbing pipe was located and go to the room below. He stated "once in a blue moon, they (the residents) put too much in it (the toilet) and it will drip". His company had been out twice in six (6) months to the facility for clogged toilets. Interview, on 04/19/12 at 10:00 AM, with the Administrator revealed the Non Clinical Rounds form was completed and if tiles needed to be changed, maintenance changed them out. He revealed if a leak was identified from a room above a 400 Wing room, the leak would be repaired and the tile replaced. He stated if a plumber needed to be called, then a plumber would come in, repair and fix. Interview, on 04/19/12 at 3:00 PM, with Resident "A" revealed there were stained tiles in both his/her bedroom and bathroom. He/she used the word "gross" to describe the ceiling tile in his/her bathroom. Interview, on 04/19/12 at 3:15 PM, with CNA #4 revealed the stains on the ceiling tiles in Room 410 were from the overflow of the toilet upstairs. There was not a current work order to replace the ceiling tiles in Room 410.	F 253	provided by the Executive Director by 05/15/2012 to the Management Staff responsible for non-clinical rounds on their assignments and items on the form. Education included the addition of resident common areas, hallways, laundry department, and therapy departments for needed maintenance issues (including ceiling and ceiling tiles) and or housekeeping issues (including odors). <i>4) How will the facility monitor its performance to ensure that solutions are sustained?</i> Non-clinical rounds will be completed weekly by Management staff for resident rooms, resident common areas, hallways, laundry department and therapy departments. Areas of concern will be reported to maintenance or housekeeping and documented on the Non-clinical round form then discussed in the Executive Director AM meeting (M-F). Executive Director and Maintenance Supervisor or Maintenance assistant in their absence will round daily for 4 weeks in the affected area (M-F) Results from these rounds will be presented weekly to the QAA committee for review for 4 weeks starting 05/14/2012, then monthly to QAA. Any areas of non-compliance will be addressed with re-education and or disciplinary action.		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			



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F 441 Continued From page 6

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.

(c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

F 441

1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

Observed items corrected immediately if possible. Resident "B" Oxygen tubing was discarded on 4/19/12 by the Director of Nursing and replaced with new tubing that was stored properly. **Resident #4 wound was re-dressed on 4/19/2012. Resident #5 wound was re-dressed on 4/19/2012. CNA#2 removed resident from shower area until area cleaned, then completed the shower.** CNA #1 was educated by the LPN, Unit Manager on 5/10/2012 on proper hand washing upon entering and exiting resident rooms after providing care. LPN/Unit Manager #3 was educated on hand hygiene during clean dressing changes by the Director of Clinical Education on 4/18/2012. LPN #2 was educated on hand hygiene during skin assessments by the Director of Clinical Education on 4/18/12. CNA #2 was educated on cleaning the shower room when visibly soiled between resident showers by the Director of Nursing on 5/10/12.

5/22/12



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F 441	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the CDC (Centers for Disease Control) Guideline for Hand Washing Techniques; CDC Guideline for Hand Hygiene in Health-Care Settings; the facility's policy and procedures for Hand Hygiene and Proper Handwashing Technique, not dated; Handwashing Procedure 430, dated 2006; Clean Dressing Change, undated, the 7-Step Daily Washroom Cleaning, dated 01/01/2000; and Oxygen Therapy, no date noted, it was determined the facility failed to maintain an Infection Control Program to prevent the development and transmission of disease and infection for four (4) of the twenty-five (25) sampled residents, Residents #4, #5, #6 and #13 and one (1) of the two (2) un-sampled residents, Resident "B". During a dressing change for Resident #4, the facility staff failed to perform hand washing and gloves were not changed after cleaning the residents wound before applying a clean dressing. During a dressing change for Resident #5 the Certified Nursing Assistant (CNA) failed to perform hand hygiene after removing dirty gloves and applying new gloves. During skin assessments for Resident's #6 and #13 the facility staff failed to perform handwashing and change gloves. The shower room was not cleaned in-between residents as evidence of brown substance found on the floor tile of the shower room. During meal service un-sampled Resident B was found with improperly stored oxygen tubing. The findings include:	F 441	2) How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. An audit was conducted on 5-10-2012 by the Unit Managers to ensure all tubing and supplies were labeled, dated, clean and stored correctly. Observation rounds were completed by the Unit Managers on 5/14/2012 to audit compliance of hand hygiene and cleaning of shower rooms in between residents. Any issues identified were corrected immediately. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Infection control education was conducted by the Director of Clinical Education to the nursing (CNA, LPN's, RN's) staff to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection from 5/10/2012 to 5/15/12. This education included, but was not limited to, hand washing, glove use and storage of respiratory tubing. Post test was completed with nursing staff (CNA, LPN, RN) to ensure understanding of infection control topics, from 5/10/2012 to 5/15/12. Education also provided to the housekeeping department on 5/14/2012 by the Housekeeping manager on cleaning of shower rooms.		

