

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

PRINTED: 11/08/2013
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 R 11/08/2013
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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
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{F 000} INITIAL COMMENTS

An offsite revisit was conducted and based on the acceptable POC the facility was deemed to be in compliance as alleged on 10/28/13.

{F 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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 000 INITIAL COMMENTS

F 000: This Plan of Correction is the center's credible allegation of Compliance.

A Standard Re-Licensure / Re-certification Survey was initiated on 10/01/13 and concluded on 10/04/13. No substandard quality of care was identified; however, deficient practice was identified and cited with the highest Scope and Severity of an "E".

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

F 371 483.35(i) FOOD PROCURE, SS=E STORE/PREPARE/SERVE - SANITARY

F 371

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

F 371 E Corrective Actions for Targeted Residents:

No residents were affected by this alleged deficient practice

Identification of Other Residents with Potential to Be Affected:

All residents on north hall had the potential to be affected by this alleged deficient practice.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and review of facility policy, it was determined the facility failed to ensure food was stored, distributed and served to prevent the outbreak of food borne illness. Observation of the refrigerator in the North Unit medication room revealed pudding was held for use during the medication pass. No date indicating when the pudding was delivered or when it would expire was present on the container or the covering.

Systemic Changes:

- 1) Food products delivered to nursing for use with medication pass, snacks, or stored in the nourishment refrigerator for later use by nursing staff will be labeled and dated prior to leaving the Dietary Department.
- 2) An in-service will be completed by the Dietary Manager to dietary staff and to other staff by the Director of Clinical Education and a return demonstration of correct procedure will be required. The in-service will include but will not be limited to dating of food as it comes out of the Dietary Department and to the nursing staff not to receive food that is not dated.

The findings include:

Review of the policy titled "Nourishments", undated, revealed all items sent from the dietary

RECEIVED
OCT 28 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Yvonne L. ...</i>	TITLE Executive Director	(X6) DATE 10/28/2013
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F 371 Continued From page 1
department should be labeled and dated, including items sent to be used for the medication pass.

Observation of the refrigerator located in the North Unit medication room, on 10/03/13 at 9:15 AM, revealed pudding was stored in a bowl with a plastic wrap covering. Continued observation revealed neither the bowl nor the plastic wrap had been dated to indicate when the pudding was delivered or when it would expire.

Interview with Licensed Practical Nurse (LPN) #4, on 10/03/13 at the time of the observation, revealed food items in the refrigerator were used to facilitate ease of swallowing during the medication pass. She stated new items were brought to the medication room from the kitchen each morning. LPN #4 confirmed the pudding was not dated. She stated all items were generally used up each day. She further stated the pudding probably was delivered earlier that morning, but she could not know for sure.

Continued interview revealed the pudding did not appear to have been used because the bowl remained tightly wrapped. LPN #4 acknowledged there was no way to know how long the pudding had been in the refrigerator.

Interview with the Charge Nurse for the North Unit, on 10/013/13 at 11:05 AM, revealed food items in the medication room refrigerator were used during the medication pass. She stated new items were delivered every shift and unused items were supposed to be discarded at the time of delivery. She further stated all items should be dated when they leave the kitchen. Continued interview revealed without a date, it could not be known with certainty when the item was placed in

F 371 Monitoring:
1) Random audits of nursing med pass, med refrigerators, and nourishment room refrigerator will be performed by the Director of Nursing, Assistant Director of Nursing, Director of Clinical Education and the Dietary Services Manager or designee to ensure items are labeled and dated. These audits will be conducted bi-weekly x4 weeks, then weekly x4, and monthly for 3 months. If no further issues audits will be discontinued and regular monitoring by QAPI will be completed. The QAPI Committee Members are, but are not limited to, Executive Director, Medical Director, Director of Nursing, Assistant Director of Nursing, Director of Clinical Education, MDS Coordinator, Social Worker, Director of Activities, Director of Maintenance

Corrected Date:
October 28, 2013

1028203

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 371 Continued From page 2
the refrigerator or when it expired.

F 371

Interview with the Dining Services Manager, on 10/013/13 at 4:15 PM, revealed food items for delivery to the medication rooms were assembled on a tray for each unit three (3) times a day. He stated the tray was dated but individual items were not. He further stated the nurse should discard any unused items every day.

Interview with the Administrator, on 10/3/13 at 4:30 PM, revealed she had been made aware of the unlabeled pudding in the medication room refrigerator. She stated she did not believe the pudding was outdated but the container should have been labeled. She further stated everything that comes out of the kitchen should be dated.

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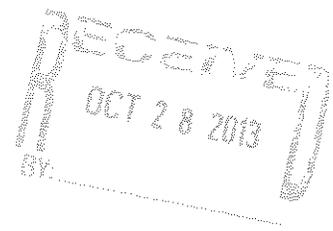
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185257	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-GREEN HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 213 INDUSTRIAL ROAD GREENSBURG, KY 42743
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1979 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111(000) SMOKE COMPARTMENTS: Nine smoke compartments FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system. GENERATOR: Type II generator. Fuel source is diesel. A life safety code survey was initiated and concluded on 10/02/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD SS=F	K 062		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Vicki Trump* TITLE: *Executive Director* (X6) DATE: *10/28/2013*

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K 062 Continued From page 1
Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5

K 062

This Plan of Correction is the center's credible allegation of Compliance.

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

K 062
Corrective Actions for Targeted Residents:

No residents were identified by being affected by this alleged deficient practice

Identification of Other Residents with Potential to Be Affected:

72 Residents on south hall had the potential to be affected by this alleged deficient practice.

Systemic Changes:

1) The facility will have B and B Fire protection replace 63 brass vertical sidewall sprinklers (1/2" x 165 deg), 4 brass upright sprinklers (1/2 x 165 deg), 17 chrome dry pendent sprinklers (1/2' 165 deg) and 2 brass upright sprinklers (1/2' x 200 deg).

This STANDARD is not met as evidenced by:
Based on observation and interview the facility failed to ensure that sprinkler heads were maintained as required. This deficient practice affected seven (7) of nine (9) smoke compartments, staff and approximately seventy two (72) residents. The facility has the capacity for 118 beds with a census of 94 the day of survey.

The findings include:

During the Life Safety Code survey on 10/02/13 at 09:10 AM with the Director of Maintenance (DOM), Mismatched temperature rated sprinkler heads were observed in resident room 120. This condition may affect the way the sprinkler system reacts in a fire situation.
An interview with the DOM on 10/02/13 at 09:10 AM revealed he was not aware sprinkler heads should have the same rating per compartment. During the survey mismatched temperature rate sprinkler heads were observed throughout the facility.

The findings were revealed to the Administrator on exit.

Reference: NFPA 13 1999 edition

5-3.1.5.2

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K 062 Continued From page 2
When existing light hazard systems are converted to use quick-response or residential sprinklers, all sprinklers in a compartmented space shall be changed.

K 062 Monitoring:
1) Our Contractor B&B Fire Protection will completed a quarterly review of our sprinkler system. Any issues will be submitted to the QAP: Committee for follow up. If needed. The QA Committee consists of , but is not limited to the Executive Director, Medical Director, Director of Nursing, Assistant Director of Nursing, Director of Clinical Education, Social Worker, Activities, Director of Maintenance, MDS Coordinator, Dietary Manager, and Pharmacist

Corrected Date:
November 18, 2013

11-18-2013