

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

PRINTED: 11/02/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185176</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/30/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - MT HOLLY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>446 MT. HOLLY AVE</b> <b>LOUISVILLE, KY 40206</b>
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{F 000}	INITIAL COMMENTS  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/30/15 as alleged.	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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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F 000 INITIAL COMMENTS

A Recertification Survey was initiated on 09/22/15 and concluded on 09/24/15 with deficiencies cited at the highest scope and severity of a "D".

An Abbreviated Survey was initiated on 09/22/15 during the Recertification Survey to investigate complaint KY23853 and was concluded on 09/24/15. The Division of Health Care unsubstantiated the allegation with no deficiencies cited.

F 279 483.20(d), 483.20(k)(1) DEVELOP  
SS=D 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).

This REQUIREMENT is not met as evidenced

F 000

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

F 279

F 279 DEVELOP  
COMPREHENSIVE CARE PLANS

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

Resident #13 had a care plan developed related to MRSA of the blood developed on 9/24/2015 and since resolved on 10/1/2015.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All residents have the potential to be affected. All care plans will be reviewed by the Interdisciplinary team to ensure resident's current physical, mental, and psycho-social needs are addressed by 10/30/2015.

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

*[Signature]*

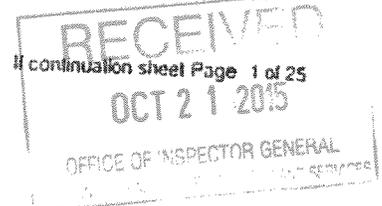
TITLE

*Executive Director*

(X6) DATE

10/21/15

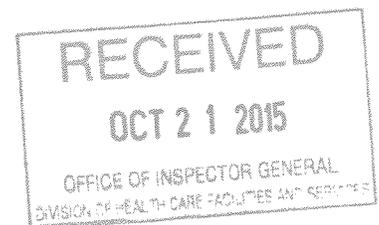
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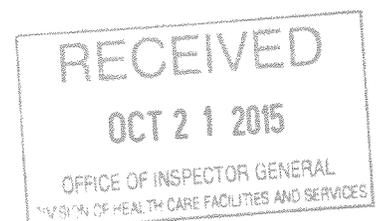
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F 279	Continued From page 1 by: Based on interview, record review, and review of the facility's policies, it was determined the facility failed to develop an Infection Control Care Plan for one (1) of twenty one (21) sampled residents (Resident #13) in regards to an active Methicillin Resistant Staphylococcus Aureus (MRSA) infection.  The findings include:  Review of the facility's Resident Assessment Instrument (RAI) Process Policy, dated 08/20/15, revealed the facility would adhere to all Centers for Medicare and Medicaid Services (CMS) regulations which are considered the definitive source in completion of the RAI process. This would include coding the Minimum Data Set (MDS), completion of Care Area Assessments (CAA's) and the development of the comprehensive plan of care.  Review of the facility's Interdisciplinary Care Plan Policy, dated 02/26/15, revealed the purpose of the interdisciplinary care plan was to guide the facility in providing the necessary care and services to attain or maintain the highest practicable physical, mental, and psycho-social wellbeing of the resident.  Review of the facility's Infections - Clinical Protocol Policy, dated 12/01/14, revealed the facility would provide supportive measures as needed and wear an isolation gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment for residents in contact isolation precautions.	F 279	<b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> The interdisciplinary team and direct care nurses including floor staff are being educated by the DNS and ADNS on updating care plans as resident has changes in needs including physical, mental, and psycho-social by 10/30/2015.  <b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> The RNAC, DNS, ADNS, an/or Unit Managers will audit care plans for residents that are new admissions, readmissions as well as new order to ensure care plans have been made to meet current needs including physical, mental and psychosocial daily x 2 weeks, then 5 times per week for 4 weeks. Any issues will be addressed by employee re-education and/or discipline or revision of this plan by the DNS. Any issues with lack of compliance plan to reach compliance. The QAPI committee will determine if further action needs to be taken, and determine the continued time schedule for further audits. The QAPI committee will meet monthly and the	



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F 279	<p>Continued From page 2</p> <p>Review of the clinical record, revealed the facility admitted Resident #13 on 05/16/15 with diagnoses of history of Skin Infections, Chronic Obstructive Pulmonary Disease (COPD), Infectious Disease of the Nares, Congestive Heart Failure (CHF), Depressive Disorder, Toxic Liver Disease, Insomnia, Dysphagia, Cirrhosis of the Liver, History of Cellulitis and Schizophrenia.</p> <p>Record Review of the Discharge Instruction Notes from another facility, dated 09/15/15, revealed Resident #13 had a positive MRSA Bacteremia (of the Blood) and received treatment with intravenous (IV) Vancomycin (antibiotic) for a total of fourteen (14) days.</p> <p>Review of Resident #13's Minimum Data Set (MDS) Assessment, dated 08/25/15, revealed the facility assessed the resident with an active diagnosis of Heart Failure with shortness of breath while sitting at rest and on exertion. In addition the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15 of 15, meaning Resident #13 was interviewable.</p> <p>Review of the Comprehensive Care Plan for Resident #13, revealed a plan of care had not been developed for an active infection or contact isolation precautions at the time of re-admission to the facility on 09/15/15 nor after the facility received confirmation Resident #13 had MRSA of the bloodstream.</p> <p>Interview with the Unit Manager, on 09/23/15 at 3:25 PM, revealed after a nurse received a physician's order she should update the resident's care plan with the appropriate</p>	F 279	<p>Executive Director will direct any changes.</p> <p>Completion date - 10/30/2015</p>	



