

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

FORM APPROVED  
OMB NO. 0938-0391

**RECEIVED**

AUG 31 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185257	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/09/2012
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER-GREEN HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 213 INDUSTRIAL ROAD GREENSBURG, KY 42743
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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 000	INITIAL COMMENTS	F 000		
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, the facility failed to provide effective housekeeping/maintenance services to ensure a sanitary comfortable interior. The North Hall common area had a urine odor prevalent during the entire survey. A board used to cover an opening in the wall that had been created to hold an air conditioner unit in the North Hall dining room had become loose from the wall, leaving a small opening to the outside of the building. Windows in the North and South Hall dining rooms were dirty. Tiles in the South Hall shower room were observed to be broken and had a black mold-like substance in the grout between the tiles. The base of the bathtub lift had a broken, sharp edge and had been taped.</p> <p>The findings include:  Review of the facility policy, Work Order Submission Guidelines, dated May 2004, revealed staff was to submit a work order to Maintenance for any areas that needed repair.</p>	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Vicki Trump* TITLE: Executive Director DATE: 8/31/2012

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

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F 253	<p>Continued From page 1</p> <p>Review of the Light Housekeeping Routine (undated) revealed housekeepers were to clean the common areas including dining rooms and shower rooms. The cleaning schedule included cleaning shower stalls and cleaning/checking any vertical/horizontal surface areas.</p> <p>Observation during the environmental tour on 08/07/12, 08/08/12, and 08/09/12, revealed the North Hall dining room/common room area had a strong urine odor, the dining room windows on the North and South Halls were dirty with smears and smudges, and a board used to cover an opening in the wall that been created to hold an air conditioner unit in the North Hall dining room had become loose from the wall, leaving a small opening to the outside of the building.</p> <p>Observation of the South Hall shower room on 08/09/12, at 10:00 AM, revealed the base of the chair lift to the whirlpool tub had been taped and an opening in the tape revealed a broken, jagged/sharp area. Further observation of the South Hall shower room revealed broken floor tiles and a black mold-like substance on the grout between the shower stall tiles.</p> <p>Interview with the Maintenance Supervisor and the Housekeeping Supervisor on 08/09/12, at 10:30 AM, revealed the windows and shower rooms were part of the housekeepers' duties that were to be completed on a daily basis. According to the Maintenance Supervisor and the Housekeeping Supervisor, they were aware of a urine odor on the North side that came from a bathroom located in resident room 19. The Maintenance Supervisor stated the commode had overflowed and the tile, wallboard, and toilet</p>	F 253		
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F 253	<p>Continued From page 2</p> <p>had to be removed to complete the repair to remove the odor. The Maintenance Supervisor further stated he was not aware of the broken, jagged/sharp area on the base of the chair lift in the South Hall shower room and stated the area should not have been taped and should have been repaired immediately. The Maintenance Supervisor further stated he was not aware of the opening in the wallboard in the North Hall dining room. The Maintenance Supervisor and the Housekeeping Supervisor stated the staff could report any items that needed to be repaired to the Maintenance Supervisor. Both the Maintenance Supervisor and the Housekeeping Supervisor stated they made daily rounds but did not identify the above findings.</p> <p>Interview with the Administrator on 08/09/12, at 3:00 PM, revealed the Maintenance Supervisor and the Housekeeping Supervisor were to make rounds on a daily basis, Monday through Friday, to observe for cleanliness and areas in need of repair. In addition, the Administrator said staff was to complete and submit work orders to the appropriate department for any area in need of repair and/or cleaning. The Administrator stated she was unaware of the needed repairs, the black mold-like substance in the shower room, the dirty windows, or the urine odors in the North Dining room areas.</p>	F 253		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p>	F 281		