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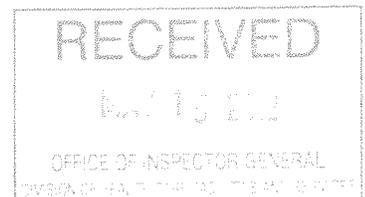
MAY 18 2012

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE SERVICES

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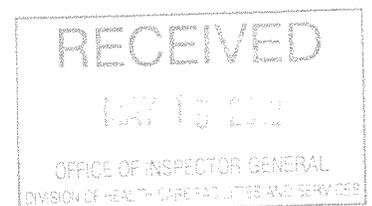
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F 441	Continued From page 8 Review of the CDC Guidelines for Hand Hygiene in Health-Care Settings, dated 10/25/02, revealed the following indications for handwashing and hand antisepsis: decontaminate hands before having direct contact with patients; decontaminate hands after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings; change gloves during patient care if moving from a contaminated body site to a clean body site; decontaminate hands after removing gloves; and decontaminate hands after having contact with inanimate objects in the immediate vicinity of the patient. Record Review of the facility's policy titled Hand Washing Procedure 430, dated 2006, revealed the facility staff were to their wash hands before and after resident contact and when soiled. An additional facility handout titled Hand Hygiene and Proper Handwashing Technique, undated, revealed hands should be washed after contact with blood or body fluids, mucous membranes, secretions or excretions, even if gloves were worn. The use of gloves does not replace hand hygiene because gloves may be cut or torn during use. Bacteria can multiply quickly on gloves, and hands may become contaminated while gloves are being removed. 1. Observation during Resident #5's dressing change, on 04/19/12 at 10:05 AM, revealed CNA #1, (Certified Nursing Assistant) failed to wash her hands after removing her gloves and exiting Resident #5's room. Upon CNA #1's re-entrance of Resident #5's room, she did not wash her hands before putting on gloves when she assisted LPN #1 (Licensed Practical Nurse) with	F 441	4) How will the facility monitor its performance to ensure that solutions are sustained? An audit of infection control practices will be completed using the Monitoring Compliance with Infection Control Checklist, which includes, but is not limited to, monitoring of hand hygiene during skin assessments, hand hygiene during clean dressing change, hand hygiene when entering and exiting residents rooms, cleaning of shower room in between residents when visibly soiled, and storage of respiratory tubing and supplies, by the Director of Clinical Education weekly for 4 weeks, then monthly thereafter. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.		



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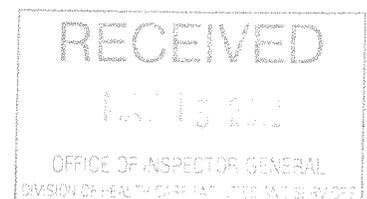
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F 441	<p>Continued From page 9 Resident #5's personal care.</p> <p>Interview, on 04/19/12 at 10:25 AM, with CNA #1 revealed she was a new employee and had completed her orientation training required by the facility. She further revealed she viewed an infection control video and signed the facility policy related to infection control. CNA #1 revealed she had failed to wash her hands after removing her gloves and put clean gloves back on. The CNA stated the facility policy was to wash yours hands after glove changes as well as before and after resident care. CNA #1 further stated it was important to wash her hands and the risk for not washing her hands could spread infection to facility co-workers and other residents.</p> <p>Interview, on 04/19/12 at 1:20 PM, with LPN #1 revealed the facility policy was for employee's to wash hands before and after each resident contact, which included washing hands after glove change. LPN #1 also stated the facility provided infection control in orientation and annually to all facility staff. LPN #1 revealed the DCE Director of Clinical Education had provided training to facility staff on infection control and he had seen her throughout the facility performing surveillance. LPN #1 stated it was his duty to re-train CNA #1 that day on the facility policy on infection control and hand washing.</p> <p>2. Review of the policy Clean Dressing Change,</p>	F 441		