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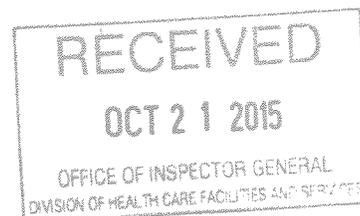
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F 279	<p>Continued From page 3</p> <p>interventions related to the order or resident change. In regards to infections and isolation precautions, she stated, the hospital usually told them in report if the resident had been in isolation precautions during the hospital stay. She could not recall if the hospital had reported this information in regards to Resident #13.</p> <p>Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), on 09/23/15 at 4:05 PM, revealed the DON had received the Discharge Instructions Summary for Resident #13 and had reviewed them. She continued to say as Nursing Administration she reviewed all resident Discharge Summaries upon return from the hospital. Although the ADON had the role of Infectious Preventionists, the ADON and DON concurred that the DON had made the decision to not place Resident #13 in contact isolation precautions; however, during the interview she realized Resident #13 should have been placed in contact isolation precautions per protocol. The DON continued to state an infection care plan had not been developed and she expected any of the nurses to initiate an infection care plan.</p> <p>Interview with the ADON, on 09/24/15 at 8:45 AM, revealed the process, when a resident comes to the facility with an active infection, was to review the discharge summary for the type of infection then review and discuss this in the stand-up meeting with the interdisciplinary team what would need to be put in place for the resident based on the type of infection. She could not recall why this process had not occurred for Resident #13.</p> <p>Telephone interview, on 09/24/15 at 10:00 AM,</p>	F 279			

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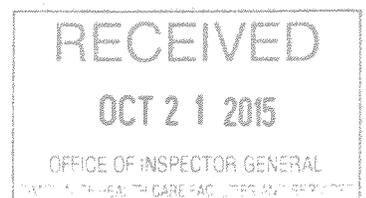
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F 279	Continued From page 4 with Licensed Practical Nurse (LPN) #4, who re-admitted Resident #13, revealed she was responsible along with all the nurses to develop care plans. However, she could not give a reason as to why an initial infection control care plan was not developed.  Interview with MDS Coordinator, on 09/24/15 at 11:00 AM, revealed staff nurses were expected to develop resident care plans with physician orders or changes in interventions. She continued to state Resident #13 should have had an infection care plan developed for MRSA infection and placed in contact isolation precautions upon returning to the facility; however, was unaware a care plan had not been developed.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and 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 ensure physician orders were followed for one (1) of twenty one (21) sampled residents, (Resident #13). The facility failed to provide evidence daily weights were obtained for Resident #13 as ordered.	F 309	<b>F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> On 9/23/2015 the DNS contacted Dr. Kutmah and received new order to discontinue daily weights. The DNS and ADNS are educating the nurses on following MD orders including daily weights when ordered by the physician by 10/30/2015.	



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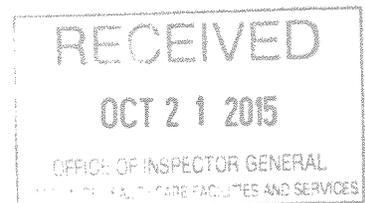
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F 309	Continued From page 5  The findings include:  The facility did not provide a policy for following physician orders.  Review of the clinical record for Resident #13, revealed the facility admitted the resident on 05/16/15 with diagnoses of Congestive Heart Failure (CHF), Depressive Disorder, Toxic Liver Disease, Insomnia, Dysphagia, Cirrhosis of the Liver, Hypokalemia and Schizophrenia.  Review of Resident #13's Minimum Data Set (MDS) Assessment, dated 08/25/15, revealed the facility assessed the resident with an active diagnosis of Heart Failure with shortness of breath while sitting at rest and on exertion. In addition the facility completed an a Brief Interview for Mental Status (BIMS) with score of 15, meaning Resident #13 was interviewable.  Review of Resident #13's Physician Orders from a local hospital, dated 09/15/15, revealed an order for daily weights every morning. If the weight went up more than three (3) pounds in a day or five (5) pounds in a week, the nurse was to contact the Doctor.  Review of Resident #13's Medication Administration Record (MAR), for September 2015, revealed an order for a daily weight every morning to monitor the resident's Congestive Heart Failure. It stated if the weight went up more than three (3) pounds in one day or five (5) pounds in one week the nurse was to contact the physician. Continued review revealed a check mark inside of the box for each date	F 309	<b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> All residents have the potential to be affected. The DNS, ADNS, and RNAC are auditing all resident orders to determine if any residents with orders for daily weights and validate the order being followed by 10/30/2015.  <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> The Interdisciplinary team is reviewing all admissions, readmissions, and new orders for daily weights and validate being followed began 9/28/2015.  <b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> The DNS, ADNS, Unit Managers, or RNAC will audit daily weight orders daily x 2 weeks, then twice weekly x 2 weeks, then weekly x 4 weeks. Results of the audits will be reported to QAPI committee meeting.		



