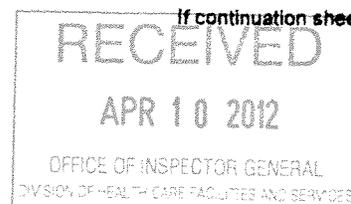


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CENTERS FOR MEDICARE & MEDICAID SERVICES

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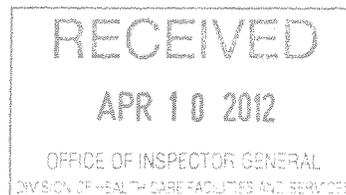
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206	
(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 224	Continued From page 1 Further review revealed on page 3 it states: the investigation shall be documented and there were to be documented interviews with employees, visitors, vendors, volunteers, and residents. The facility must also report alleged misappropriation of property to state licensure agencies and the police. Interview with Social Services, on 03/15/12 at 10:00 AM, revealed Resident #14 reported to her that he/she had \$50.00 missing as the resident passed her in the hallway on 12/16/11. Social Services questioned the resident about the money, then reported it to the facility Executive Director that day. Interview with the facility's Executive Director (ED), on 03/15/12 at 11:00 AM, revealed Resident #14 made an allegation that some of his/her money was missing. Further interview with the facility's Executive Director, on 03/15/12 at 3:05 PM, revealed the facility did not conduct a formal investigation of the allegation. The Executive Director stated the facility did not report the allegation because they could not validate if Resident #14 had \$50.00 in his/her possession. The Executive Director stated they did not follow their policy for reporting misappropriation.	F 224	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. Grievances from December 2011 through current will be audited to ensure thorough investigation and appropriate reporting to state agencies has been completed by interdisciplinary team by 4/13/12. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Director of clinical education, Director of Nursing and Executive Director will in-service staff on abuse, investigations and reporting process by 4/13/12. 4) How will the facility monitor its performance to ensure that solutions are sustained? Facility will monitor grievances Monday through Friday at morning stand-up meeting by Executive Director or Director of Nursing and by manager on duty Saturday and Sunday. Pattern and trends of grievance and reportables will be reviewed at monthly QAA committee for 3 months then quarterly thereafter.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		4/24/12



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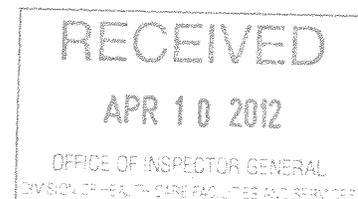
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 226	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of facility policy, it was determined the facility failed to report an allegation of misappropriation of property for one (1) of twenty-two (22) sampled residents (Resident #14). Resident #14 reported missing \$50.00 on 12/16/11. The findings include: Review of the facility's policy and procedure for abuse, revised 07/01/2010, revealed on page 1 an investigation shall be conducted by the Director of Nursing Services (DNS), Executive Director (ED), or the Charge Nurse (CN) for allegations of misappropriation of property. Further review revealed on page 3 it states: the investigation shall be documented and there were to be documented interviews with employees, visitors, vendors, volunteers, and residents. The facility must also report alleged misappropriation of property to state licensure agencies and the police. Interview with Social Services, on 03/15/12 at 10:00 AM, revealed Resident #14 reported to her that he/she had \$50.00 missing as the resident passed her in the hallway on 12/16/11. Social Services questioned the resident about the money, then reported it to the facility Executive Director that day. Interview with the facility's Executive Director (ED), on 03/15/12 at 11:00 AM, revealed Resident #14 made an allegation that some of	F 226	F 226 D 1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #14 grievance of missing \$50 was investigated. Missing \$50 for resident #14 has been reported. 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. Grievances from December 2011 through current will be audited to ensure thorough investigation and appropriate reporting to state agencies has been completed by interdisciplinary team by 4/13/12. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Director of Clinical Education, Director of Nursing and Executive Director will in-service staff on abuse, investigations and reporting process by 4/13/12.	4/20/12



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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206	
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F 241	Continued From page 4 the window curtain in Resident #3's room was left open during a head to toe skin assessment. The resident's room was on the first (1st) floor, exposing the resident to any passers-by to see into the room. Interview with the Licensed Practical Nurse (LPN) # 1, on 03/15/12 at 3:45 PM, revealed the window curtains should have been closed during the skin assessment. She stated leaving the window curtain open was a privacy issue and anyone could have walked by the resident's window.	F 241	4) How will the facility monitor its performance to ensure that solutions are sustained? Dignity Audits to review 10 resident care areas along with nursing practices using the Dignity Program Care Audit tool will be conducted by ADNS 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.	4/20/12
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F 279 D 1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Res #3 had care plans reviewed and revised by interdisciplinary team to integrate the facility care plans with the hospice care plans by 4/6/2012. 2) How will the facility identify other residents having the potential to be affected by the same deficient practice? Hospice resident care plans were reviewed and revised as necessary by the interdisciplinary team on 4/6/2012. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Interdisciplinary team have completed training led by the DNS on the integration of care plans to include coordination of care plans with hospice by 4/13/2012.	4/20/12



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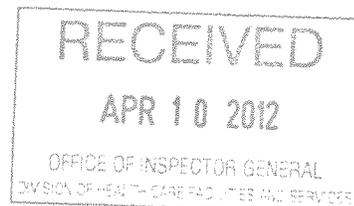
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206	
(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 279	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy, it was determined the facility failed to develop a comprehensive care plan for one (1) of twenty-two (22) sampled residents (Resident #3) integrating the facility care plan and the Hosparus care plan. The findings include: Review of the clinical record for Resident #3, on 03/15/12, revealed the facility admitted the resident 07/25/11 with diagnoses of Dementia, Hypertension, Diabetes, Congestive Heart Failure, Depression, Anxiety, and Lung Cancer. The resident was admitted to hospice care on December 2011. The Minimum Data Set (MDS) assessment, dated 12/18/11, revealed the resident was identified as receiving hospice care. The comprehensive care plan for Resident #3, dated 12/29/11, for hospice care contained interventions which included: coordinate care with hospice, notify hospice of any change in condition or medication changes, and medications as ordered, report to Hosparus if medications were ineffective. The facility's care plan for the resident did not mention the scope and services, or frequency of visits Hosparus would provide. Interview, on 03/15/12 at 4:15 PM, with the MDS Coordinator revealed the care plan for Resident #3 contained hospice care but did not coordinate care with hospice services. She stated the facility attempts to coordinate care with hospice but the care plan did not specify what specific services Hosparus would provide.	F 279	<i>cont</i> 4) How will the facility monitor its performance to ensure that solutions are sustained? Ten active resident care plans will be audited weekly by the ADNS to ensure integration of services. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.	4/20/12
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		