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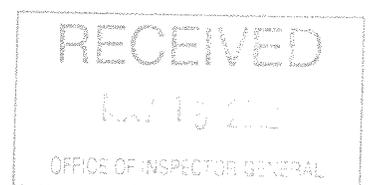
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F 441	<p>Continued From page 10</p> <p>undated, revealed after cleaning a wound, hands were to be washed and a clean pair of gloves were to be put on prior to applying a dressing.</p> <p>Interview, on 04/19/12 at 11:20 AM, with the Director of Nursing (DON) revealed during a dressing change gloves were to be removed after cleansing wounds and prior to putting a new dressing on the wounds. She revealed the staff had been in-serviced on dressing changes.</p> <p>Interview, on 04/19/12 at 11:25 AM, with the Clinical Educator revealed during a dressing change, hands were to be washed and clean gloves put on prior to starting the dressing change. This was repeated after the old dressing was removed, and again repeated after the wound was cleansed, prior to applying the new dressing. A final hand washing was to occur when the dressing change was completed. She revealed the purpose of the hand washing and glove changes had to do with not getting any clean areas dirty and to prevent the spread of infection.</p> <p>Observation, on 04/18/12 at 9:55 AM, revealed during the dressing change for Resident #4, Licensed Practical Nurse (LPN) Unit Manager #3 had washed her hands and put on clean gloves to cleanse the wounds, however, she did not removed the soiled gloves or wash her hands prior to applying the new dressing.</p> <p>Interview, on 04/18/12 at 10:30 AM, with LPN Unit Manager #3 revealed she did know that she was to wash her hands and put on a clean pair of gloves prior to the application of a clean dressing.</p>	F 441	



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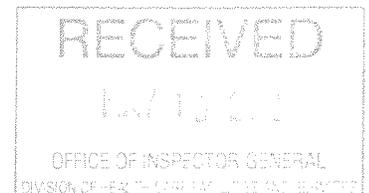
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F 441	<p>Continued From page 11</p> <p>3. Observation of Licensed Practical Nurse (LPN) #2 completing Resident #6's skin assessment, on 04/18/12 at 10:15 AM, revealed LPN #2 did not wash her hands upon entering the patient's room and donned clean gloves. LPN #2 did not perform the skin assesement using a clean to dirty progression as evidenced by touching the peri-area, then proceeding to assess Resident #6's back, feet, and hands. LPN #2 then obtained a paper towel to wipe secretions from Resident #6's mouth without removing soiled gloves, washing hands, and putting on clean gloves.</p> <p>Observation of LPN #2 completing Resident #13's skin assessment, on 04/18/12 at 10:40 AM, revealed LPN #2 did not wash her hands prior to donning gloves to perform the skin assessment on Resident #13. LPN #2 touched Resident #13's peri area, but did not remove gloves, wash hands, or put on clean gloves before completing the assesemnt of Resident #13's back, legs, and feet.</p> <p>Interview with LPN #2, on 04/18/12 at 10:50 AM, revealed LPN #2 was not aware she wiped secretions from the mouth of Resident #6 with the same gloves used to assess the patient's skin and peri area. LPN #2 stated gloves should be removed, hands washed, and clean gloves applied before wiping the secretions. LPN #2 stated she did not realize she moved from dirty to clean areas during both skin assessments. LPN #2 stated prevention of infections was the goal of moving from body areas considered clean to those considered dirty.</p> <p>Interview with Unit Manager #2, on 04/19/12 at</p>	F 441	