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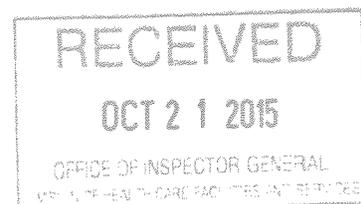
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F 309	<p>Continued From page 6</p> <p>corresponding to the order, which meant the order had been completed for the dates of 09/16/15 through 09/23/15, except for 09/20/15.</p> <p>Review of the Weights and Vitals Summary sheet, dated 09/24/15, revealed weights were done for 09/17/15 and 09/19/15. No other weights were found in the clinical record for the dates of 09/16/15, 09/18/15, 09/21/15, 09/22/15 or 09/23/15.</p> <p>Review of the Certified Nursing Assistant (CNA) Care Card revealed no indication of a daily weight to be obtained.</p> <p>Observation, on 09/23/15 at 8:20 AM, revealed Resident #13 was up in wheelchair for breakfast. Interview with Resident #13, at that time, revealed he/she had not been weighed that morning.</p> <p>Interview with the Director of Nursing, on 09/24/15 at 11:15 AM, revealed when Resident #13's daily weight order was documented by the nurses, her expectation of the electronic MAR documentation for weights was the nurse was verifying that the weight was obtained and completed and she expected her staff to follow physician orders. The DON continued by saying, CNA's were responsible for obtaining the weights according to the weight list given to them by the nurses. The DON stated she was responsible for making sure the list was compiled and the weights were obtained and recorded; however, she was unaware Resident #13's weights were not obtained by the nursing staff.</p> <p>Interview with Certified Nursing Assistant (CNA) #5, on 09/24/15 at 1:30 PM, revealed the CNA's</p>	F 309	<p>Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken, and determine the continued time schedule for further audits. The QAPI committee will meet monthly and the Executive Director will direct any changes.</p> <p><b>Completion date – 10/30/2015</b></p>		



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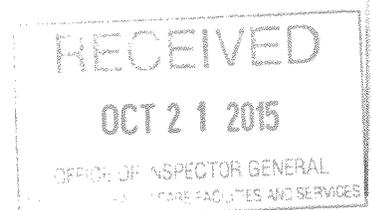
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F 309	Continued From page 7 only weighed the residents on the weight list given to them by the nurse. The completed list is turned in to the nurse to put the weights in the computer. CNA #5 stated she was not familiar with Resident #13, she normally did not work that hall.  Interview with Licensed Practical Nurse (LPN) #6, on 09/24/15 at 1:40 PM, revealed the nurses would normally record the weights in the computer or turn the weight list in to the Unit Manager to record in the computer. LPN #6 stated if she did the weight herself, she recorded it in the computer. Resident #13's weight order was discontinued on 09/23/15.  Interview with the Unit Manager (UM) Registered Nurse, on 09/24/15 at 3:00 PM, revealed when the weight list is complete, each nurse for their hall would record the weights in the computer. The UM stated in addition, the facility had recently made some changes in nursing administration roles and revealed she may end up having the responsibility in the future for recording the weights in the computer for all residents, but has not to date. The UM stated she did not know why the weights for Resident #13 were not obtained.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	<b>F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b>  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 9/24/2015 the DNS validated the can of Mal Odor Eliminate had been removed from the unlocked cabinet in the kitchenette on Annex hall.	



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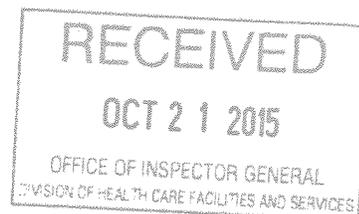
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F 323	Continued From page 8  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy and procedure review, it was determined the facility failed to ensure the environment was free from potentially hazardous substances to prevent accidents. A bottle of Mal Odor Eliminate was observed stored in an unlocked cabinet, in one (1) of two (2) kitchenettes.  The findings include:  Review of the facility's policy regarding Chemical Safety, dated 2011, revealed under the heading of Safe Chemical Storage, staff was to store chemicals in a separate area away from food and disposables such as paper.  Review of the facility's policy regarding Safety-Overview, dated 01/01/11, revealed the staff was to never leave chemicals unattended on the carts.  Review of the facility's housekeeping procedure regarding Accident Prevention, dated 01/01/00, revealed the staff was to keep all bottles out of the patients' reach and have all bottles labeled. Further, the staff was to keep all janitor closets locked at all times and not spray any cleaning chemicals in the direction of a patient.  Observation during the initial environmental tour, on 09/22/15 at 9:22 AM, revealed a white spray bottle labeled Mal Odor Eliminate, under the sink in an unlocked cabinet, in the resident's open area kitchenette on the Annex Hall.	F 323	<b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> All residents have the potential to be affect by the alleged deficient practice. All staff will be educated on ensuring all chemicals are stored per the policy by the Housekeeping Director, DNS, ADNS, or Human Resource Specialist by 10/30/2015.  <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> The Executive Director, Maintenance Director and Housekeeping supervisor performed building wide inspection to validate no other chemicals were stored in unlocked cabinets or accessible to residents on 9/25/2015.	



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F 323	<p>Continued From page 9</p> <p>Review of the Material Safety Data Sheet (MSDS), dated 10/01/97, revealed the product named Enzymatic Foul Odor Digester (Mal Odor Eliminate) had the ingredients of Bacteria Spores, Nonionic Surfactant, Acrylic Emulsion, and Perfume Oil. The MSDS also revealed, the product had health hazards that consisted of the following: SKIN-Slight irritant, prolonged or repeated contact may cause dermatitis, may infect open wounds; EYES-Eye irritant, liquid and mist may infect the eyes; INGESTION-May be irritating to the mouth, throat, and gastrointestinal system, vomiting and diarrhea are expected from large doses.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 09/23/15 at 12:00 PM, revealed all cleaning supplies and chemicals were to be kept locked on the housekeeping carts or in the locked storage areas to prevent residents from being harmed or poisoned. CNA #1 stated they were in-serviced yearly on supervision and the MSDS book located at the nursing station. CNA #1 also stated that all residents on the Annex Hall had open access to the kitchenette because that's where the resident's snacks and paper supplies; such as, napkins, cups, and forks are located.</p> <p>Interview with the Housekeeping Manager, on 09/23/15 at 3:43 PM, revealed all housekeeping cleaning supplies and chemicals were to be kept under lock and key in the environmental service areas. The Housekeeping Manager stated all cleaning was done by housekeeping staff only, however, staff did borrow cleaning supplies and chemicals upon request. The Housekeeping Manager also stated that cleaning supplies located in any unlocked area accessible to residents would be a problem. Further interview</p>	F 323	<p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>The Executive Director, Housekeeping Supervisor, or Maintenance Director will make rounds to validate no chemicals are stored inappropriately daily x 2 weeks, 5 days per week x 2 weeks, twice weekly x 2 weeks, then weekly x 4 weeks. Results of the audits will be reported to the QAPI committee meeting.</p> <p>Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken, and determine the continued time schedule for further audits. The QAPI committee will meet monthly and the Executive Director will direct any changes.</p> <p><b>Completion date - 10/30/2015</b></p>		