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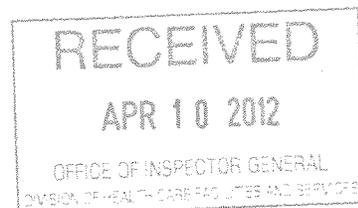
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206	
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F 280	Continued From page 6 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the clinical record, it was determined the facility failed to revise the care plan for one (1) of twenty-two (22) sampled residents. The care plan for Resident #4 included a therapeutic diet; however, the resident had a feeding tube and was not to take anything by mouth. The findings include: Review of the clinical record for Resident #4 revealed the facility admitted Resident #4 on 12/23/11 with diagnoses of Dementia, Diabetes.	F 280	F 280 D 1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #4 is no longer an active resident in the facility. LPN #2, #3, #4 and MDS Coordinator have been educated by the DNS on updating care plans to include diet changes of residents on tube feedings by 4/13/2012. 2) How will the facility identify other residents having the potential to be affected by the same deficient practice? Nutrition and tube feeding care plans were reviewed and revised as necessary by the IDT by 4/11/2012. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? IDT have completed training led by the DNS on the importance of updating nutrition and tube feeding care plans for residents to include any diet changes by 4/13/2012. 4) How will the facility monitor its performance to ensure that solutions are sustained? Ten active resident nutrition and tube feeding care plans will be audited weekly by the ADNS. Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.	4/20/12



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206		
(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 280	<p>Continued From page 7</p> <p>Hypertension, and Stroke. The Admission Minimum Data Set (MDS) assessment, completed on 12/30/11, revealed the resident was severely cognitively impaired with a Brief Interview Mental Status (BIMS) score of three (3). The facility developed a care plan for the resident for nutrition, dated 01/02/12, which included honor food preferences and monitor oral intakes. The physician notes revealed Resident #4 had a feeding tube ordered 01/18/12 which was placed on 01/20/12.</p> <p>Review of the March 2012 physician orders revealed Resident #4 was not to have anything by mouth. Nutrition, water, and medications were ordered administered by feeding tube.</p> <p>Observation, on 03/12/12 at 8:05 AM, during the initial tour revealed Resident #4 had a feeding tube. The resident's room did not have water or food available to the resident.</p> <p>Interview on, 03/15/12 at 2:15 PM, with Licensed Practical Nurse (LPN) # 3, revealed resident care plans were kept in a book at the nurse's station and were updated by the MDS Coordinator. The LPN stated nurses were supposed to check the care plan every shift for updates.</p> <p>Interview with LPN # 4, on 03/15/12 at 2:20 PM, revealed the resident's care plans were updated by the resident's nurse when a change occurs. The care plan team would review the updated care plan the next day and make any necessary changes to the care plan.</p> <p>Interview, on 03/15/12 at 2:40 PM, with LPN # 2</p>	F 280			



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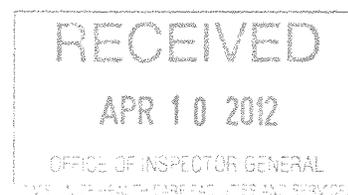
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206		
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F 280	Continued From page 8 revealed the unit nurses were to update the resident care plans and are checked daily by the MDS Coordinator. The LPN stated some nurses were trained by the facility how to update the care plan. Interview, on 03/15/12 at 4:15 PM, with the MDS Coordinator revealed she was unaware the resident was not to receive anything by mouth, and that Resident #4 used to eat in addition to the feeding tube. The MDS Coordinator stated the nurses write in the update onto the resident care plans in the care plan books at the nurse's station. The MDS Coordinator uses the written updated care plans to update the care plans stored on the computer when the binder gets full, annually, and when there is a significant change to the resident. Resident #4 had a care plan for a feeding tube; however, the therapeutic diet care plan was still active.	F 280			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policies, it was determined the facility	F 371	F 371 E <i>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> The identified pellet warmer and meat slicer were deep cleaned by the dining staff on 3/16/2012. Meat slicer is covered with a plastic bag. The tray delivery cart stored in dish washing room was removed upon finding. Staff members not using a paper towel to turn off water faucet were corrected by RD consultant at the time of incident.	4/20/12	



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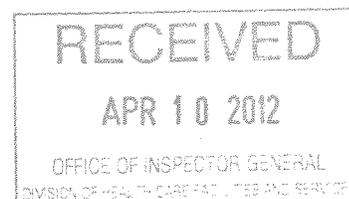
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206		
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F 371	<p>Continued From page 9</p> <p>failed to ensure food was stored, prepared and served under sanitary conditions. Nursing and dietary staff were noted to wash their hands incorrectly in the dining room and in the kitchen. A tray delivery cart with opened doors was noted to be filled with clean trays, silverware and napkins and stored in the dish washing room touching a cart of soiled dishes. The meat slicer and the plate warmer were noted to be soiled on three (3) of three (3) visits to the kitchen. These practices affected all residents receiving oral nutrition.</p> <p>The findings include:</p> <p>No policy on cleaning was provided by the facility.</p> <p>Review of the facility policy on Handwashing, undated, revealed the water faucet should be turned off using a paper towel after drying your hands.</p> <p>Observation of the kitchen, on 03/13/12 at 8:10 AM, revealed an open tray cart parked in the dishwashing room. Inside the cart were clean trays, napkins and silverware. The cart extended into the soiled part of the room and was touching a metal cart piled with food soiled dishes. The plate warmer was noted to have brown and black particles around the outside and on the solid metal shelf, inside the warmer, holding the dishes.</p> <p>Interview with the Dining Service Director, on</p>	F 371	<p><i>2) How will the facility identify other residents having the potential to be affected by the same deficient practice?</i></p> <p>All residents have the potential to be affected</p> <p><i>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i></p> <p>Daily cleaning of the pellet warmer will continue and the weekly deep cleaning was changed to two times per week on cleaning schedule and the pellet warmer added to sanitation audit. Kitchen staff in-service completed by DSM and RD by 4/13/12 for the topic of how to deep clean pellet warmer and cleaning of slicer and covering with plastic bag when not in use.</p> <p>Kitchen staff completed a competency check off regarding hand hygiene & proper hand washing techniques by 3/25/12.</p> <p>Pellet warmer, meat slicer, tray delivery cart and hand washing competency have been added to the sanitation audit.</p>	4/24/12	