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F 281	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of quality for two of twenty-two sampled residents (Residents #9 and #18). Resident #9 had physician's orders for leg coverings to the lower extremities, to be worn every day on every shift, however, observations conducted on 08/07/12 and 08/08/12, revealed staff failed to ensure the leg coverings were on Resident #9's legs. Resident #9 also had a physician's order to discontinue the use of a dietary supplement, Ensure, which was to be provided with meals. However, observations conducted of the resident on 08/07/12, and 08/08/12, revealed the resident continued to receive Ensure with meal trays. In addition, the facility's dietitian recommended a therapy evaluation for Resident #18 but there was no evidence the evaluation had been conducted.</p> <p>The findings include:</p> <p>An interview with the Corporate Clinical Coordinator on 08/09/12, at 1:00 PM, revealed the facility did not have a policy related to ensuring care was provided in accordance with physician's orders.</p> <p>1. A review of the medical record for Resident #9 revealed the facility admitted the Resident on 02/21/08, with diagnoses that included Alzheimer's Disease, Hypertension, Peripheral Vascular Disease, and Coronary Artery Disease. Further review of the medical record revealed a physician's order, dated 04/29/10, for "Derma Saver Shin Tubes to both lower extremities to</p>	F 281		

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F 281	<p>Continued From page 4</p> <p>prevent irritation caused by the resident continually crossing his/her legs tightly - every shift, every day."</p> <p>Observations of Resident #9 on 08/07/12, at 12:40 PM and 1:20 PM, and on 08/08/12, at 08:30 AM, revealed Shin Tubes were not in use for the resident.</p> <p>An interview with Licensed Practical Nurse (LPN) #3 on 08/09/12, at 9:20 AM, revealed LPN #3 was responsible to monitor the "Activities of Daily Living" (ADL) notebook. According to LPN #3, the nurse aides were to initial the ADL book when they had met the resident's care needs. LPN #3 stated that she did random audits throughout the building to ensure nurse aides were providing care according to the ADL book. LPN #3 further stated she had not monitored any of the residents or nurse aides on 08/07/12 or 08/08/12.</p> <p>Further review of Resident #9's medical record revealed a physician's order, dated 06/13/12, to discontinue "Ensure - one (1) can with meals." A review of the resident's tray card revealed "Ensure, Strawberry, 8 ounces."</p> <p>Observations of meals on 08/07/12, at 2:00 PM, and 08/08/12, at 8:45 AM, revealed one can of Ensure was included on Resident #9's tray.</p> <p>An interview with the Director of Nursing (DON) on 08/08/12, at 1:30 PM, revealed the order to discontinue the Ensure for Resident #9 should have been noted in the daily morning staff meeting. According to the DON, the Dietary Manager should have been notified at that time to correct the resident's tray card. The DON did not</p>	F 281		

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F 281	<p>Continued From page 5</p> <p>know why the order had not been sent to the Dietary Department.</p> <p>An interview with the Dietary Manager (DM) on 08/08/12, at 3:30 PM, revealed the DM was unable to locate a copy of the physician's order to discontinue Ensure with meals for Resident #9.</p> <p>2. A review of the medical record for Resident #18 revealed the facility admitted the resident on 09/09/09, with diagnoses that included Renal Failure, Parkinson's Disease, Hypertension, Seizure Disorder, and Anxiety. Further record review revealed progress notes/recommendations, dated 03/20/12, by the facility's Registered Dietitian (RD) that revealed the resident "shakes very badly, Speech Therapy to visit with the resident for possible utensils or bowls to encourage intake." However, there was no evidence Speech Therapy evaluated Resident #18 for interventions to assist the resident with meals.</p> <p>Observations on 08/09/12, at 9:40 AM, revealed Resident #18 was feeding him/herself breakfast. The resident was observed to have tremors of the head and hands and had some difficulty feeding her/himself. Resident #18 was observed to place the coffee cup on the edge of the table and lower her/his head to sip from it. The resident was also observed to lower his/her head near the plate to shorten the distance from the plate to the mouth. No adaptive equipment was in use.</p> <p>An interview with the Speech Therapist (ST) on 08/09/12, at 1:10 PM, revealed the ST had talked to Resident #18, but the resident did not want any adaptive equipment. The ST further stated he did</p>	F 281		