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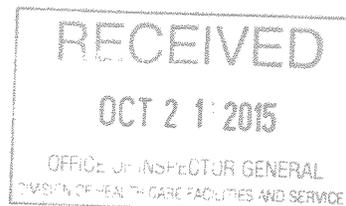
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F 323	<p>Continued From page 10</p> <p>with the Housekeeping Manager, on 09/24/15 at 8:46 AM, revealed his housekeeping staff had been oriented on how to stock housekeeping carts, on chemical awareness, and on storage of chemicals upon hire and that he had in-serviced his staff monthly on those topics.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 09/24/15 at 8:12 AM, revealed cleaning bottles should not be stored in the kitchenettes unlocked because any of the residents could possibly consume or spray the liquid into their eyes or on their skin. LPN #1 stated the residents on the Annex Hall had different cognitive levels. LPN #1 also stated if he knew a resident had sprayed a chemical in his/her eyes or consumed a cleaning chemical he would pull the MSDS sheet to see how to proceed in assessing the resident for treatment and the physician would be called to obtain further orders. LPN #1 stated the unlocked chemical in the Annex Hall kitchenette could cause a resident to vomit if ingested and eye irritation if sprayed into the eyes and those symptoms would also trigger a call to the physician.</p> <p>Interview with Housekeeper #2, on 09/24/15 at 8:37 AM, revealed all cleaning supplies and chemicals they use were kept locked on their carts or in the designated storage areas. Housekeeping Staff #2 stated she would sometimes allow other staff to borrow her cleaning supplies and chemicals, but she did not know where those staff would store those chemicals if they were not returned to her. Housekeeping Staff #2 also stated she had received training on storage of cleaning chemicals and she knew they should be kept locked.</p>	F 323			

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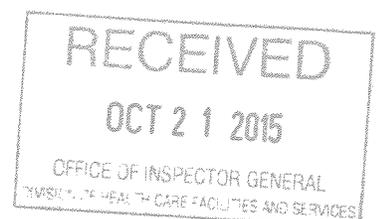
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F 323	Continued From page 11  Interview with the Physician, on 09/24/15 at 10:14 AM, revealed he would treat a resident of the facility who had consumed a cleaning chemical or sprayed a cleaning chemical into his/her eyes by following the guidance from the Centers for Disease Control (CDC). The Physician stated treatment would depend on the injury, timeframe of consumption, and information obtained from the CDC. The Physician also stated injury to the mouth, digestive system, eyes, skin, and liver could result from consumption or spray of cleaning chemicals.  Interview with the Poison Control Operator, on 09/24/15 at 11:41 AM, revealed consumption of Mal Odor Eliminate or spray onto skin or into eyes could cause irritation of the mouth, throat, or eyes and could develop into vomiting and diarrhea. The Poison control Operator stated Mal Odor Eliminate was not poisonous, but if consumed or sprayed onto the skin or into the eyes, medical attention should be sought immediately.  Interview with the Director of Nursing, on 09/24/15 at 2:06 PM, revealed nursing staff were trained to obtain the MSDS information when a resident consumed and/or sprayed a cleaning material into their eyes. The Director of Nursing stated there was always a risk of injury to residents who were cognitively impaired when unlocked chemicals were kept on the halls. The Director of Nursing also stated the treatment of a resident would depend upon how they came into contact with the cleaning chemical.	F 323			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	F 431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS		



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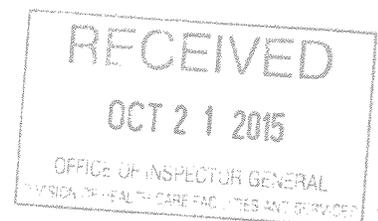
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F 431	Continued From page 12  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; 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 controls, and permit only authorized personnel to have access to the keys.  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.  This REQUIREMENT is not met as evidenced by:	F 431	<b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident # 15 now takes her medications in the presence of a nurse. The DNS validated on 9/25/2015. LPN #1 was educated on Oral Medication Administration Policy by the ADNS including the requirement to not leave medications at the bedside unless specifically ordered by the prescriber.  <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> All residents have the potential to be affected by the alleged deficient practice.  <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> All nurses are being educated by the DNS, ADNS, and/or the Unit Managers on the Oral Medication Administration Policy including the requirement to not leaving medications at the bedside unless specifically ordered by the prescriber to be completed by 10/30/2015.	