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F 371	<p>Continued From page 10</p> <p>03/13/12 at 8:15 AM, revealed the tray cart was stored in the dish room as it was not being used for breakfast and so it was moved to provide more space. She stated the dietary practice was to wipe down the plate warmer daily and clean it weekly. She stated the warmer did have debris outside and inside. She stated soiled surface could cause illness.</p> <p>Observation of the lunch meal, on 03/13/12 at 12:20 PM, revealed Registered Nurse (RN) #1 and Certified Nurse Aide (CNA) #5 washed their hands then turned the water faucets off with their bare hands.</p> <p>Observation of the lunch meal, on 03/13/12 at 12:30 PM, revealed Licensed Practical Nurse (LPN) #3 washed her hands, took a paper towel and turned off the water faucets then used the same paper towels to dry her hands.</p> <p>Interviews with RN #1, CNA #5 and LPN #3, on 03/13/12 at 12:55 PM, revealed they did not realize they used incorrect technique for hand hygiene and the spread of germs was possible.</p> <p>Observation of the tray line, on 03/14/12 at 11:50 AM, revealed Dietary Aides (DA) #1 and #2 washing their hands. DAs #1 and #2 were observed to turn the water faucet off with bare hands.</p> <p>Interview with DA #1, on 03/14/12 at 12:05 PM,</p>	F 371	<p><i>Cont.</i></p> <p>4) How will the facility monitor its performance to ensure that solutions are sustained?</p> <p>Sanitation checklist audit will be conducted twice a week, once by the DSM and once by the RD x 4 weeks, then by the RD once a week x 4 weeks, then monthly. Finding from this audit will be presented to the QAA committee monthly x 3 months, then quarterly thereafter.</p>	4/20/12



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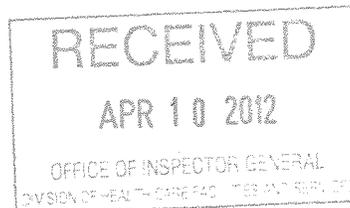
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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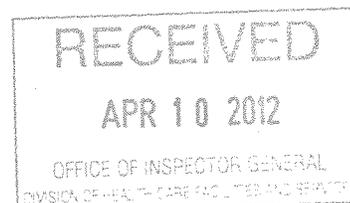
F 371	Continued From page 11 revealed she was not aware she should turn the water faucet off using a paper towel. She stated unclean hands could cause infection. Interview with DA #2, on 03/14/12 at 12:10 PM, revealed he knew the water faucets should be turned off using a paper towel but he forgot. He stated unclean hands could cause infection. Interview with the Dining Service Supervisor, on 03/15/12 at 2:50 PM, revealed handwashing policy stated the water faucet was to be turned off using a paper towel after drying your hands to prevent the spread of bacteria.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	F 431 E <i>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> LPN #4, #6, #7, #8, RN #2, #3 were educated by the DNS on the facility procedure for calibrating glucometer machines, dating the glucose testing solution when opened, and checking for expiration dates on Gluco-Chlor wipes by 4/13/2012.	4/20/12



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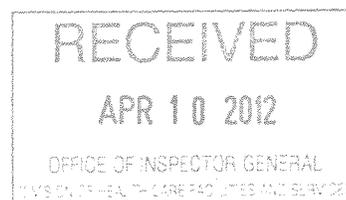
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED 03/15/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 448 MT. HOLLY AVE LOUISVILLE, KY 40206	
(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 431	<p>Continued From page 12</p> <p>controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and the User's Guide for blood glucose testing meters, it was determined the facility failed to calibrate with a control solution test for six (6) of six (6) blood glucose testing meters. The facility failed to sanitize testing meters appropriately and was using a sanitizing system which expired in April 2011. Additionally, four (4) of six (6) testing meter control solutions were opened and not dated.</p> <p>The findings include:</p> <p>1. Review of the blood glucose testing meter User's Guide revealed instructions how to complete a control solution test. The guide recommended a control solution test be completed to make sure the monitor was working properly.</p> <p>The facility did not provide a policy on calibrating</p>	F 431	<p><i>cont.</i></p> <p>2) How will the facility identify other residents having the potential to be affected by the same deficient practice? Glucometer supplies including test solution, test strips, and wipes were audited to ensure nothing had expired and machines were calibrated by unit managers by 4/6/2012.</p> <p>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Nurses have been trained on daily glucometer machine calibration, dating of glucose testing solution when opened and on checking for expiration dates on Gluco-Chlor wipes by 4/13/2012.</p> <p>4) How will the facility monitor its performance to ensure that solutions are sustained? Glucometer testing log will be brought by unit managers to morning meeting Mon-Fri and reviewed by DNS or ADNS to verify that calibrations have occurred. Glucose testing solution will be monitored by ADNS weekly for dates opened and the Gluco-Chlor wipes will be monitored weekly by the ADNS for expiration dates. The Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.</p>	4/20/12



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F 431	<p>Continued From page 13 blood glucose testing meters.</p> <p>Observation, on 03/14/12 at 3:50 PM and on 03/15/12 at 1:35 PM, the facility had six (6) medication carts. Each cart contained one (1) blood glucose testing meter, for a total of six (6) meters in the facility.</p> <p>Interview, on 03/14/12 at 3:50 PM, with Licensed Practical Nurse (LPN) #8 revealed she did not know how to calibrate the blood glucose testing meter and calibration is completed by third (3rd) shift nurses.</p> <p>Interview, on 03/14/12 at 4:10 PM, with LPN #9 revealed she did not know how to calibrate the testing meter and 3rd shift nurses were responsible to calibrate them. She stated each medication cart has its own blood glucose testing meter for a total of six (6) meters in the facility.</p> <p>Interview with Registered Nurse (RN) #2, on 03/14/12 at 4:40 PM revealed 3rd shift nurses were responsible for completing the calibration for the testing meters. The RN also stated the blood glucose testing meters would allow continued testing of resident blood sugars without calibrating the machine.</p> <p>Interview with LPN #6, on 03/15/12 at 7:40 AM, revealed 3rd shift nurses were responsible for calibrating the blood glucose testing meters and the meters would allow continued use if the machines were not calibrated. The LPN stated the meters were to be calibrated each night by the House Supervisor or the nurse responsible for the medication cart. The nurse stated the unit manager was responsible to ensure the 3rd shift</p>	F 431			