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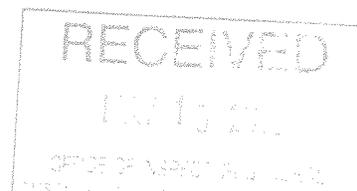
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F 441	<p>Continued From page 12</p> <p>1:50 PM, revealed Unit Manager #2 was ultimately responsible for ensuring unit staff members maintain infection control procedures. Unit Manager #2 stated the most recent hand hygiene inservice occurred 01/12 and all infection control policies were available to staff through the facility's intranet.</p> <p>Interview with the Director of Clinical Education, on 04/19/12 at 2:10 PM, revealed she was responsible for monitoring all infection control procedures, and she used a hand washing evaluation tool titled Hand Hygiene and Proper Handwashing Techniques, not dated, when observing staff members wash their hands and perform resident care.</p> <p>Inteview with the Director of Nursing (DON), on 04/19/12 at 3:15 PM, revealed all staff members should wash their hands before begining resident care, and between glove changes. Training on infection control procedures was standard during new employee orientation, and inservices. All staff have access to infection control policies through the facility's intranet, and hard copies were also available. The Director of Clinical Education makes rounds to identify any infection control problems, but as DON, she stated she was ultimately responsible for assuring infection control procedures were always followed.</p> <p>4. Review of the policy Bath, Shower, dated 2006, revealed the responsibility to clean the shower chair belongs to the nursing department.</p> <p>Review of the policy 7-Step Daily Washroom Cleaning, 01/01/2000, did not address cleaning</p>	F 441	



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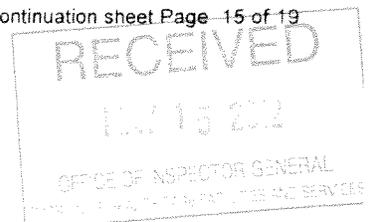
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F 441	<p>Continued From page 13</p> <p>shower stalls. It did state to damp mop using the proper mop and germicide solution to disinfect the floor.</p> <p>Interview, on 04/19/12 at 10:15 AM, with the Clinical Educator revealed the CNA was responsible to clean the shower chair and housekeeping was responsible for the floor. This was to occur twice a day unless extra cleaning was needed. Housekeeping was to be notified if the shower was soiled and needed to be sanitized before the next resident. She stated this was the process to prevent any spread of infection.</p> <p>Observation, on 04/18/12 at 9:10 AM, in the unoccupied 200 Wing shower room revealed a brown substance on the floor of the shower room in several different areas, particularly around the outer rim of the shower.</p> <p>Observation, on 04/18/12 at 9:30 AM, in the 200 Wing shower room revealed Certified Nursing Assistant (CNA) #2 completing a shower of a resident. The brown substance remained on the floor.</p> <p>Interview, on 04/18/12 at 9:30 AM, with CNA #2 revealed housekeeping was to clean the shower room between residents.</p> <p>Interview, on 04/18/12 at 9:30 AM, with LPN Unit Manager #1 revealed housekeeping was responsible to keep the showers clean.</p> <p>Interview, on 04/19/12 at 11:20 AM, with the DON revealed housekeeping did the full cleaning of the shower rooms. If there was soiling on the floor,</p>	F 441		



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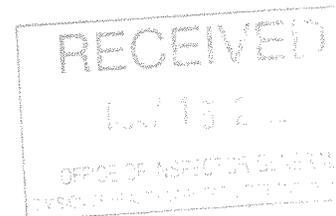
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F 441	Continued From page 14 either a housekeeper or a CNA could clean and sanitize the shower room. If there was obvious soiling, the floor would be cleaned. Additionally, she revealed whoever noticed the soil should notify housekeeping. 5. Review of the policy Oxygen Therapy, undated, revealed unused oxygen tubing, for reasons of infection control, should be stored to prevent contamination. Interview, on 04/19/12 at 11:20 AM, with the Director of Nursing (DON) revealed, for the purpose of infection control, oxygen tubing was to be stored in a plastic bag when not in use and stored off the floor. She stated the staff had been educated to the storage of the oxygen equipment and all of the staff monitors the storage of the equipment. Observation, on 04/17/12, during the noon meal in the main dining room, revealed Resident "B" in a wheelchair, sitting at a table with an oxygen tank to the back of his/her chair with oxygen tubing uncovered, wrapped around the top of the tank. Observation, on 04/18/12 at 9:30 AM, of Resident "B" sitting alone in the dining room revealed an oxygen tank to the back of his/her chair with oxygen tubing uncovered, wrapped around the top of the tank. Observation, on 04/18/12 at 12:00 PM, of Resident "B" revealed oxygen tubing uncovered, wrapped around the top of the oxygen tank on the back of the wheelchair.	F 441			



