

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

PRINTED: 08/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	Division of Health Care Enforcement Southern Enforcement Branch	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>A standard health survey was conducted on 07/21-23/15. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>An abbreviated standard survey (KY23563) was also conducted at this time. The complaint was substantiated with deficient practice identified.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</p> <p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>	<p><i>This Plan of Correction is the provider's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>F-225</p> <p><u>1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?</u></p> <p>Resident A - was monitored at the facility. Internal investigation was completed and interviews with resident A's spouse. Resident A discharged from the facility in stable condition with spouse on 5/5/2015. Reported to OIG on 7/24/2015.</p> <p><u>2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken?</u></p> <p>All residents residing in the facility have the potential to be affected.</p> <p><u>3. What action did the provider take to assure that the alleged deficient practice does not recur?</u></p> <p>In services related to abuse/neglect, and reporting procedures will be given to the staff and administration on 8/20/2015. The Executive Director will ensure that all allegations are reported according to state regulations and reported within the 24 hour time frame. All investigations will be reported to state agencies by the Director of Nursing or designee in the absence of the Executive Director.</p> <p><u>4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?</u></p> <p>All allegations of abuse/neglect will be reviewed to ensure that all allegations have been reported to state agencies as needed to include follow up with resolution during the monthly Quality Assurance Process Improvement Meeting.</p> <p>Expected date of completion: 8/28/2015</p>		

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

R. M. [Signature]

TITLE

Administrator

(X8) DATE

8/14/15

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.

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F 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the incident, interview, record review, and review of the facility policy it was determined the facility failed to report allegations of abuse to the state survey agency for one (1) unsampled resident (Resident A). On 04/17/15, Resident A was noted to be very lethargic and difficult to arouse after a visit from his/her spouse and was unable to participate in physical therapy. A Urine Drug Screen collected on 04/18/15 was positive for high levels of benzodiazepines; however, Resident A was not prescribed benzodiazepines. The facility investigated the incident and suspected Resident A's spouse gave the resident medication that was not prescribed for the resident. The facility failed to report the alleged abuse to the state survey agency as required.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Reporting Alleged Abuse Violation," (not dated) revealed it was the policy of the facility to take appropriate steps to prevent the occurrence of abuse, neglect, and misappropriation of resident property. Any employee who suspected an alleged violation was to immediately notify the Administrator or</p>	F 225		

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F 225	<p>Continued From page 2</p> <p>designee. Furthermore, the Administrator notified the appropriate state agency in accordance with state law. The policy further stated if a family member, visitor, or friend was responsible for the alleged incident, they would not be allowed to visit the resident until the investigation was completed. The results of the investigation would determine the future contact with the resident.</p> <p>Record review of Resident A revealed the facility admitted the resident on 04/15/15 with diagnoses of Muscle Weakness, Psychosis, Depression, Hypertension, Esophageal Reflux, Arthropathy, Anorexia, History of Falls, and Hip Joint Replacement.</p> <p>Review of a facility investigation revealed on 04/17/15 Resident A was noted to be very lethargic and difficult to arouse after a visit from his/her spouse and was unable to participate in physical therapy. A Urine Drug Screen collected on 04/18/15 was positive for high levels of benzodiazepines. Review of Resident A's medication list indicated no benzodiazepines were ordered upon admission to the facility and were not prescribed while in the facility. The Physician Assistant and Physical Therapist met with the Director of Nursing (DON) to discuss their concerns. On 04/20/15, there was a discussion with the spouse by the Social Services Director and the Administrator about the results of the drug screen that was conducted. The spouse stated that the resident had not been on any type of medication since his/her visit to the Emergency Room while at home. During the conversation, the resident's spouse removed a bottle of medication from his/her pocket and stated it was Ativan and that he/she (the spouse) was on that medication. The spouse denied giving the</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>resident any medication since admission to the facility. It was explained to the spouse that any medications for the resident should be prescribed by the physician while at the facility and provided by the facility pharmacy. Resident A's spouse verbalized understanding and was told the facility would be monitoring the resident for changes in mental status. On 04/24/15, it was noted that Resident A was alert and greeted staff when entering the room and Resident A's spouse was visiting. After the spouse left later in the morning, the resident was noted to be very lethargic and unable to be fed during lunch due to increased lethargy. On 04/28/15, the resident's spouse was visiting again when a Certified Nursing Assistant (CNA) overheard the resident's spouse stating to the resident while holding his/her hand, "I will give you something to make you sleep, but do not tell anybody." The Social Worker was contacted and she suggested supervised visits with the spouse and recommended a referral to Adult Protective Services.</p> <p>Interview with the Social Services Director on 07/23/15 at 8:05 PM revealed that she was present when the Director of Nursing (DON) and the Administrator spoke to the spouse regarding the incident. The Social Services Director stated she thought there were problems in the past with the spouse giving medication to Resident A prior to admission to the facility. The Social Services Director stated she reported any concerns to the Administrator or the DON and then they called and reported to the state agencies.</p> <p>Interview with the Director of Nursing (DON) on 07/23/15 at 8:10 PM revealed that she along with the Administrator reports allegations of abuse to the state survey agency. The DON stated they</p>	F 225			