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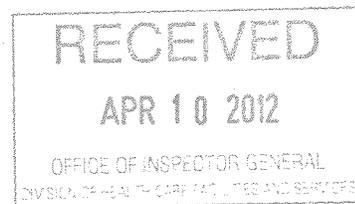
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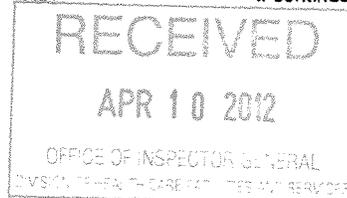
F 431	<p>Continued From page 14</p> <p>nursing duties were completed. The LPN also stated if the meters were not calibrated then blood glucose testing results may not be accurate, which could result in a resident becoming ill. She reported the facility did not provide training how to calibrate the machines.</p> <p>Interview, on 03/15/12 at 8:05 AM, with LPN #7 revealed the blood glucose testing meters were to be calibrated every night, and if the machines were not calibrated the resident blood glucose testing may not be accurate which could lead the resident to a high or low blood sugar. She stated she was not trained by the facility how to calibrate the meters.</p> <p>Interview with RN #3, on 03/15/12 at 1:45 PM, revealed the night shift nurses calibrate the meters daily.</p> <p>Review of the facility Blood Glucose System Daily Quality Control Record revealed one log for each of the six (6) blood glucose testing meters. The South log revealed calibration of the meter on two (2) of twenty-nine (29) days for February 2012 and three (3) of fourteen (14) days for March 2012. The East log revealed the meter was calibrated three (3) of fourteen (14) days in March 2012. The North and West logs revealed each meter was calibrated one (1) of fourteen (14) days for March 2012 and both Annex logs revealed both meters were calibrated twelve (12) of fourteen (14) days in March. The facility did not provide logs for the South meter prior to 02/12, nor for the North, West, East, nor either Annex logs prior to 03/12.</p> <p>2. The facility did not provide a policy on</p>	F 431		
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F 431	<p>Continued From page 15 sanitizing the blood glucose testing meters.</p> <p>Observation, on 03/15/12 at 10:05 AM, revealed the East medication cart had six (6) of six (6) Gluco-Chlor sanitizing wipe,s for the blood glucose testing meters, that had expired April 2011. The wipes were individually packaged, each with an imprinted expiration date of 04/11.</p> <p>Observation, on 03/15/12 at 10:10 AM, revealed Central Supply storage contained two (2) boxes of wipes, one (1) unopened box of one hundred (100) Gluco-Chlor sanitizing wipes and one (1) opened box. Both boxes had a stamped expiration date of 04/11.</p> <p>Observation of the South medication cart, on 03/15/12 at 10:15 AM, revealed eight (8) of eight (8) Gluco-Chlor wipes that expired 04/11.</p> <p>Observation, on 03/15/12 at 10:20 AM, revealed the Main Station supply closet contained one (1) box of wipes. The one (1) box of the sanitizing wipes was opened and had a stamped expiration date of 04/11.</p> <p>Observation, on 03/15/12 at 10:25 AM, revealed the West medication cart had eleven (11) of eleven (11) expired Gluco-Chlor wipes, expiration dated 04/11.</p> <p>Interview, on 03/15/12 at 10:15 AM, with Licensed Practical Nurse (LPN) #4 revealed the blood glucose testing meters should be cleaned after every use. The Gluco-Chlor sanitizing wipes are located in the medication cart, the supply closet, and Central Supply. The LPN stated the sanitizing wipes may not work if expired and the</p>	F 431		



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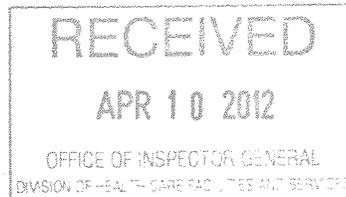
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F 431	<p>Continued From page 15 sanitizing the blood glucose testing meters.</p> <p>Observation, on 03/15/12 at 10:05 AM, revealed the East medication cart had six (6) of six (6) Gluco-Chlor sanitizing wipe,s for the blood glucose testing meters, that had expired April 2011. The wipes were individually packaged, each with an imprinted expiration date of 04/11.</p> <p>Observation, on 03/15/12 at 10:10 AM, revealed Central Supply storage contained two (2) boxes of wipes, one (1) unopened box of one hundred (100) Gluco-Chlor sanitizing wipes and one (1) opened box. Both boxes had a stamped expiration date of 04/11.</p> <p>Observation of the South medication cart, on 03/15/12 at 10:15 AM, revealed eight (8) of eight (8) Gluco-Chlor wipes that expired 04/11.</p> <p>Observation, on 03/15/12 at 10:20 AM, revealed the Main Station supply closet contained one (1) box of wipes. The one (1) box of the sanitizing wipes was opened and had a stamped expiration date of 04/11.</p> <p>Observation, on 03/15/12 at 10:25 AM, revealed the West medication cart had eleven (11) of eleven (11) expired Gluco-Chlor wipes, expiration dated 04/11.</p> <p>Interview, on 03/15/12 at 10:15 AM, with Licensed Practical Nurse (LPN) #4 revealed the blood glucose testing meters should be cleaned after every use. The Gluco-Chlor sanitizing wipes are located in the medication cart, the supply closet, and Central Supply. The LPN stated the sanitizing wipes may not work if expired and the</p>	F 431		
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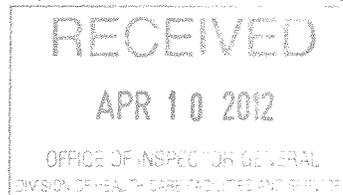
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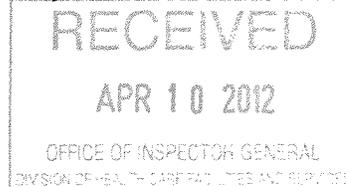
F 431	<p>Continued From page 16 wipes should be disposed of.</p> <p>Interview with the Purchasing Manager, on 03/15/12 at 10:35 AM, revealed he conducted an inventory of supplies in Central Supply every Friday to determine what items need to be ordered. The Purchasing Manager stated he rotates stock and checks expiration dates on supplies; however he had not been taking inventory of the Gluco-Chlor sanitizing wipes as they were not listed on the inventory sheet he created. He stated if facility employees used expired sanitizing wipes then the blood glucose testing meters would not be cleaned.</p> <p>The facility did not provide an invoice for the last order of the Gluco-Chlor sanitizing wipes.</p> <p>3. Review of the blood glucose testing meter User's Guide revealed when a control solution bottle is opened for the first time, the date opened plus ninety (90) days should be written on the bottle.</p> <p>Observation, on 03/15/12 at 10:25 AM, of the Main nurse's station revealed two (2) of four (4) blood glucose testing meter control solution bottles were opened and were not dated when opened.</p> <p>Observation on the Annex nurse's station, on 03/15/12 at 1:45 PM, revealed two (2) of two (2) control solution bottles were not dated when opened.</p> <p>Interview, on 03/15/12 at 10:25 AM, with LPN #4 revealed she was unaware when the control</p>	F 431		
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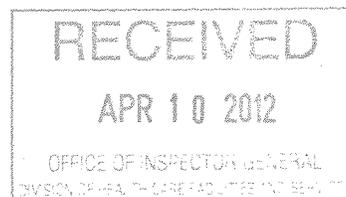
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F 431	Continued From page 17 solutions were opened without the open date labeled on the bottle. The LPN stated she was unaware how long the solutions were to be used after opening and was unable to determine if the control solutions were expired since opened. She stated using expired control solutions for calibration of the blood glucose testing meter could result in inaccurate readings. Interview with RN #3, on 03/15/12 at 1:45 PM, revealed she did not know how long the opened control solutions had been in use or how long after opening the solutions would be expired.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	F 441 E <i>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> LPN #1, RN #6 and Unit Manager were educated led by the DNS on the facility procedure for infection control related to proper hand washing, proper disposal of soiled briefs and linens, proper bagging of O2 tubing, mini-nebulizer tubing and trach tubing. Also included was the importance of keeping tubing off of floor by 4/13/2012. Resident #3, #5, #11, #16 rooms were audited by the DNS for proper placement of O2 tubing, mini-nebulizer tubing, & trach tubing off of the floor, bagged and labeled by 4/6/2012.	4/20/12	