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F 441	Continued From page 15	F 441			
F 465 SS=F	<p>Interview, on 04/19/12 at 1:50 PM, with Licensed Practical Nurse (LPN) Unit Manager #1 revealed oxygen tubing was to be stored in a plastic bag when not in use for infection control purposes. She stated the Certified Nursing Assistants (CNA) had been educated to store the tubing in that manner.</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Infection Control Guidelines, Work Order List and Invoice records, it was determined the facility failed to provide a safe and sanitary environment in one (1) of one (1) clean linen/laundry room. An open hole was present in the ceiling of the clean side of the laundry room. Multiple water stains were present around the hole and in the vicinity of the hole. A bucket was sitting on the folding table to collect water as it dripped from the ceiling.</p> <p>The findings include: Review of the Infection Control Guidelines revealed working fields were to remain clean. The facility did not provide a policy on environmental hazards and/or safety.</p>	F 465	<p>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The ceiling on the clean side of the laundry room will be repaired by John Schnur Drywall (vendor) by 5/14/2012. The bucket was removed by Housekeeping supervisor on 04/19/2012. The maintenance supervisor and assistant removed all of the existing caulk from the shower room above the laundry and the reapplied caulk.</p> <p>2) How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected. An audit was conducted by Maintenance Director and Housekeeping supervisor on 5/2/2012 of the clean and dirty side of the laundry department to determine the areas that needed additional maintenance or cleaning. Issues identified during the audit were addressed by the Housekeeping Manager on 5/2/2012 and the Maintenance Director by 5/14/2012.</p>	5/22/12	



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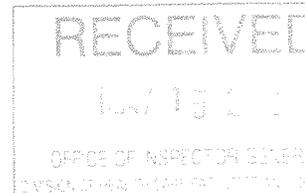
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F 465	<p>Continued From page 16</p> <p>Review of the Work Order List, dated 04/17/12, revealed no current work order to repair or replace the open area in the ceiling of the clean side of the laundry room.</p> <p>Review of invoice records from Advance Mechanical, the company which provided work with water related problems to the facility, revealed no work was performed in the laundry room.</p> <p>Observation, on 04/17/12 at 4:25 PM, revealed a hole in the ceiling of the clean side of the laundry room. All around the hole and along a dropped part of the ceiling, which looked to follow duct work, on the left, as you face the machines, water damage and discoloration, brown, beige and black, was present. A collection bucket was noted at the end of a table, a table used to fold clothes, to catch water as it leaked out of the ceiling. Clean laundry was observed being folded at the same time the ceiling hole and water damage were observed.</p> <p>Interview, on 04/17/12 at 4:25 PM, with the District Housekeeping Manager revealed the ceiling in the laundry room leaks, but it has not leaked lately. He revealed laundry personnel kept the bucket on the table to catch the water as it comes out of the ceiling.</p> <p>Interview, on 04/17/12 at 4:50 PM, with the Maintenance Manager revealed work orders were generated in the computer. Once the work was completed, it was removed from the computer. As evidenced by no current work order, there was no plan to repair the hole in the ceiling located in</p>	F 465	<p>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? <i>Education will be provided by the Housekeeping Manager on 5/14/2012 to the housekeeping staff to report maintenance issues. Education will be provided by the Executive Director on 5/15/2012 to the Management Staff responsible for weekly non-clinical rounds on their assignments and new items on the form such as the addition of resident common areas, hallways, laundry department, and therapy departments for needed maintenance issues (including ceiling and ceiling tiles).</i></p> <p>4) How will the facility monitor its performance to ensure that solutions are sustained? Non-clinical rounds will be completed weekly by the Housekeeping Manager (Safety Director will be the backup) of the laundry department and both therapy departments. Areas of concern will be reported to maintenance or housekeeping and documented on the Non-clinical round form then discussed in the Executive Director AM meeting (M-F). Results from these rounds will be presented weekly to the QAA committee for review for 4 weeks starting 5/14/2012, then monthly to QAA.</p>	
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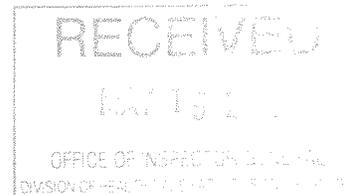
Any areas of non-compliance will be addressed with re-education and or disciplinary action.