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F 225	Continued From page 4 called the Department for Community Based Services and discussed the incident, but did not remember if the incident was reported to the state survey agency. Interview with the Administrator on 07/23/15 at 8:38 PM revealed that he reviews all investigations and stated, "This should have been reported." The Administrator stated he talked with Adult Protective Services (APS) about the incident. The Administrator stated he "thought" he faxed and reported the incident to the state survey agency, but stated, "I guess I did not."	F 225			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	<i>This Plan of Correction is the provider's credible allegation of compliance.</i> <i>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.</i> F 279 E 1) <u>1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?</u> Residents #16, #17, #19, #21 Care Plan was reviewed and updated as relates to indwelling catheters to include Risk Factors, Risk for Injury and leg bands/clips used to prevent injury of urinary tract. <u>2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken?</u> All residents have the potential to be affected by this deficient practice. Current residents with indwelling catheters had care plans reviewed/reviced to reflect Risk Factors/Risk for Injury and interventions to include use of leg bands/clips to secure tubing to prevent injury to urinary tract.		

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F 279	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined the facility failed to develop a comprehensive plan of care for four (4) of twenty-four (24) sampled residents (Residents #16, #17, #19, and #21). Residents #16, #17, #19, and #21 were observed to have indwelling urinary catheters; however, review of the residents' comprehensive care plans revealed the facility failed to develop a care plan to include interventions to address risk factors associated with the indwelling urinary catheter to include risk for injury to the urinary tract related to pulling/pressure of the resident's urinary catheter tubing.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON) on 07/02/15 at 3:45 PM revealed the facility did not have a policy related to developing a care plan.</p> <p>1. Review of the medical record for Resident #16 revealed the facility admitted the resident on 11/12/07, with diagnoses that include Neurogenic Bladder, Alzheimer's Disease, History of Urinary Tract Infection, Depressive Disorder, and Dementia.</p> <p>Review of the physician's orders for Resident #16 revealed a physician's order dated 12/21/12, for the resident to have an indwelling urinary catheter to bedside drainage.</p> <p>Review of an annual Minimum Data Set (MDS) assessment dated 06/26/15 revealed Resident #16 required the use of an indwelling urinary catheter.</p>	F 279	<p><u>3. What action did the provider take to assure that the alleged deficient practice does not recur?</u></p> <p>An In-Service will be conducted on 8/20/15 by the DNS/ADNS/Designee to nursing staff as relates to indwelling catheters to include Risk Factors/Risk for Injury/Leg band/clip to secure tubing to prevent injury.</p> <p>Charge nurses will monitor daily during rounds to ensure residents with indwelling catheters have leg band/clip to secure tubing to prevent injury.</p> <p>DNS/ADNS/Designee will monitor daily during rounds to ensure leg bands/clips are used to secure indwelling catheter tubing to prevent injury.</p> <p>IDT will monitor care plans daily to ensure Risk Factors/Risk for Injury and leg bands/clips are on residents care plans with indwelling catheters.</p> <p>IDT will also monitor for new orders/new admissions daily to ensure care plans reflect Risk Factors/Risk for Injury/leg bands/clips for all residents with indwelling catheters.</p> <p><u>4) What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?</u></p> <p>Charge nurses will monitor daily during rounds to ensure residents with indwelling catheters have leg band/clip to secure tubing to prevent injury.</p> <p>DNS/ADNS/Designee will monitor daily during rounds to ensure leg bands/clips are used to secure indwelling catheter tubing to prevent injury.</p> <p>IDT will monitor care plans to ensure Risk Factors/Risk for Injury and leg bands/clips are on residents care plans with indwelling catheters.</p> <p>IDT will also monitor for new orders/new admissions to ensure care plans reflect Risk Factors/Risk for Injury/leg bands/clips for all residents with indwelling catheters.</p> <p>QA&A committee will review residents monthly with indwelling catheters to ensure documentation supports use of indwelling catheters to include securing tubing to prevent injury. Action Plans will be developed as indicated.</p> <p>Expected date of completion: 8/28/2015</p>		