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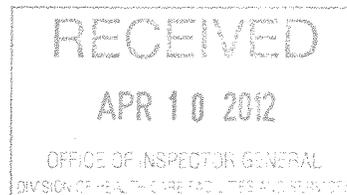
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F 441	<p>Continued From page 18</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy, it was determined the facility failed to maintain infection control practices to prevent the spread of illness and infection as evidenced by staff failure to handle soiled linen and trash in a manner to prevent cross contamination. The facility failed to ensure nurses completed skin assessments on residents with correct hand hygiene and correct use of gloves. The facility failed to follow infection control practices as evidenced by the placement of soiled briefs and linens on carpeted floors. In addition, the facility failed to ensure the use of clean resident equipment as evidenced by oxygen tubing, indwelling catheter tubing and tracheotomy oxygen mask being in direct contact with the floor and a mininebulizer mouthpiece stored uncovered in a drawer.</p>	F 441	<p><i>Cont.</i></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.</p> <p>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Licensed nursing staff and CNA's will be in-serviced led by the DNS on infection control and proper hand washing, proper glove technique, proper disposal of soiled linen, briefs and trash, bagging O2 tubing, trach mask, mini-nebulizer tubing and labeling them and the importance of keeping tubing off of floor and properly put away by 4/13/2012. Facility sweep for identifying any infection control issues was completed by April 6, 2012. Any issues were corrected immediately.</p> <p>4) How will the facility monitor its performance to ensure that solutions are sustained? Infection control audit that includes 14 care areas(i.e. Nursing services, Foley Catheters, Tube Feeding, Tracheostomy, Ostomy/Wound Care, IV Therapy, Needle Handling, Dietary Services, Laundry and Housekeeping Services, Maintenance Services, Employee Health, Infection Control Monitoring for Facility trends and PPE) for monitoring infection control practices including but not limited to hand washing, proper glove use, handling of soiled</p>	4/20/12	



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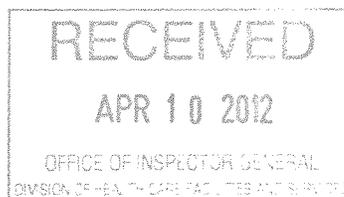
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F 441	<p>Continued From page 19 The findings included:</p> <p>Review of the facility policy, Infection Control Guidelines (undated) revealed the guidelines may include, but are not limited to: Maintain sterility or cleanliness of . . . equipment. Review of the facility policy, Respiratory Therapy - Prevention of Infection (undated) revealed: Keep the oxygen cannulae and tubing used. . . in a plastic bag when not in use. 7. Store the circuit (mini-nebulizer) in a plastic bag, marked with date and resident's name, between uses.</p> <p>Observation of Resident #16's room, on 03/13/12 at 10:30 AM, revealed the resident's mini-nebulizer tubing with the mouthpiece lying in the bedside table drawer uncovered. Observation of Resident #5's room, on 03/13/12 at 11:30 AM, revealed the resident's tracheotomy oxygen mask and tubing lying on the floor.</p> <p>Review of the records for Resident #16 and Resident #5, on 03/14/12 at 10:00 AM, did not reveal any documentation of nursing education regarding the importance of keeping their medical equipment stored properly. Review of those records also revealed the facility assessed Resident #16 and Resident #5 each as having had a cognitive score of fifteen (15) which indicated no cognitive deficit.</p> <p>Interview with LPN #1 on 03/13/12 at 1:00 PM revealed Resident #16 was responsible for placing the mini-nebulizer tubing and mouthpiece in the bedside drawer uncovered and Resident #5</p>	F 441	<p><i>Correct</i></p> <p>linens, briefs, trash, bagging of tubing and keeping tubing off of floor will be conducted weekly by the ADNS for 4 weeks, then monthly thereafter. Any issues found will be immediately corrected. The Findings will be reported monthly to the facility QAA committee for review for 3 months and then quarterly thereafter.</p>	4/20/12



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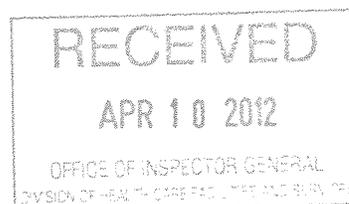
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 20</p> <p>was responsible for throwing his/her tracheotomy oxygen mask and tubing on the floor. LPN #1 stated it was nursing staff's responsibility to ensure the cleanliness or sterility of resident medical equipment. She stated she knew the mini-nebulizer tubing and mouthpiece and the tracheotomy oxygen mask and tubing would be considered dirty and should be replaced. She also stated the residents should have nursing education regarding the importance of keeping the mini-nebulizer tubing and mouthpiece and the oxygen mask and tubing in the clean bag which was provided for that purpose. She further stated she was unaware of any documentation of nursing education for Resident #16 and Resident #5's items.</p> <p>Interview with the RN Unit Manager, on 03/13/12 at 2:00 PM, revealed tracheotomy oxygen masks and tubings and mini-nebulizer tubings and mouthpieces were to be stored in a plastic bag provided for that purpose. She stated she knew it was the facility policy to keep resident medical equipment clean and that it was nursing's responsibility to do so. She also stated Resident #16 and Resident #5 should have had nursing education regarding the importance of keeping their medical equipment stored properly and that the education should be documented.</p> <p>Observation, on 03/14/12 at 9:30 AM, of a skin assessment for Resident #3 revealed the resident's oxygen tubing was touching the floor. The resident was lying in bed with oxygen, by nasal cannula, in place. The oxygen concentrator was to the left side of the bed against the back</p>	F 441			