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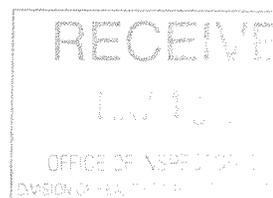
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F 465	<p>Continued From page 17 the clean linen side of the laundry room.</p> <p>Interview, on 04/19/12 at 7:30 AM, with Laundry Staff #1 revealed when the shower room above the clean side laundry room was used, water came down into the laundry room. She stated "They have fixed it three (3) times now". She stated the water did not get on the linen because the bucket would catch the water. However, she revealed it was a concern that water could get on the newly washed items.</p> <p>Interview, on 04/19/12 at 7:35 AM, with Laundry Staff #2 revealed the ceiling currently leaks when the shower located above the laundry room runs for a long time. She stated it was reported to her manager when it leaked. In addition, she revealed the ceiling was a safety concern because the ceiling could fall.</p> <p>Interview, on 04/19/12 at 3:00 PM, with the Administrator revealed the hole in the ceiling of the laundry room was caused by water leaking down from the shower room located above the laundry room. He stated the shower was caulked and he was not aware of the shower leaking in quite a while. He stated the laundry room ceiling was not repaired.</p> <p>Interview, on 04/19/12 at 9:25 AM, with the Housekeeping Manager revealed his staff had reported to him the ceiling had leaked and he reported it to maintenance. He revealed he understood the shower above the clean laundry room was repaired; however, observations during the survey revealed the water catch bucket was noted to remain in place and staff had indicated through interview, the ceiling currently had</p>	F 465		



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(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 465	Continued From page 18 leaked.	F 465		



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

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1970, 1984 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: Two (2) levels, Type III Protected. SMOKE COMPARTMENTS: Eight (8) smoke compartments in the Upper Level and three (3) in the Lower Level. FIRE ALARM: Complete fire alarm system. SPRINKLER SYSTEM: Complete automatic, dry sprinkler system; pipe schedule design. GENERATOR: Type II, 350 KW generator; fuel source is diesel. Installed new in 2007. A standard Life Safety Code survey was initiated on 04/17/12 and concluded on 04/18/12. Golden LivingCenter - Hillcreek was found not in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) Deficiencies were cited with the highest	K 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
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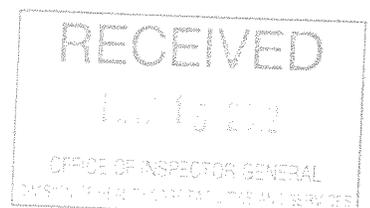
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *X [Signature]* TITLE *X Executive Director* (X6) DATE *X 5/10/12*

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 000	Continued From page 1 deficiency identified at E level.	K 000			
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eleven (11) smoke compartments, approximately thirty (30) residents, staff and visitors. The facility is licensed for one-hundred and seventy-two (172) beds and the census was one-hundred and sixty-two (162) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 04/17/12 at 1:00 PM, with the Safety Director and the Maintenance Director revealed the doors to the two (2) Medical Records Rooms located in the 200 Wing, did not</p>	K 029	<p>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Maintenance Director installed self closing devices to the 2 Medical Records Doors on 05/11/2012.</p> <p>2) How will the facility identify other residents having the potential to be affected by the same deficient practice? An audit was conducted by the Maintenance Director and Executive Director on 05/02/2012 for doors required to be self-closing or automatic-closing. All other doors were found to be in compliance.</p> <p>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Education was provided to the Maintenance Director and the Medical Record Clerk by Executive Director on 05/11/2012 for the need for self-closing doors.</p>	5/22/12	



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K 029	<p>Continued From page 2 have self closing devices installed on the doors.</p> <p>Interview, on 04/17/12 at 1:00 PM, with the Safety Director and the Maintenance Director revealed they were not aware of the Medical Records Rooms being categorized as hazardous storage areas and the requirement that the doors be equipped with self closing devices.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous</p>	K 029	<p>4) How will the facility monitor its performance to ensure that solutions are sustained? Monthly the Maintenance Director will audit doors requiring self-closures and document on a log. Results from this audit will be presented monthly to the Safety committee for six months. After this time the audit will be conducted quarterly and results taken to the Safety committee quarterly.</p> <p>Any areas of non-compliance will be addressed with re-education and or disciplinary action.</p>		

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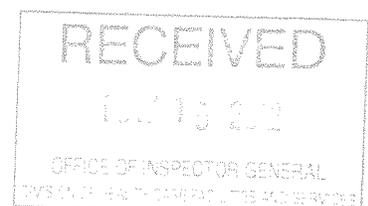
OFFICE OF ASPECTOR GENERAL