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F 431	<p>Continued From page 13</p> <p>Based on observation, interview, record review and policy review, it was determined the facility failed to ensure medications were administered to residents under direct observation of nursing staff for one (1) of twenty-one (21) sampled residents, (Resident #15). Licensed Practical Nurse #1 left medications in a cup on the bedside table for Resident #15 to self administer.</p> <p>The findings include:</p> <p>Review of the Oral Medication Administration Policy, dated May 2012, revealed the purpose was to administer oral medication in a safe, accurate, and effective manner. The staff was to administer medication and remain with the resident while the medication was swallowed. They were to use caution with residents who had difficulty with swallowing and not leave medications at the bedside, unless specifically ordered by the prescriber.</p> <p>Review of Resident #15's record revealed the facility admitted the resident on 08/20/15 with diagnoses of Type 2 Diabetes, Gastro Esophageal Reflux, Morbid Obesity, Essential Hypertension, Venous Insufficiency, Peripheral Vascular Disease, Right Lower Extremity Wound, Status Post Debridement and Valvular Heart Disease. Review of Resident #15's Minimum Data Set (MDS) Admission Assessment, dated 08/27/15, revealed the facility assessed Resident #15 with a Brief Interview for Mental Status (BIMS) score of fifteen (15) of fifteen (15) which meant Resident #15 was interviewable.</p> <p>Observation and interview of Resident #15, on 09/24/15 at 8:37 AM, revealed Resident #15 had a cup of medications on his/her bedside table.</p>	F 431	<p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>The DNS, ADNS and/or Unit Managers will observe oral medication administration to validate the nurses are following the Oral Medication Administration Policy including not leaving medications at bedside at least 5 observations per week x 2 weeks, then twice weekly x 2 weeks, then weekly x 4 weeks and report findings to the QAPI committee meeting.</p> <p>Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken, and determine the continued time schedule for further audits. The QAPI committee will meet monthly and the Executive Director will direct any changes.</p> <p><b>Completion date – 10/30/2015</b></p>		



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F 431	<p>Continued From page 14</p> <p>Resident #15 was observed to take his/her medications without a nurse present. Resident #15 stated the nurse did not normally leave medications at the bedside, but he/she was trying to finish breakfast.</p> <p>Review of Resident #15's Physician Orders, dated 08/20/15, revealed there was no physician order for Resident #15 to administer his/her own medications.</p> <p>Review of Resident #15's Medication Administration Record (MAR), dated 09/24/15, revealed Resident #15 was given Aldactone (betablocker for the heart) 25 mg, Multivitamin, Norvasc (cholesterol) 10 mg, Protonix (proton pump inhibitor for the stomach) 40 mg, Atenolol (vasodilator) 25 mg, Calcium/Vitamin 600/200 mg, Coreg (beta blocker for the heart) 6.25 mg, Vitamin C 500 mg and Dilaudid (pain medication narcotic) 2 mg.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 09/24/15 at 8:42 AM, revealed he knew the resident was supposed to take his/her medications while he was present in the room. LPN #1 stated Resident #15 was a patient who would take his/her medications later and usually he would stand outside of the resident's room. LPN #1 stated Resident #15 did not have an order from a Physician that stated the resident could administer his/her own medications. LPN #1 stated Resident #15 could choke on medication and no one be present to help him/her. LPN #1 stated he provided Dilaudid to the resident with the other medications.</p> <p>Interview with the Annex Unit Manager, on 09/24/15 at 1:22 PM, revealed the staff was not to</p>	F 431			

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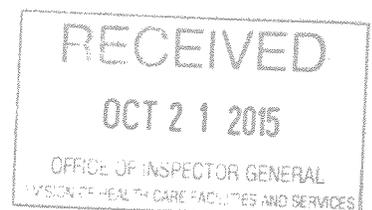
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F 431	Continued From page 15 leave medications unattended in resident rooms for safety reasons, such as wandering residents may consume another residents medications. If a resident refused their medications the nurse was supposed to secure the residents medications in the medication cart.  Interview with the Director of Nursing (DON), on 09/24/15 at 1:55 PM, revealed nursing staff was to be present with the residents while the residents took their medications. The DON stated the residents needed to be monitored with their medications to ensure the residents were not pocketing the medications and administering to themselves later. She stated she wanted to know that the staff were following the physician orders and ensured the residents were receiving a therapeutic effect from the medication. The DON stated if a resident refused to take medication at the time allotted, the nurse should take the medication back to the medication cart and secure and lock it.	F 431			
F 441 SS=D	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	F 441	F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 9/24/2015 resident #13 was placed in contact precautions. The DNS and ADNS were educated on 9/25/15 by the Nurse Consultant on isolation precautions per the CDC guidelines, facility Infections-Clinical Protocol Policy and the Contact Precautions Fact Sheet.		

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F 441	<p>Continued From page 16</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</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, record review and review of the facility's policy, it was determined the facility failed to follow Infection Control Standard of Practice for one (1) of twenty one (21) sampled residents (Resident #13). The facility staff failed to place Resident #13 in contact isolation precautions for an active MRSA infection.</p> <p>The findings include:</p>	F 441	<p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Any resident has the potential to be affected by the alleged deficient practice. The DNS and ADNS reviewed all other residents were to identify any other residents requiring precautions on 9/25/2015, with no other residents being identified.</b></p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p>All nurses are being educated by the DNS and ADNS on isolation precautions per the CDC guidelines, facility Infections-Clinical Protocol Policy and the Contact Precautions Fact Sheet by 10/30/2015.</p>		