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 21 wall. Interview with Licensed Practical Nurse (LPN) #1, on 03/15/12 at 3:45 PM, revealed the resident's oxygen tubing should have been contained in a bag and not touching the floor. She stated she did not know the tubing was on the floor and if the tubing touched the floor there was a potential for germs and cross-contamination. The LPN stated she should have changed her gloves after touching Resident #3's buttocks and perineal area due to the potential to spread infection. The nurse stated she had been trained by the facility on infection control procedures. Record review of the facility policy titled Infection Control Policy and Procedure Manual, revised October 2011, revealed handwashing and may include the use of alcohol gel based products, should be done thoroughly and immediately after contact with blood/body fluids, before and after each patient/resident contact, and before and after removing gloves. The Infection Control Guidelines may include, but are not limited to maintain sterility or cleanliness of the equipment and working field as necessary, dispose of disposable equipment appropriately, and dispose of soiled linen appropriately. Review of the Resident # 11's clinical record revealed the facility admitted the resident on 02/25/12 for rehabilitation services after surgery for a fractured hip. The facility completed an admission Minimum Data Set (MDS) assessment, dated 03/02/12, and revealed	F 441		



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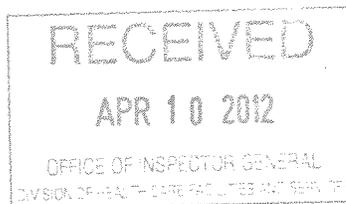
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 448 MT. HOLLY AVE LOUISVILLE, KY 40206
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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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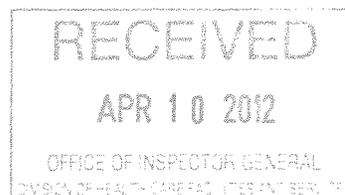
F 441	<p>Continued From page 22</p> <p>Resident #11 had a cognition score of 12, and required the extensive assist of one (1) person for transfers, toilet use, and personal hygiene. The resident wore adult briefs for incontinence of the bowel and bladder.</p> <p>Observation, on 03/14/12 at 3:15 PM, revealed Registered Nurse (RN) #6, during Resident #11's skin assessment, washed her hands at the resident's sink in the room and turned the water facet off with her bare hands, dried her hands, and then put on gloves. The resident had a feces and urine soiled brief in place during the skin assessment. The RN removed the soiled brief from the resident, and directly placed the soiled brief onto the residents' carpeted floor, she continued to use a packaged wet wipe to clean the resident's skin then placed the soiled wet wipe on top of the soiled brief laying on the carpeted floor. The RN removed her gloves and put new gloves on without washing her hands. The RN placed a new brief on the resident and prior to securing the adult brief, RN #6 reached into the residents bedside table with the same gloved hand and removed the baby powder from the drawer. The RN also was observed removing a soiled top sheet from Resident #11's bed and placing directly placed the soiled sheet onto the residents' carpeted floor.</p> <p>Interview with RN #6, on 03/14/12 at 3:45 PM, revealed she did turn off the water faucet with her bare hands at the resident's sink but should have used the paper towel to turn the water facet off. The nurse acknowledged placing the resident's soiled brief onto the carpeted floor along with the</p>	F 441		
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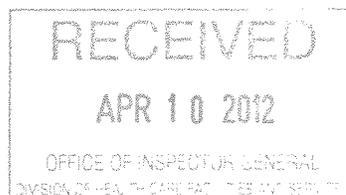
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 23 soiled top sheet from the resident's bed. She also stated she did not wash her hands or use hand sanitizer in between changing her gloves during the skin assessment and soiled brief change. The nurse further revealed she had received education on hand hygiene from nursing school as well as the facility orientation skills check off when she was hired which included infection control. RN #6 stated the facility policy was to wash hands before and after resident contact and to place soiled briefs and sheets into trash bags, not on the floor. The nurse revealed poor hand hygiene could have spread infection to other facility staff and residents. Observation of a skin assessment, on 03/14/12 at 9:30 AM, for Resident #3 revealed the nurse did not change her gloves or wash her hands after assessing the resident's skin, moving from the buttocks and perineal area to the resident's breasts. Interview, on 03/15/12 at 3:45 PM, with Licensed Practical Nurse (LPN) #1 revealed she should have assessed the resident's perineal area last or should have changed her gloves after touching Resident #3's buttocks and perineal area and before assessing the resident's breasts. The LPN stated there was a risk of spreading infection if she did not change her gloves or wash her hands when assessing the resident buttocks and perineal area then the resident's breasts.	F 441			
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465			



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FORM APPROVE
OMB NO. 0938-034

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206		
(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	<p>Continued From page 24 residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide a safe, sanitary and comfortable environment for residents and staff.</p> <p>The findings include:</p> <p>The facility did not provide any maintenance department policies. Review of a housekeeping procedure titled Daily Cleaning (undated) did not reveal the housekeeping staff should look up for any dust on ceiling fans or elsewhere.</p> <p>Observation of the facility on 03/13/12 from 8:15 AM to 5:00 PM, on 03/14/12 from 8:15 AM to 5:00 PM, and on 03/15/12 from 8:15 AM to 10:30 AM revealed the following concerns:</p> <ul style="list-style-type: none"> * A ceiling fan at the East/West nursing station with approximately one-half (1/2) inch of white/gray dust-like particles covering the blades and housing, * Room 311 - the call light wall housing hanging out of the wall, * A window open with the window screen up approximately five (5) inches in the three hundred (300) resident lounge, * A piece (approximately twenty [20] inches long) of window frame missing from a door in the three hundred (300) resident lounge, * Room 102 - the wheelchair arms frayed and 	F 465	<p>F 465 D</p> <p>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The ceiling fan in East/West nursing station was cleaned. Room 311, call light was reattached to wall. The window and screen in the 300 lounge was closed. The window frame on the exit door in the 300 lounge was repaired. The following wheelchairs/equipment were repaired and cleaned or replaced in the noted rooms: 102, 110, 122, 126-1, 213, 305. Unsecured oxygen tank in room 317 was removed. Room 111-1 personal fan was cleaned and replaced, baseboard behind bed was repaired and cleaned. Cardboard boxes removed from use in rooms 219 and 221 on 3/15/12. Rooms 105-2, 109-2, 112-2, 116, 117-2, 126-1, 221-1, all medical equipment removed from power strip or multi plug outlets. All items listed above were corrected by April 6, 2012.</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.</p>	4/20/12	