1100 MARKET STREET, SUITE 1200, PHOENIX, AZ 85004

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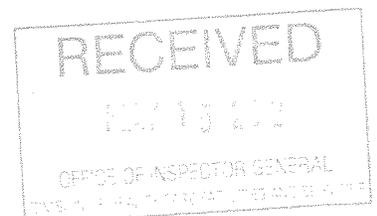
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K 029	Continued From page 3 by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFFA 101 LIFE SAFETY CODE STANDARD	K 029			
K 056 SS=D	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eleven (11) smoke compartments, residents, staff, and visitors. The facility is licensed for one-hundred and seventy-two (172) beds and the census was one-hundred and sixty-two (162) on the day of the	K 056	1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? An automatic sprinkler was installed on the roof overhang at the exit from the Kitchen on 05/14/2012 by Kentuckiana Sprinkler (vendor). 2) How will the facility identify other residents having the potential to be affected by the same deficient practice? An audit was conducted by Maintenance Director on 5/1/2012 of roof overhangs exceeding 4 ft. All other areas were found to be in compliance. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Education was provided to the Maintenance Director and the Safety Director by the Executive Director on 5/11/2012 on the need for automatic sprinklers on exterior roof overhangs or canopies.	5/22/12	



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K 056	Continued From page 4 survey. The findings include: Observation, on 04/17/12 at 1:18 PM, with the Safety Director and the Maintenance Director revealed the roof overhang, at the exit from the Kitchen, was not protected by automatic sprinkler coverage. The roof overhang was approximately five (5) feet by eight (8) feet in area and constructed with combustible materials. Interview, on 04/17/12 at 1:18 PM, with the Safety Director and the Maintenance Director revealed they were not aware the roof overhang was not protected by automatic sprinkler coverage. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056	<i>4) How will the facility monitor its performance to ensure that solutions are sustained?</i> Quarterly the Sprinkler system is inspected by an outside vendor. Results from this inspection will be presented quarterly to the Safety committee. Any areas of non-compliance will be addressed with re-education and or disciplinary action.	
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.	K 076	<i>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> The two oxygen storage cabinets located outside the Central Supply room were locked, identified with empty and full signage, and a precautionary gas storage sign posted on 5/10/2012 by the Executive Director.	5/22/12

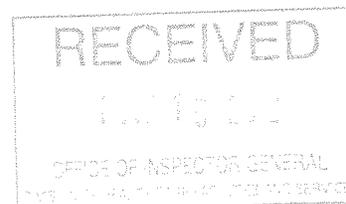


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K 076	<p>Continued From page 5</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored in accordance with NFPA standards. This deficiency had the potential to affect one (1) of eleven (11) smoke compartments, residents, staff, and visitors. The facility is licensed for one-hundred and seventy-two (172) beds and the census was one-hundred and sixty-two (162) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 04/17/12 at 11:55 AM, with the Maintenance Director revealed the two (2) oxygen storage cabinets located outside of the Central Supply Room, were not locked to prevent unauthorized entry, were not identified with empty and full signage, and did not have a precautionary gas storage sign posted.</p> <p>Interview, on 04/17/12 at 11:55 AM, with the Maintenance Director revealed he was not aware of the two (2) oxygen storage cabinets were not being locked, not identified with an empty and full signage, and a precautionary, oxygen storage</p>	K 076	<p>2) How will the facility identify other residents having the potential to be affected by the same deficient practice? The identified areas are the only oxygen storage areas for the facility.</p> <p>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Education was provided to the Maintenance Director, Safety Director, and the Central Supply clerk by the Executive Director on 5/11/2012 on the requirement for having a locked storage area that is appropriately labeled and identified for oxygen storage. Education will be provided to all Nursing staff (RNs, LPNs, CNAs) by the Director of Clinical Education on importance of keeping the storage doors locked and secured between 05/10/2012 & 5/15/2012.</p> <p>4) How will the facility monitor its performance to ensure that solutions are sustained? Non-clinical Rounds will be conducted weekly of the central supply area by the Safety Director (Maintenance Director as backup), to include the oxygen storage area. Issues identified will be corrected. Results from these rounds will be presented weekly for 4 weeks to the QAA committee for review, then monthly thereafter.</p>	