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F 281	Continued From page 6.	F 281		
F 282 SS=D	not document his encounter with the resident regarding the resident's difficulty with eating. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide services in accordance with the written plan of care for one of twenty-two sampled residents (Resident #6). Resident #6 was assessed to require the use of elbow protectors at all times; however, the elbow protectors were not in place for Resident #6 on 08/07/12 and 08/08/12.  The findings include:  Interview with the Clinical Services Consultant (CSC) on 08/08/12, at 4:00 PM, revealed the facility staff was supposed to follow the Comprehensive Care Plan. The CSC stated there was no policy regarding following the Care Plans.  A review of Resident #6's medical record revealed physician's orders dated August 2012 for the use of elbow protectors to the resident's elbows bilaterally. Further review of the medical	F 282		

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F 282	Continued From page 7 record revealed staff had documented on the current Certified Nurse Aide (CNA) Care Plan (undated) and the Comprehensive Care Plan (initiated 02/01/12) that Resident #8 required the use of elbow protectors bilaterally.  Observations of Resident #6 on 08/07/12, at 12:25 PM, 1:05 PM, 1:35 PM, 2:00 PM, 2:30 PM, 3:05 PM, 4:00 PM, 5:00 PM, and 6:00 PM, and on 08/08/12, at 8:30 AM, 10:00 AM, 11:30 AM, 1:00 PM, and 1:30 PM, revealed elbow protectors were not in use for Resident #6. A skin observation on 08/08/12, at 1:30 PM, revealed Resident #6's lower arms had multiple discolored areas.  Interviews with CNA #2 on 08/08/12, at 3:05 PM, with CNA #3 at 3:15 PM, with CNA #4 at 3:25 PM, and with Licensed Practical Nurse (LPN) #2 at 3:20 PM, revealed they had provided care for Resident #6 on 08/07/12 and/or 08/08/12, and stated the resident was to wear the elbow protectors on both elbows to prevent injuries. The staff did not know why the elbow protectors were not in place for Resident #6 on 08/07/12 or 08/08/12, as identified in the resident's plan of care.  Interview with the Director of Nursing on 08/08/12, at 3:35 PM, revealed the elbow protectors should have been in place for Resident #6 if the physician had prescribed the elbow protectors and if it had been identified on the Comprehensive Care Plan and the CNA Care plan. The DON did not know why the elbow protectors were not in place for Resident #6.	F 282		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED	F 363		

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F 363	<p>Continued From page 8</p> <p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility policy/procedure, observation, interview, and record review, it was determined the facility failed to provide the correct serving size of pureed lasagna to seventeen of seventeen facility residents on pureed consistency. In addition, Resident #13 did not receive vanilla wafers as indicated on the resident's tray card or menu.</p> <p>The findings include:</p> <p>Review of the Food Service Distribution policy/procedures (dated 2011) revealed the facility was to serve proper portions according to the menu.</p> <p>1. Observation of the steam table for the noon meal at 12:30 PM (CDT) on 08/07/12, revealed the entree for the meal was lasagna. Observation of staff serving the tray line revealed staff was utilizing a #8 scoop (equal to 4 ounces) for the serving size for residents on a pureed consistency diet.</p> <p>Interview with the staff member serving the pureed lasagna at 12:45 PM on 08/07/12, revealed he was using a #8 scoop for the pureed</p>	F 363		
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F 363	<p>Continued From page 9</p> <p>lasagna. The staff member stated a #8 scoop was equal to 8 ounces.</p> <p>Interview with the Dietary Manager (DM) at 12:50 PM on 08/07/12, revealed there were 17 residents in the facility that received pureed diets. The DM stated the serving size for the residents on a pureed consistency should have been 1 cup (8 ounces). The DM confirmed the #8 scoop was only a 4-ounce serving size.</p> <p>2. Review of the Menu Planning Policy (dated 2011) revealed the menu was reviewed by the Registered Dietitian, and any changes to the menu would be noted on the menu spreadsheets.</p> <p>A review of Resident #13's medical record revealed a physician's order for a concentrated carbohydrates and heart healthy diet.</p> <p>A review of the Therapeutic Menu Spreadsheet for the Concentrated Carbohydrates and Heart Healthy meal served on 08/07/12, at the noon meal, revealed residents on the diet were to receive three vanilla wafers.</p> <p>Observation of the noon meal on 08/07/12, at 3:07 PM (Eastern Daylight Time), revealed although Resident #13 received a Concentrated Carbohydrate Heart Healthy diet, the resident did not receive the three vanilla wafers as indicated on the menu.</p> <p>Interview with the Dietary Manager (DM) on 08/07/12, at 3:10 PM, and the Dietary Assistant on 08/07/12, at 3:15 PM, revealed Resident #13 should have received three vanilla wafers at the noon meal served on 08/07/12. The Dietary</p>	F 363			