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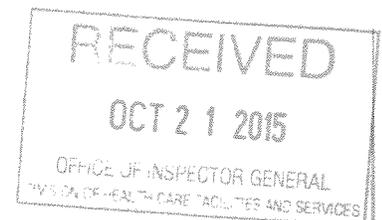
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F 441	<p>Continued From page 17</p> <p>Review of the facility's Infections-Clinical Protocol Policy, dated 12/01/14, revealed the facility was to provide supportive measures as needed and wear an isolation gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment for residents in contact precautions. In addition, in regards to monitoring/compliance portion of the policy, the facility was to monitor the progress of a resident with an infection until it would resolved. The nursing staff was to communicate with the physician on the status of the infection and resident, the physician would help the staff identify complications such as abscess, sepsis and delirium. If the resident had been receiving parenteral antibiotics, the physician would consider a switch to oral antibiotics once the individual had been without a fever and without symptoms for at least 48 hours, or would justify continued parenteral antibiotics.</p> <p>Review of the Contact Precautions Fact Sheet, dated July 2009, revealed Contact Precautions were intended to prevent transmission of infectious agents, including epidemiologically important microorganisms (e.g. multi-drug resistant organisms or MDRO's), which are spread by direct and/or indirect contact with the resident or the resident's environment. Personal Protective Equipment (PPE) meant healthcare personnel caring for residents on Contact Isolation Precautions should wear an isolation gown and gloves for all interactions that would involve contact with the resident or potentially contaminated areas in the resident's environment. Donning PPE upon room entry and discarding before exiting the resident room would be done to contain pathogens, especially those</p>	F 441	<p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>The Interdisciplinary team will audit all new admissions, readmissions and orders for MRDO infections to determine appropriate precautions were in place 7 days per week x 2 weeks then 5 times per week x 4 weeks with results reported in monthly QAPI meetings.</p> <p>Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken, and determine the continued time schedule for further audits. The QAPI committee will meet monthly and the Executive Director will direct any changes.</p> <p><b>Completion date – 10/30/2015</b></p>		

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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  09/24/2015
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 18</p> <p>that had been implicated in the transmission through environmental contamination. Resident Care Items and Equipment meant resident's care items would preferably remain in the contact isolation room for use on that resident only. Room Set Up meant isolation supplies would be located just outside the door to the resident's room, trash and linen containers would be near the door inside the room and the containers lined with a plastic liner and closed or tied prior to removing them from the room. The reference for this policy was the Center for Disease Control (CDC).</p> <p>Review of the clinical record, revealed the facility admitted Resident #13 on 05/16/15 with diagnoses of history of Skin Infections, and Infectious Disease of the Nares,</p> <p>Review of the Discharge Instruction Notes from another facility, dated 09/15/15, revealed Resident #13 had tested positive for Methicillin Resistant Staphylococcus Aureus (MRSA) Bacteremia (in the bloodstream) from a blood culture, which required treatment of intravenous (IV) Vancomycin (antibiotic) for a total of fourteen (14) days.</p> <p>Review of Resident #13's Minimum Data Set (MDS) Assessment, dated 08/25/15, revealed the facility assessed the resident with an active diagnosis of Heart Failure with shortness of breath while sitting at rest and on exertion. In addition the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of a 15, meaning Resident #13 was interviewable.</p> <p>Observation, on 09/22/15 at 1:45 PM, of Resident #13's room revealed no contact isolation precaution sign on or near the door, no visible</p>	F 441			



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

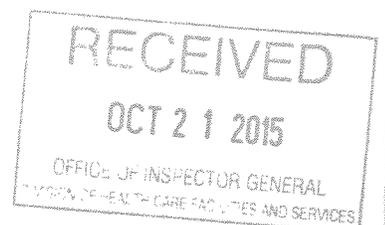
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F 441	<p>Continued From page 19</p> <p>PPE and no waste receptacles. The resident was in their room abed.</p> <p>Observation, on 09/22/15 at 2:40 PM, of Resident #13's room revealed the facility staff members were entering the room with gloves on; exiting the room the staff members would remove their gloves and used either alcohol from the dispenser on the wall or washed their hands at the sink in the room.</p> <p>Observation, on 09/23/15 at 8:40 AM, of Resident #13's room revealed a staff member entered the room with no gloves, delivered a tray and assisted with the tray items, washed their hands and exited the room.</p> <p>Observation during medication pass, on 09/23/15 at 11:35 AM, revealed LPN #7 entered Resident #13's room to administer intravenous (IV) Vancomycin via a Peripherally Inserted Central Catheter (PICC) to the resident. LPN #7 completed hand hygiene and donned gloves, no other PPE was donned. After administering the IV Vancomycin antibiotic, the gloves were removed and hand hygiene performed. The syringes used for flushing the lines were placed in the sharps container.</p> <p>Observation, on 09/23/15 at 12:21 PM, of Resident #13's room revealed a staff member entered the room to assist Resident #13's roommate with no PPE on; however, hand hygiene was performed.</p> <p>Interview with Resident #13, on 09/24/15 at 2:45 PM, revealed the resident was aware of the type of blood infection and why he/she was placed in contact isolation precautions and it was explained</p>	F 441			

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F 441	<p>Continued From page 20 to him/her at the hospital.</p> <p>Interview with the Unit Manager, on 09/23/15 at 3:35 PM, revealed Resident #13 should have been placed in contact isolation precautions according to the facility's protocol.</p> <p>Telephone interview with LPN #4, on 09/24/15 at 10:00 AM, who admitted Resident #13 revealed a resident with active MRSA being treated would be placed in contact isolation precautions, but could not recall why Resident #13 had not been. However, she was only responsible for the physician orders that night and not the full admission on Resident #13.</p> <p>Interview with LPN #3, on 09/23/15 at 3:45 PM, revealed a resident with active MRSA should be in contact isolation precautions with PPE on the door, a sign on the door and waste receptacles by the door for PPE when staff left the room.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, on 09/23/15 at 3:55 PM, revealed she would want to know if she was taking care of a resident who had an infection that required contact isolation precautions. She continued to state she was trained on isolation precautions and PPE and stated Resident #13 should be in contact isolation precautions, if the organism was MRSA, according to her infection control training. CNA #2 stated the importance of knowing which residents had an active infection helped reduce the spread of the infections.</p> <p>Interview with the ADON, on 09/24/15 at 8:45 AM, revealed the process when a resident comes to the facility with an active infection they were to review the Discharge Summary for the type of</p>	F 441			