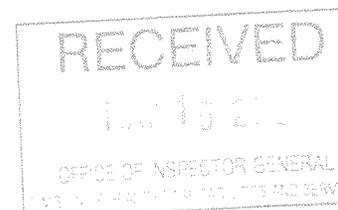
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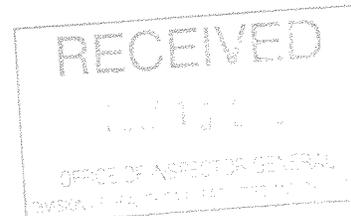
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K 076	Continued From page 6 sign, was not posted. Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (A) Storage locations shall be outdoors in an enclosure or within 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	K 076			



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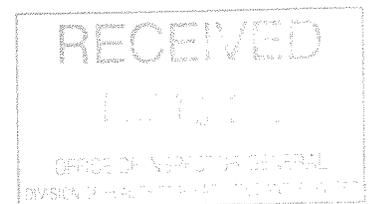
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K 076 K 130 SS=D	<p>Continued From page 7 WITHIN NO SMOKING NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of the six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for one-hundred and seventy-two (172) beds and the census was one-hundred and sixty-two (162) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 04/17/12 at 11:45 AM, with the Safety Director and the Maintenance Director revealed an unapproved lock (padlock type) installed on the exterior, exit door from the Central Supply Room, located in the Lower Level. Further observation, on 04/17/12 at 1:15 PM, revealed an unapproved lock (slide bolt type) installed on the exterior, exit door from the Kitchen, located in the Upper Level of the facility.</p> <p>Interviews, on 04/17/12 at 11:30 AM and 1:15 PM, with the Safety Director and the Maintenance Director revealed they were aware of the locks installed on the doors; however, they were not</p>	K 076 K 130	<p>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The unapproved locks were removed from the exit door of the kitchen on 4/18/2012 by the Maintenance Director and the exit door from central supply on 05/10/2012 by the Maintenance Director.</p> <p>2) How will the facility identify other residents having the potential to be affected by the same deficient practice? An audit was conducted of doors within a required means of egress on 04/26/2012 by the Maintenance Director and Executive Director. No other doors were identified during the audit.</p> <p>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Education was provided to the Maintenance Director, Safety Director, Central Supply clerk and the Dining Services Director by the Executive Director on 5/11/2012 on maintaining doors within a required means of egress and unapproved locks.</p> <p style="text-align: right;">5/22/12</p>



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K 147	<p>Continued From page 9</p> <p>Observations, on 04/17/12 between 11:50 AM and 1:40 PM, with the Safety Director and the Maintenance Director revealed:</p> <ol style="list-style-type: none"> In the Central Supply Room, items were being stored within the required, clear floor space around electrical panels and switchgear. In Resident Room 138, a refrigerator and medical equipment (concentrator) were plugged into a power strip. In Resident Room 109, a refrigerator and medical equipment (resident bed) were plugged into a power strip. <p>Interviews, on 04/17/12 between 11:50 AM and 1:40 PM, with the Safety Director and the Maintenance Director revealed they were not aware of the items being stored within the required clear floor space around electrical panels and switchgear. They were also not aware that power strips were being misused in the resident rooms.</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p>	K 147	<p>2) How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>An audit was conducted of power strips in resident rooms on 05/11/2012 by the management team. <i>During the audit, 3 additional resident rooms were identified to have power strips with medical equipment plugged in to them. All 3 identified were corrected immediately.</i> Issues identified were corrected during the audit. An audit was conducted of electrical panels to allow for access by Maintenance Director on 04/20/2012.</p> <p>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Education was provided on 5/15/2012 to staff by Director of Clinical Education using K147 Electrical, Tips for Compliance from the OIG Newsletter. The ED notified families by letter with this information.</p>	



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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GOLDEN LIVING CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 10 Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	4) How will the facility monitor its performance to ensure that solutions are sustained? Non-clinical Rounds will be conducted weekly by the Management staff and observe for power strip use. Issues identified will be corrected. Non-clinical Rounds will be conducted weekly of the central supply area by the Safety Director (Maintenance Director as backup), to include checking for access to electrical panels. Results from these rounds will be presented weekly for 4 weeks to the QAA committee for review, then monthly thereafter. Any areas of non-compliance will be addressed with re-education and or disciplinary action.	