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F 363	Continued From page 10 Assistant stated the kitchen was out of vanilla wafers on 08/07/12.  Interview with the Registered Dietitian (RD) on 08/07/12, at 4:00 PM, revealed kitchen staff was to prepare meals in accordance with the Therapeutic Menu Spreadsheet for each individual's physician prescribed diet. The RD stated if an item was out of stock that was listed on the menu, a substitute for the item of equal nutrient value should be provided by the kitchen staff. The RD stated graham crackers would have been an appropriate substitute for vanilla wafers for Resident #13.	F 363		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS  The facility must provide special eating equipment and utensils for residents who need them.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and review of facility policy, it was determined the facility failed to provide one of twenty-two sampled residents (Resident #6) with special dining equipment as recommended by a Speech Therapist and prescribed by the resident's physician.  The findings include:  Review of the Adaptive Eating Devices policy (undated) revealed the adaptive utensils were to be provided to the residents by the Dining Services Department.	F 369		

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F 369	<p>Continued From page 11</p> <p>Review of the medical record for Resident #6 revealed physician's orders dated August 2012 for the resident to receive a pureed diet and a "maroon spoon" (a smaller sized spoon to assist the resident with swallowing difficulties) at all meals. In addition, a review of the current CNA care plan (undated) and the Comprehensive Care Plan (initiated on 05/11/12) developed for Resident #6 revealed the resident was to use the "maroon spoon" for meals.</p> <p>Observation of Resident #6 during the breakfast meal on 08/08/12, at 10:00 AM (Eastern Daylight Time), revealed the resident received a pureed meal with thin liquids. Continued observation of the breakfast meal revealed Licensed Practical Nurse (LPN) #6 assisted/fed Resident #3 with a regular spoon. The facility staff failed to provide Resident #6 the "maroon spoon" as prescribed.</p> <p>Interview with LPN #3 on 08/08/12, at 10:05 AM, revealed he/she was not aware staff was to use the "maroon spoon" when he/she assisted Resident #6 with his/her meal.</p> <p>Interview with the Dietary Manager (DM) on 08/08/12, at 10:00 AM, revealed the dietary personnel were required to get the adaptive equipment for each resident and place the equipment on the meal tray for that resident. The DM stated adaptive equipment ordered for a resident would be identified on each resident's meal card. The DM stated Resident #6 was required to have a maroon spoon, and acknowledged staff had failed to place the spoon on the resident's breakfast tray. Observation of Resident #6's meal card on 08/08/12, at 10:00 AM, confirmed the use of the "maroon spoon"</p>	F 369		