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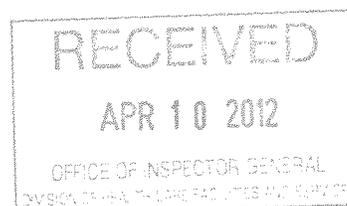
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OMB NO. 0938-035

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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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 465	<p>Continued From page 25</p> <p>torn, Room 110 - the wheelchair arms torn and frayed, Room 122 - a torn wheelchair back held in place with duct tape, Room 126 bed 1 - wheelchair with cracked and torn wheelchair arms, Room 213 - a geri-chair with a frayed seat and back cushion and Room 305 - a wheelchair with torn arm covering and a strong urine odor,</p> <ul style="list-style-type: none"> * Room 317 - an unsecured oxygen tank, * Room 111 bed 1 - approximately five (5) feet of baseboard unattached from the wall exposing an expanse of wallboard covered with black and rust colored material, * Room 111 - a resident fan on the bedside table with all exposed fan facets covered with a layer of white/gray dust-like particles * Room 219 and Room 221 with multiple cardboard boxes sitting directly on the floor, and * Seven (7) rooms: 105 bed 2, 109 bed 2, 112 bed 2, 116, 117 bed 2, 126 bed 1, and 221 bed 1 with multiple pieces of medical equipment plugged into multi-plug electrical outlet strips to include three (3) oxygen concentrators, two (2) breathing treatment nebulizers, a suction machine, and a tube feeding pump. <p>Interview with a RN Unit Manager on 03/13/12 at 1:00 PM revealed she was unaware medical equipment should not be plugged into a multi-plug adaptor and she did not know it was unsafe to do so. Interview with LPN # 1 on 03/13/12 at 1:20 PM revealed she was unaware medical equipment should not be plugged into a multi-plug adaptor and she did not know it was unsafe to do so. LPN #1 also stated she knew it was a responsibility of nursing staff to send a</p>	F 465	<p><i>cont.</i></p> <p>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Staff including the interdisciplinary team completed training, led by the Clinical Educator and ADNS, covering recognizing and reporting housekeeping and cleaning needs, maintenance needs including wheelchair repairs, wall repairs, storage of cardboard boxes in resident rooms, unsecured oxygen tanks and any misuse of power strips by 4/13/2012.</p> <p>4) How will the facility monitor its performance to ensure that solutions are sustained? Non clinical rounds, which will monitor housekeeping and maintenance needs included but not limited to oxygen tank storage, power strip use, cleaning of resident equipment including fans, wheelchair repairs, wall repairs and storage of boxes in resident rooms will be conducted by the interdisciplinary team and reviewed by the ED weekly. Any problems found will be corrected. Findings will be reported monthly to the facility QAA committee for review monthly for 3 months and then quarterly thereafter.</p>	4/20/12
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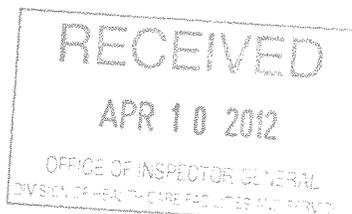
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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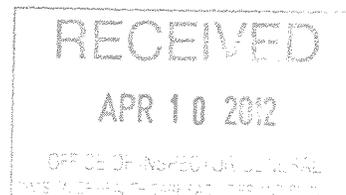
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F 465	<p>Continued From page 26</p> <p>work order to maintenance to repair wheelchairs when needed and she knew cardboard boxes were not to be on the floor of residents' rooms. She stated she did not know why six (6) wheelchairs were observed to be in disrepair and she did not know why cardboard boxes were found to be on the floor of resident rooms 219 and 221. LPN #1 revealed she knew an oxygen tank should be in a holder when in a resident's room and she did not know why there was an unsecured oxygen tank in room 317.</p> <p>Interview with the Housekeeping Director on 03/15/12 at 10:10 AM revealed he had been in his position for one (1) month. He stated he had an orientation of ninety (90) days by the corporation prior to being at the facility. The Housekeeping Director stated he received work orders from the Maintenance Director for any housekeeping issues but he had not received a work order for the dust on the East/West nursing station ceiling fan and the resident's personal fan.</p> <p>Interview with the Maintenance Director on 03/15/12 at 10:40 AM revealed he is the only maintenance person for the building and he could not keep up with all the work required. The Maintenance Director stated he could not remember any work order for the housekeeping department which had not been passed on to the Housekeeping Director. He further stated he relied on the nursing staff to send work orders to repair the wheelchairs and for any other maintenance concerns in resident rooms or the building. The Maintenance Director stated he was aware of the dangers of having an unsecured oxygen tank in a residents' room but he was not aware an unsecured oxygen tank was</p>	F 465		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 448 MT. HOLLY AVE LOUISVILLE, KY 40206		
(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 27 in a resident's room. Interview with the Administrator, on 03/15/12 at 10:50 AM, revealed she was unaware of the observed problems with the environment of the facility in regards a safe, sanitary and comfortable environment for residents and staff. Record review of the past one (1) month's work orders revealed a request to remove dust from a ceiling fan in the kitchen dated 03/09/12 and a work order for a call light which was disconnected from the wall in resident room 311 dated 03/12/12.	F 465			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 04/26/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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{K 000}	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1964 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type V (111) SMOKE COMPARTMENTS: Seven (7) smoke compartments FIRE ALARM: Complete fire alarm system with smoke detectors SPRINKLER SYSTEM: Complete automatic dry sprinkler system. GENERATOR: Type II generator. Fuel source is natural gas. A standard Life Safety Code survey was conducted on 03/13/12. Golden Living Center-Mt Holly was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred three (103) beds with a census of ninety six (96) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	{K 000}	<u>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.</u> K 130 D 1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Tops of all three dryers in laundry were cleaned and lint removed on 4/26/12. 2) How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	
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LABORATORY/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X [Signature]</i>	TITLE X Executive Director X	(X6) DATE 5/5/2012
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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{K 000} Continued From page 1

Deficiencies were cited with the highest deficiency identified at "F" level.

A standard Life Safety Code follow-up survey was conducted on 04/26/12. Golden Living Center-Mt Holly was found not to be in compliance with the requirements for participation in Medicare and Medicaid.

