

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

PRINTED: 12/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/09/2015
NAME OF PROVIDER OR SUPPLIER THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
(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 Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 12/09/15 as alleged.	{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.

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.

(Y1) Provider / Supplier / CLIA / Identification Number 185268	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 12/9/2015
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Name of Facility THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN	Street Address, City, State, Zip Code 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299
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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 F0441 Reg. # 483.65 LSC _____	Correction Completed 12/09/2015	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
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <i>mmj</i>	Reviewed By <i>KT</i>	Date: <i>01/06/16</i>	Signature of Surveyor: <i>Millie Zimatore</i>	Date: <i>01/06/16</i>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 11/19/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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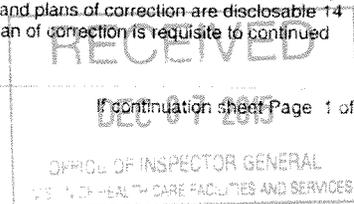
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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 11/16/15 and concluded on 11/19/15 with deficiencies cited at the highest scope and severity of a "D".	F 000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
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 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	Hand hygiene requirements were reviewed with RN #1 on 11/20/2015 by Director of Nursing. RN #1 verbalized and demonstrated appropriate Hand Hygiene during Medication Administration. All residents have the potential to be affected by this deficiency All licensed nurses will receive re-education by DON or Staff Development Coordinator on hand washing requirements during medication administration per GSS policy and Procedure by Dec 08, 2015 or prior to next shift worked. Hand washing policy and procedure will be reviewed during Nursing Staff Meeting December 8, 2015	12/09/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 11/20/15

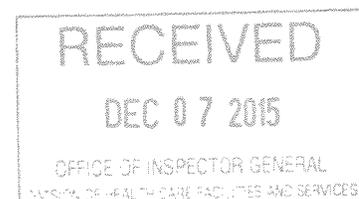
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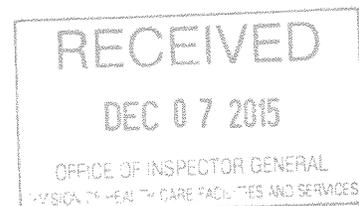
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F 441	<p>Continued From page 1</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews, record reviews and facility policy review, it was determined the facility failed to ensure the staff followed infection control practices for two (2) of two (2) unsampled residents, (Unsampled Residents A and B). RN #1 failed to complete hand hygiene between medication administration for Unsampled Residents A and B.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure regarding Medication Administration and Scheduling, revised September 2015, page 4, revealed the procedure outlined hand washing during medication administration which stated hands should be washed before passing medications; between residents during medication pass; and, when appropriate gloves should be worn.</p> <p>Observation of RN #1, on 11/17/15 at 9:45 AM, during medication administration revealed the RN did not perform hand hygiene between Unsampled Resident A and B. In addition, the RN removed a medication from a blisterpack with his bare hands and administered the medication to Unsampled Resident A. The RN proceeded to</p>	F 441	<p>Continued From Page 1</p> <p>Medication pass audits for proper hand hygiene techniques will be completed by the DON or Staff Development Coordinator on each shift one time /week X 4 weeks, then on each shift 2 times/month X 2 months, then on each shift 1 time/month X 3 month. Audit results will be submitted to Quality Committee for review and further recommendations.</p>		



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F 441	<p>Continued From page 2</p> <p>prepare and administer medications to Unsampld Resident B without performing hand hygiene. Further observation revealed, the RN then proceeded to administer eye drops, Refresh 0.5 %, 1 drop in each eye of Unsampld Resident B without washing or sanitizing his hands, or utilizing gloves.</p> <p>Interview with RN #1, on 11/18/15 at 3:03 PM, 3:11 PM, and 3:20 PM, revealed the RN stated it was necessary to wash his hands before and after administering medications to residents. He was also stated gloves should be worn when administering eye drops to a resident. RN #1 stated without using effective hand hygiene infections could be spread. RN #1 stated he had received a medication administration in-service during orientation. Furthermore, RN #1 pointed out a hand washing procedure posted on the wall behind the nurses station.</p> <p>Observation, on 11/18/15 at 3:20 PM, of the medication pass procedure posted on the wall behind the nurses station revealed item number one (1) stated hands were to be washed prior to med pass and following administration of medications to residents.</p> <p>Interview with the Director of Nursing (DON), on 11/19/15 at 9:52 AM, revealed all staff were educated via computer modules on infection control, and hand washing was a sub-module required as part of orientation. The DON stated hand washing was required before and after every patient contact to avoid infections.</p>	F 441			



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{K 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 12/19/15 as alleged.</p>	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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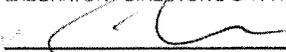
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1980</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story with a partial basement, Type III unprotected.</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet / dry) sprinkler system.</p> <p>GENERATOR: Two (2) Type II generators; one (1) 60 KW generator and one (1) new 150 KW, installed in 2014. Fuel source is diesel in both.</p> <p>A Recertification Life Safety Code Survey, utilizing the 2786S short form, was conducted on 11/17/15. The facility was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p>	

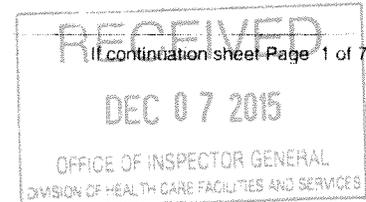
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(X6) DATE