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:  185257	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/09/2012
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER-GREEN HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 213 INDUSTRIAL ROAD GREENSBURG, KY 42743	
(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 369	Continued From page 12	F 369		
F 469 SS=E	had been identified on the meal card. 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM  The facility must maintain an effective pest control program so that the facility is free of pests and rodents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy, it was determined the facility failed to maintain an effective pest control program to ensure the facility remained free of pests. Flies were observed in the North and South dining rooms on 08/07/12, 08/08/12, and 08/09/12.  The findings include:  Review of the Pest Management Services Plan dated and signed 10/23/07 revealed the pest control company would come to the facility on a month-by-month basis unless the need to come more frequently arose.  Interview with a group of alert and oriented residents on 08/07/12, at 4:00 PM, revealed flies were present in the building, especially in the dining room areas during meal times.  Observation on 08/07/12, at 2:20 PM, in the South Hall dining room, on 08/07/12, at 3:00 PM, in the North Hall dining room, and on 08/08/12, at the breakfast meal in the South Hall revealed flies around residents and residents' food.	F 469		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185257	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/09/2012
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER-GREEN HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 213 INDUSTRIAL ROAD GREENSBURG, KY 42743
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F 469	<p>Continued From page 13</p> <p>Observation of the North Hall dining room on 08/08/12, at 9:30 AM, revealed flies landing on the tables where residents were sitting.</p> <p>Observation of the North and South Hall dining rooms during the environmental tour with the Maintenance Supervisor and the Housekeeping Supervisor on 08/09/12, at 10:30 AM, revealed flies in both dining rooms.</p> <p>Interview with the Maintenance Supervisor (MS) on 08/09/12, at 10:30 AM, revealed the facility had a contract with a pest control company and had flytraps by most of the exit doors. A review of invoices from 06/8/12, 07/13/12, and 08/02/12, revealed the facility had paid for a pest control company to eliminate flies. According to the MS, the pest control company had also put a blower on the kitchen doors where food deliveries were received. However, the MS stated there was no system in place to prevent flies from entering at the front entrance of the facility where other deliveries were often received (pop machine, paper products, etc.).</p> <p>Interview with the Administrator on 08/09/12, at 3:00 PM, revealed even though the facility had contracted with a pest control company for a fly prevention program, the facility continued to have a fly problem.</p>	F 469		

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 means to continually improve the quality of care and to comply with all applicable state and federal regulatory requirements.

F 253 E

**Corrective Actions for Targeted Residents:**

No individuals were identified to be affected by this alleged deficient practice. North Hall dining room/common areas will be deep cleaned. Any items (i.e. furniture, chairs, cushions), will be cleaned and/or replaced.

Windows were cleaned on North and South Halls.

The opening on the wall on North Hall was repaired.

The base of the tub in the Shower Room on South Hall was replaced, on August 10, 2012. Ensuring no exposed screws and eliminating the tape.

The tile in the shower room on South will be replaced.

**Identification of Other Residents with Potential to Be Affected:**

All residents have a potential to be affected by this alleged deficient practice. Director of Housekeeping and the Director of Maintenance completed a facility tour to monitor a sanitary, orderly and comfortable interior. Any issues were resolved immediately.

**Systemic Changes:**

The Director of Housekeeping initiated a new protocol for cleaning windows.

Director of Maintenance will complete observation rounds of the environment, five times a week. Issues identified will be corrected.

Housekeeping and Laundry staff were in-serviced on the new protocol for cleaning windows.

Staff including ancillary staff were in-service on placing work orders in Building Engines as issues are identified.

**Monitoring:**

Observation rounds will be reported to the five days a week Stand-up meeting for compliance. The stand-up meeting includes but is not limited to the Executive Director, Director of Nursing Services, Assistant Director of Nursing Services, Director of Education, Social Worker, Director of Activities,

Maintenance Director, Director of Housekeeping/Laundry, Rehab Manager and Director of Dining Services. Summaries of these observations will be submitted to the monthly QA Committee to ensure compliance and for follow-up, if needed for 3 months then quarterly. The Quality Assurance Committee Members include but is not limited to the following: Executive Director, Medical Director, Director of Nursing, Assistant Director of Nursing, Director of Education, Social Worker, Director of Housekeeping/Laundry, Director of Maintenance, Director of Activities, Rehab Manager, Director of Admissions, and Business Office Manager.