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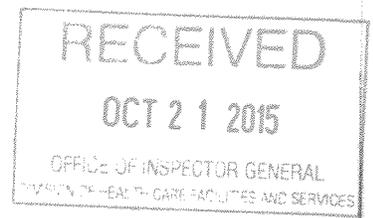
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F 441	Continued From page 21 infection, then review and discuss this in the early morning stand-up meeting with the interdisciplinary team, regarding what would need to be put in place for the resident based on the type of infection. She could not recall why this process had not occurred for Resident #13.  Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), on 09/23/15 at 4:05 PM, revealed the DON received the Discharge Instructions Summary for Resident #13 and reviewed them. She continued to say as Nursing Administration she reviews all resident Discharge Summaries upon returning from the hospital. Although the ADON had the role of Infectious Preventionists, the ADON and DON had concluded the DON made the decision to not place Resident #13 in contact isolation precautions; however, during this interview she had realized Resident #13 should have been placed in contact isolation precautions. The ADON and DON both stated by not following the proper infection control protocols, infections could spread and place others at risk.	F 441			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514	F 514 RES RECORDS - COMPLETE/ACCURATE/ACCESSIBLE  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The order for daily weights was discontinued on 9/23/2015 on Resident #13.		

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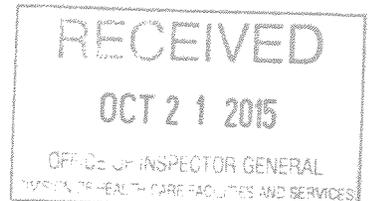
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F 514	<p>Continued From page 22 preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review it was determined the facility failed to ensure an accurate clinical record for one (1) of twenty-one (21) sampled residents, (Resident #13). The nursing staff failed to ensure weights were obtained for Resident #13 prior to documenting on the Medication Administration Record (MAR) that had been completed.</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding the accuracy of the clinical record.</p> <p>Review of the Weight Monitoring Policy, dated 02/12/15, revealed weights were to be recorded by the Nursing Department.</p> <p>Review of the clinical record for Resident #13, revealed the facility admitted the resident on 05/16/15 with diagnoses of Depressive Disorder, Toxic Liver Disease, Insomnia, Dysphagia, Cirrhosis of the Liver, Hypokalemia and Schizophrenia.</p> <p>Review of Resident #13's Medication Administration Record (MAR), for the September 2015 orders, revealed an order for a daily weight every morning to monitor the resident's Congestive Heart Failure, if the weight went up</p>	F 514	<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Any residents have the potential to be affected by the alleged deficient practice. The DNS and ADNS performed audit on 9/25/2015 to validate accurate medical records specifically for daily weighs.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All nurses are being educated by the DNS and ADNS on the requirement to maintain an accurate medical record including documenting weights in the medical record on the Medication Administration Record by 10/30/2015.</p>		



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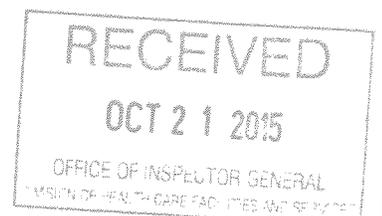
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F 514	<p>Continued From page 23 more than three (3) pounds in one day or five (5) pounds in one week the staff was to contact the physician.</p> <p>Review of Resident #13's Medication Administration Record (MAR), revealed a check mark had been placed inside the box for each date corresponding to the order. Continued review for the dates of 09/16/15 through 09/23/15, revealed a check mark was placed on all the dates except 09/20/15.</p> <p>Review of the Weights and Vitals Summary, dated 09/24/15, revealed weights were done for 09/17/15 and 09/19/15. No weight was found in the clinical record for the dates of 09/16/15, 09/18/15, 09/21/15, 09/22/15 and 09/23/15. The daily weight was discontinued on 09/23/15.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, on 09/24/15 at 11:00 AM, revealed the nurses were responsible for updating orders as they are recieved, along with the care-plan.</p> <p>Interview with Certified Nursing Assistant (CNA) #5, on 09/24/15 at 1:30 PM, revealed the nurses give the CNA's a list of weights weekly to be obtained. When the list is completed the CNA's turn them back in to the nurses or manager to be documented in the computer.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 09/24/15 at 1:40 PM, revealed if the MAR box was marked with a check; the weight should have been obtained by the Nursing Department and documented by a nurse.</p> <p>Interview with the Director of Nursing (DON), on 09/24/15 at 8:45 AM, revealed a daily weight for</p>	F 514	<p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>The DNS, ADON, or Unit Managers will complete audits of the Medication Administration Record daily x 2 weeks, then 5 days a week for four weeks, then biweekly for four weeks, and then monthly for four months. The DNS will bring audit results to monthly QAPI meetings.</p> <p>Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken, and determine the continued time schedule for further audits.</p> <p>The QAPI committee will meet monthly and the Executive Director will direct any changes.</p> <p><b>Completion date – 10/30/2015</b></p>		



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F 514	Continued From page 24 Resident #13 should have been completed and if not, there should not be a check mark on the Medication Administration Record (MAR) for that corresponding day. In addition, the DON stated a check mark in the box on the (MAR) meant the nurse was saying the weight had been obtained and documented in the resident's clinical record.	F 514			



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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - MT HOLLY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>446 MT. HOLLY AVE</b> <b>LOUISVILLE, KY 40206</b>	
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{K 000}	INITIAL COMMENTS  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/31/15 as alleged.	{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.

**Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

<b>(Y1) Provider / Supplier / CLIA / Identification Number</b> 185176	<b>(Y2) Multiple Construction</b> A. Building <b>01 - MAIN BUILDING 01</b> B. Wing	<b>(Y3) Date of Revisit</b> 10/31/2015
--------------------------------------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------

<b>Name of Facility</b> GOLDEN LIVINGCENTER - MT HOLLY	<b>Street Address, City, State, Zip Code</b> 446 MT. HOLLY AVE LOUISVILLE, KY 40206
-----------------------------------------------------------	-------------------------------------------------------------------------------------------

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # <b>NFPA 101</b> LSC <b>K0046</b>	Correction Completed <b>10/30/2015</b>	ID Prefix _____ Reg. # <b>NFPA 101</b> LSC <b>K0147</b>	Correction Completed <b>10/31/2015</b>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <i>my</i>	Reviewed By <i>lt</i>	Date: <i>11/02/15</i>	Signature of Surveyor: <i>Melie Z...</i>	Date: <i>11/2/15</i>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 9/22/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <b>YES</b> <b>NO</b>
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K 000	INITIAL COMMENTS	K 000	
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CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1964

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One (1) floor and a partial basement, Type III Unprotected Construction.

SMOKE COMPARTMENTS: Seven (7) smoke compartments on the Ground Floor.

FIRE ALARM: Complete fire alarm system with smoke detectors.

SPRINKLER SYSTEM: Complete automatic dry sprinkler system.

GENERATOR: Type II 18.5 KW generator. Fuel source is natural gas.

A Recertification Life Safety Code Survey was conducted on 09/22/15. The facility was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *X [Signature]* TITLE: *X Executive Director* (X6) DATE: *10/21/15*

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.

RECEIVED  
OCT 21 2015  
OFFICE OF INSPECTOR GENERAL  
DEPARTMENT OF HEALTH & HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	Continued From page 1	K 000			
K 046 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to maintain emergency lighting in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the seven (7) smoke compartments, all residents, staff and visitors. The facility has one-hundred and ten (110) certified beds and the census was one-hundred and three (103) on the day of the survey.</p> <p>The findings include:</p> <p>Review of the battery-powered emergency lighting records, on 09/22/15 at 2:04 PM, with the Executive Director and the Director of Maintenance revealed the facility had been conducting thirty (30) second monthly testing, but was not documenting that the testing had been performed. The facility was not conducting and documenting the annual ninety (90) minute test required for battery-powered emergency lighting.</p> <p>Interview, on 09/22/15 at 2:06 PM, with the Executive Director and the Director of Maintenance confirmed the facility was conducting thirty (30) second monthly testing of</p>	K 046	<p><b>K 046 LIFE SAFETY CODE STANDARDS</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> On 9/23/2015 the emergency annual ninety minute test for battery-powered emergency lighting was conducted and documented.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> Any residents have the potential to be affected by the alleged deficient practice.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> The Executive Director educated the facility Maintenance director on the requirement to perform annual 90 minute test for battery-powered emergency lighting and a functional test conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds and documented.</p>		

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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  09/22/2015
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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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K 046	<p>Continued From page 2</p> <p>battery-powered emergency lighting, but was not aware that documentation was required to be recorded. They were not aware that conducting and documenting the ninety (90) minute test was required for battery-powered emergency lighting.</p> <p>The census of one-hundred and three (103) was verified by the Executive Director on 09/22/15. The survey findings were acknowledged by the Executive Director and verified by the Director of Maintenance at the exit interview on 09/22/15.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 11/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational</p>	K 046	<p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The Executive Director or designee will audit monthly x 3 months to ensure the testing and documentation has been performed and recorded. Results of the audits will be forwarded to the QAPI meeting. Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken, and determine the continued time schedule for further audits.</p> <p>Completion date – 10/30/2015</p>	
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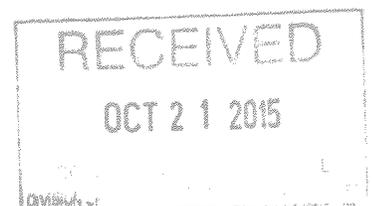
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  09/22/2015
NAME OF PROVIDER OR SUPPLIER  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 046	Continued From page 3 for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
K 147 SS=D	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, it was determined the facility failed to ensure electrical wiring was maintained in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff, and visitors. The facility has one-hundred and ten (110) certified beds and the census was one-hundred and three (103) on the day of the survey.  The findings include:  Observation, on 09/22/15 at 10:08 AM, with the Executive Director and the Director of	K 147	<b>K 147 NFPA 101 LIFE SAFETY CODE STANDARDS</b>  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The power strip was immediately removed from the activity department office on 9/22/2015.  How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Any residents have the potential to be affected by the alleged deficient practice. A full building inspection for any additional power strips was performed, and no additional power strips were found.	

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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	<p>Continued From page 4</p> <p>Maintenance revealed a small refrigerator, a microwave oven, a coffee maker and a portable fan were plugged into a power strip located within the Activities Room Office.</p> <p>Interview, on 09/22/15 at 10:10 AM, with the Executive Director and the Director of Maintenance revealed they were aware of power strips being prohibited for use with cooking appliances, but were not aware of the misuse of a power strip within the Activities Room Office.</p> <p>The census of one-hundred and three (103) was verified by the Executive Director on 09/22/15. The findings were acknowledged by the Executive Director and verified by the Director of Maintenance at the exit interview on 09/22/15.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>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.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p>	K 147	<p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> The staff is being educated on not using power strips in the facility, rather so to contact Maintenance Director for additional receptacles to be installed.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> The Maintenance Director will perform weekly rounds to inspect the facility for power cords x 4 weeks, then every other week x 4 weeks. The results of the audits will be forwarded to the QAPI committee monthly. Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken, and determine the continued time schedule for further audits.</p> <p><b>Completion date – 10/31/2015</b></p>	



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