 Administrator 11/17/15

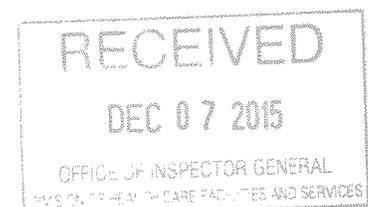
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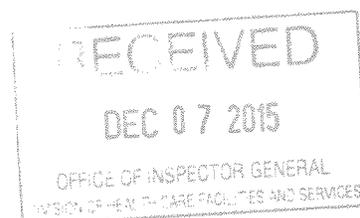
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K 000	Continued From page 1	K 000			
K 045 SS=E	<p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with emergency lighting in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, residents, staff and visitors. The facility has ninety-eight (98) certified beds and the census was seventy-nine (79) on the day of the survey. The facility failed to provide the required level of illumination outside three (3) exits for discharge from the new building addition.</p> <p>The findings include:</p> <p>1. Observation, on 11/17/15 at 12:01 PM, with the Maintenance Director revealed the secondary exit from the new Rehab addition, to the exterior of the building, did not have exterior egress lighting to provide the required level of illumination at the exit discharge. The exit was equipped with a light fixture containing only one bulb.</p>	K 045	<p>The required level of illumination outside of the identified three (3) exits for discharge from the new building addition will be equipped with an LED 12 diode light fixture. These 12 diodes (bulbs) are independent of one another, allowing continued lighting should a diode fail. This will exceed code requirement. The Environmental Services Director will ensure that the LED light fixture is in place by 12/11/2015.</p> <p>The maintenance department will inspect all means of egress by 12/11/2015 to ensure that illumination is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness.</p> <p>Any diode that malfunctions will be replaced by the maintenance department to ensure continued lighting.</p> <p>The maintenance department will inspect egress lighting weekly for one year to ensure the lights are in continued working condition.</p>	12/12/15	



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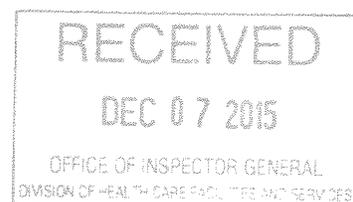
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K 045	<p>Continued From page 2</p> <p>Interview, on 11/17/15 at 12:03 PM, with the Maintenance Director revealed he was not aware of the secondary exit from the Rehab addition, to the exterior of the building, having an egress light fixture containing only one (1) bulb.</p> <p>2. Observation, on 11/17/15 at 12:14 PM, with the Maintenance Director revealed the exit from the Post-Acute Dining Room addition, to the exterior of the building, did not have exterior egress lighting to provide the required level of illumination at the exit discharge. The exit was equipped with a light fixture containing only one bulb.</p> <p>Interview, on 11/17/15 at 12:16 PM, with the Maintenance Director revealed he was not aware of the exit from the Post-Acute Dining Room addition, to the exterior of the building, having an egress light fixture containing only one (1) bulb.</p> <p>3. Observation, on 11/17/15 at 12:19 PM, with the Maintenance Director revealed the exit from the Waiting Room in the new addition, to the exterior of the building, did not have exterior egress lighting to provide the required level of illumination at the exit discharge. The exit was equipped with a light fixture containing only one bulb.</p> <p>Interview, on 11/17/15 at 12:21 PM, with the Maintenance Director revealed he was not aware of the exit from the Waiting Room in the new addition, to the exterior of the building, having an egress light fixture containing only one (1) bulb.</p> <p>The census of seventy-nine (79) was verified by the Administrator on 11/17/15. The findings were</p>	K 045	<p>Continued From page 2</p> <p>The Environmental Services Director will report the inspection outcomes to the Quality Committee for review and further recommendation.</p>	



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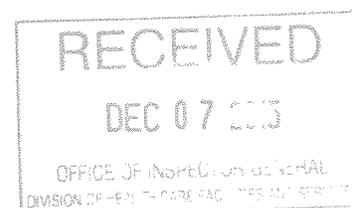
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K 045	<p>Continued From page 3 acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 11/17/15.</p> <p>Reference NFPA 101 (2000 edition)</p> <p>19.2.8 Illumination of Means of Egress.</p> <p>Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is</p>	K 045			



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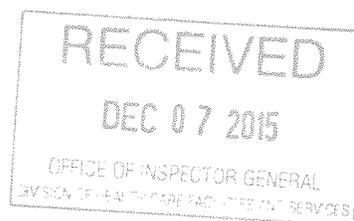
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2015
NAME OF PROVIDER OR SUPPLIER THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
(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 045	Continued From page 4 activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level	K 045			
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the new	K 144	The Annunciator for the new generator will be relocated from the electrical room to the nursing office by Payne Electric Company no later than 12/18/2015. There are no other areas of deficient practice relating to emergency generator annunciator requirements. The Environmental Services Director will report the completed work to the Quality Committee for review and further recommendation as appropriate.	12/19/15	



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K 144	<p>Continued From page 5</p> <p>emergency generator was installed and monitored in accordance with National Fire Protection (NFPA) standards. The deficiency had the potential to affect two (2) of the nine (9) smoke compartments, residents, staff, and visitors. The facility has ninety-eight (98) certified beds and the census was seventy-nine (79) on the day of the survey. The new emergency generator was installed to provide emergency power to the Rehab addition and the existing B Hall.</p> <p>The findings include:</p> <p>Observation, on 11/17/15 at 1:17 PM, with the Maintenance Director revealed the annunciator panel for the new emergency generator was located in the Electrical Room within the new Rehab addition and was not located in an area that was continuously monitored by Staff, to ensure the generator was functioning properly at all times.</p> <p>Interview, on 11/17/15 at 1:19 PM, with the Maintenance Director revealed he was not aware of the remote annunciator panel for the new emergency generator being installed in the Electrical Room and acknowledged it could not be continuously monitored by Staff, during all three (3) shifts working in the facility.</p> <p>The census of seventy-nine (79) was verified by the Administrator on 11/17/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 11/17/15.</p>	K 144		



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K 144	Continued From page 6 Reference: NFPA 99 (1999 Edition). 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]	K 144			