Correction Date: September 14, 2012

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**F 281 D**  
**Corrective Actions for Targeted Residents:**

Resident number 9 leg coverings were placed on the resident as ordered, on August 9, 2012. The order for Ensure for resident number 9 had been discontinued and the dietary tray ticket was updated to reflect the change on August 9, 2012.

Resident number 18 was re-evaluated by Speech Therapy and documentation is currently included in the Medical Record. Resident number 18 refuses the adaptive equipment and care plan has been updated to reflect the refusals

**Identification of Other Residents with Potential to Be Affected:**

All residents have a potential to be affected by this practice.

Dietary and adaptive equipment orders will be audited to ensure that they are transcribed as ordered. The audit will be completed by Nursing Administration. Nursing Administration includes the Director of Nursing, Assistant Director of Nursing, Director of Education, Resident Assessment Coordinators and Charges Nurses.

**Systemic Changes:**

Designated staff will be assigned to check that new physician orders have been transcribed correctly and appropriate disciplines have been notified of new orders during the clinical start up process. An audit sheet will be developed to ensure that nurses are aware of the new orders and visually randomly check to see that they are followed.

Nursing staff will be educated on this new practice by the Director of Education.

**Monitoring:**

Audit sheets will be reviewed M-F in daily Clinical Start Up. The daily Clinical Start Up includes but is not limited to: Director of Nursing, Assistant Director of

Nursing, Resident Assessment Coordinators, Director of Activities, Social Worker, Director of Dining Services, and Rehab Manager.

Summaries of Audits will be submitted to the monthly Quality Assurance Committee, to ensure compliance or follow up if needed, for three months.

The Quality Assurance Committee includes but is not limited to: Executive Director, Medical Director, Director of Nursing Services, Assistant Director of Nursing Services, Director of Education, Social Worker, Director of Activities, Director of Maintenance, Director of Housekeeping/Laundry, Resident Assessment Coordinators and Rehab Manager

**Correction Date: September 14, 2012**

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**F 282 D**

**Corrective Actions for Targeted Residents:**

Resident number 6 elbow protectors were placed on resident August 9, 2012 by the Director of Nursing.

**Identification of Other Residents with Potential to Be Affected:**

All residents have a potential to be affected by this practice.

Care plans of residents who have orders for adaptive equipment will be audited to ensure that they are updated. These audits will be completed by Nursing Administration. Nursing Administration includes: Director of Nursing, Assistant Director of Nursing, Resident Assessment Coordinators, Director of Education and Charge Nurses.

**Systemic Changes:**

Certified Nursing Assistant's assignment sheets will be brought to the Clinical Start Up Meeting to update the record with proper orders or changes. The Clinical Start Up Meeting includes: Director of Nursing, Assistant Director of Nursing, Residents Assessment Coordinators, Social Worker, Director of Activities, Director of Dining Services, and Rehab Manager.

An audit sheet will be utilized by nurses to follow for random visual observations checking to ensure the residents plan of care is being followed.

Nursing Staff will be educated on this change by the Director of Education.

**Monitoring:**

Audit Sheets will be reviewed in Clinical Start Up (M-F) by the Director of Nursing. Summaries of these audits will be submitted to the Monthly Quality Assurance Committee, for compliance and follow-up, if needed for 3 months. The Quality Assurance Committee includes but is not limited to: Executive

Director, Medical Director, Director of Nursing, Assistant Director of Nursing, Director of Education, Social Worker, Director of Activities, Director of Dining Services, Resident Assessment Coordinators, Director of Maintenance, Director of Housekeeping/Laundry and Rehab Manager.

**Correction Date: September 14, 2012**

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F 363 E

**Corrective Actions for Targeted Residents:**

Dietary Staff was re-educated by the Dietary Manager on proper scoop sizes. This was completed on August 9, 2012. Resident number 13 food preferences was updated by the Director of Dining Services on August 9, 2012. Resident number 13 no longer request the vanilla wafers.