{K 130} NFPA 101 MISCELLANEOUS
SS=D
OTHER LSC DEFICIENCY NOT ON 2786

This STANDARD is not met as evidenced by:
Based on observation and interview, during the follow-up survey conducted on 04/26/12, it was determined the facility failed to ensure the deficiency cited on 03/13/12 during the standard survey, was corrected as outlined in the facility's plan of correction. The facility's alleged compliance date was 04/20/12.

The findings include:

Observation, on 04/26/12 at 1:20 PM, with the Maintenance Director revealed a heavy build up of lint in the top of the dryer, in the Laundry Room.

Interview, on 04/26/12 at 1:20 PM, with the Maintenance Director revealed he was not aware the lint build up was so excessive.

{K 000}

Education was provided to the Housekeeping Supervisor (HS) and Laundry Staff on 4/27/12 to check for lint in top back of dryers each shift (laundry scheduled 2 shifts per day 7 days per week) and to notify Maintenance, whose back up is the housekeeping supervisor immediately for cleaning. This education was completed in writing and in return demonstration of the affected areas. Maintenance will immediately clean and remove the lint upon notification, back up is HS and document on a log. The routine weekly cleaning by the MD (back up HS) will also be documented on the log. The ED or the Safety Director will re-inspect the tops of dryers weekly and review the log. Systemic changes put into place was to have laundry staff check this open back area of the dryer by the pilot light for lint during each of the two shifts that run seven days a week and to notify the MD or his backup, Housekeeping Supervisor (HS), so this dryer area can be cleaned. During QA meeting on April 27, 2012 it was determined that having laundry staff's involvement in the monitoring of any lint build up and notification of the MD would allow the center to maintain compliance.

4) How will the facility monitor its performance to ensure that solutions are sustained?

The logs will be reviewed weekly by the QA Committee x 4 weeks and adjustments made to the routine weekly cleaning schedule based on frequency of cleaning needed.

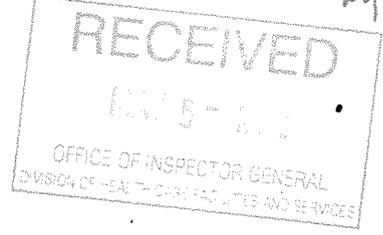
Environmental audit will be completed monthly by Safety Director to include checking lint traps and tops of dryers for cleanliness. Center will have weekly QA meetings effective April 27 2012 to monitor this process, until compliance is achieved. During weekly QA all concerns noted during MD weekly cleanings, laundry staff notification of MD and or ED's weekly monitoring will be addressed and additional steps added to this process. Any staff member found to not be following process will be re-educated and or receive disciplinary process by ED.

K130
(cont)

4/27/12
4-28-12

Per Nicole Brown

by PB 5-7-12



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

PRINTED: 04/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 04/26/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206	
(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 130}	Continued From page 2	{K 130}	K 147 E 1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	
{K 147} SS=E	Reference: NFPA 101 (2000 Edition) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, during the follow-up survey conducted on 04/26/12, it was determined the facility failed to ensure the deficiency cited on 03/13/12 during the standard survey, was corrected as outlined in the facility's plan of correction. The facility's alleged compliance date was 04/20/12. The findings include: Observations, on 04/26/12 between 12:30 PM and 2:00 PM, with the Maintenance Director revealed: 1) A refrigerator and microwave were plugged into a power strip located in the MDS Office. 2) An air conditioning unit was plugged into a power strip that was plugged into an extension cord also located in the MDS Office. 3) An IV machine and a mini nebulizer were plugged into a power strip located in room #117. 4) A microwave was plugged into an extension cord located in the Social Services Office. 5) A refrigerator was plugged into a power strip	{K 147}	In room 117 the power strip was removed and additional wall plug added for medical equipment. In the MDS office the power strip and extension cord was removed and refrigerator, microwave and air conditioner plugged into a wall plug. In the Social Services office the extension cord was removed and in the Administrators office the refrigerator was plugged into the wall plug. 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. All resident rooms and all administrative offices, storage space and nursing stations were audited 100% for extension cord use (if found they were removed) and proper power strip use (if found they were revised as necessary) by the interdisciplinary team on 4/26/2012. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? ED will issue a second notice to staff, residents and families regarding the use of extension cords and power strips in the facility in writing by 4/27/2012. Education was provided to all staff using the K147 Electrical, Tips for Compliance from the OIG Newsletter. The ED posted fliers in obvious facility common areas to remind families and staff of the intended use of power strips in patient areas. The ED notified the families by letter with this same information. Check the checker system will be established Monday through Friday by ED, DNS and ADNS	

4/27/12
4-28-12
per M. Nicole Thomas
by PG 5-7-12

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 04/26/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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{K 147}	Continued From page 3 located in the Administrators Office. Interview, on 04/26/12 between 12:30 PM and 2:00 PM, with the Maintenance Director revealed he was not aware the misuse of power strips and extension cords in these locations, were not corrected. 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}	using a daily audit tool to review 100% of resident rooms and all administrative offices, storage areas and nursing stations for 4 weeks for proper power strip usage. These daily audits completed by the ED, DNS and ADNS, will be reviewed with ED for compliance and any issues found will be addressed immediately. For continued compliance the admissions director will provide information to all new admits and readmissions prohibiting extension cords and proper use of power strips. During the first QA meeting on April 27, 2012, the QA team became aware that administrative staff members understood that medical equipment could not be plugged into power strips but were not clear on the dangers of using power strips for refrigerators, microwaves, air conditioners, etc that may pose additional risk. Administrative staff were re-educated by the ED using the K 147 Electrical Tips for Compliance from the OIG Newsletter after that QA Meeting on April 27, 2012. 4) How will the facility monitor its performance to ensure that solutions are sustained? The ED, DNS and ADNS will conduct daily audits (Mon-Fri) of the resident rooms, administrative offices, storage areas and nursing stations x 4 weeks and document on an audit tool. The results of these audits will be discussed during weekly QA meetings started April 27, 2012. Center will have weekly QA meetings effective April 27, 2012 to monitor until compliance achieved. During weekly QA all concerns noted during daily audits will be reviewed and changes to plans made as necessary. The interdisciplinary team will monitor for the use of extension cords and proper power strip use in rooms through non clinical rounds weekly. The administrative offices, storage areas and nursing stations will be reviewed weekly by the ED or Safety Director and documented on an audit tool. The audits will continue weekly thereafter and results brought to QA meeting monthly. Any staff member found to not be following process will be re-educated and or receive disciplinary process by the ED	
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4/27/12

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by PB 5-7-12

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