**Identification of Other Residents with Potential to Be Affected:**

All residents have the potential to be affected by this alleged deficient practice. A mandatory in-service for dietary staff on scoop sizes, reading production work sheets/tray tickets, making proper substitutions and documentation to support the above will be conducted by the Director of Dining Services and the Dietician. The in-service will include a post competency test to validate understanding.

**Systemic Changes:**

Director of Dining Services or his assistant will audit each tray on each cart daily times two weeks then each meal once a week times one month.

Random audits will be performed by the Director of Dining Services or the Dietician to ensure trays continue to meet tray ticket directions.

**Monitoring:**

Summaries of these audits will be submitted to the monthly Quality Assurance Committee for compliance and follow-up, if needed, for three months.

The Quality Assurance Committee consists of but is not limited to: Executive Director, Medical Director, Director of Nursing, Assistant Director of Nursing, Director of Education, Director of Dining Services, Social Worker, Director of Activities, Director of Maintenance, Director of Housekeeping/laundry and Resident Assessment Coordinator.

**Correction Date:** September 14, 2012

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F 369 D

**Corrective Actions for Targeted Residents:**

Resident number 6 was provided the adaptive equipment.

**Identification of Other Residents with Potential to be affected:**

Residents who had orders for an adaptive equipment could have been affected by this alleged deficient practice.

Dietary Staff was re-educated by the Director of Dining Services, August 9, 2012 on providing adaptive equipment.

A mandatory in-service for dietary staff will be conducted by the Director of Dining Services and the Dietician on providing adaptive equipment as ordered. Dietary Staff will demonstrate competency by passing a post test.

**Systemic Changes:**

An updated list of resident's adaptive equipment will be placed at the end of the tray line for a quick reference.

The Director of Dining Services will update this list as changes occur.

The Director of Dining Services or his assistant will audit each tray on each cart daily times two weeks, then each meal once a week times on month.

Random audits will then be performed by the Director of Dining Services or the Dietician.

**Monitoring:**

Summaries of these audits will be submitted to the monthly Quality Assurance Committee to ensure compliance for three months. The Quality Assurance Committee includes but is not limited to: Executive Director, Medical Director, Director of Nursing, Assistant Director of Nursing, Director of Education, Social Worker, Director of Activities, Director of Dining Services, Director of Maintenance, Director of

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Housekeeping/Laundry, and Rehab  
Manager.

Correction Date: September 14, 2012

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F 469 F

**Corrective Actions for Targeted Residents:**

No individual resident was identified.

**Identification of Other Residents with Potential to Be Affected:**

All residents have a potential to be affected by this practice.

The facility has a contract with Ecolab for fly prevention. Ecolab treated the facility once in August 2012, twice in July 2012, twice in June 2012, twice in May 2012 and once in April. All recommendation were followed.

**Systemic Changes:**

Staff has been directed to use the front doors for entrance and exit to the facility.

The facility will price and prepare to install a "blower" for the front entrance.

**Monitoring:**

All staff will monitor for flies daily and report issues to the Director of Maintenance. This monitoring will be part of their daily duties.

The Director of Maintenance will review report from Ecolab in the monthly Quality Assurance Meeting. The Quality Assurance Committee includes but is not limited to the follow: Executive Director, Medical Director, Director of Nursing, Assistant Director of Nursing, Director of Education, Social Worker, Director of Activities, Director of Maintenance, Director of Housekeeping/laundry, Director of Dining Services, Resident Assessment Coordinators and Rehab Manager.

**Correction Date: September 14, 2012**

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

PRINTED: 03/28/2013  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185257</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/08/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER-GREEN HILL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>213 INDUSTRIAL ROAD GREENSBURG, KY 42743</b>		
(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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1979</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 111(000)</p> <p>SMOKE COMPARTMENTS: 9</p> <p>FIRE ALARM: Complete automatic fire alarm system</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II diesel generator.</p> <p>A life safety code survey was initiated and concluded on 08/08/12, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			

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

TITLE

(X6) DATE

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