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F 279	<p>Continued From page 6</p> <p>Review of the comprehensive care plan dated 12/21/12 for Resident #16 revealed the resident had a care plan for an indwelling catheter; however, the care plan did not include interventions to address the risk for injury related to pulling/pressure of the resident's urinary catheter tubing.</p> <p>Observation of Resident #16 on 07/23/15 at 4:55 PM, revealed the resident to be lying on his/her back in bed with the urinary catheter tubing draped over the resident's left leg and the catheter bag secured to the bed. The urinary catheter tubing was not secured to the resident to prevent pulling of the urinary catheter tubing.</p> <p>2. Review of Resident #17's medical record revealed the facility admitted the resident on 11/20/14, with diagnoses that include Neurogenic Bladder, Retention of Urine, Hypertension, Senile Dementia, and Depressive Disorder. Further review of the medical record revealed the Quarterly MDS Assessment dated 06/19/15 revealed Resident #17 required the use of an indwelling urinary catheter.</p> <p>Review of the comprehensive care plan for Resident #17 dated 12/10/14, revealed the resident had a care plan for an indwelling catheter; however, the care plan did not include interventions to address the risk for injury related to pulling/pressure of the resident's urinary catheter tubing.</p> <p>Observation on 07/23/15 at 4:45 PM revealed the urinary catheter bag was anchored to the bed; however, the urinary catheter tubing was not secured to the resident to prevent pulling.</p>	F 279			

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F 279	<p>Continued From page 7</p> <p>3. Review of Resident #19's medical record revealed the facility admitted the resident on 04/30/12, with diagnoses that include Systemic Lupus Erythematosus, History of Urinary Tract Infection, Neurogenic Bladder, Idiopathic Peripheral Neuropathy, Dyspnea, and Psychosis. Further review of the medical record revealed a Quarterly MDS Assessment dated 05/01/15 that assessed Resident #19 to require the use of an indwelling urinary catheter.</p> <p>Review of the comprehensive care plan for Resident #19 dated 08/08/12, revealed the resident had a care plan for an indwelling catheter; however, the care plan did not include interventions to address the risk for injury related to pulling/pressure of the resident's urinary catheter tubing.</p> <p>Observation on 07/23/15 at 4:15 PM revealed the urinary catheter bag was anchored to the bed; however, the urinary catheter tubing was not secured to the resident to prevent trauma/pulling of the catheter tubing.</p> <p>4. Review of the medical record for Resident #21 revealed the facility admitted the resident on 04/06/11, with diagnoses that include Dementia, Depression, and Neurogenic Bladder.</p> <p>Review of the physician's orders for Resident #21 revealed a physician's order dated 04/06/11, for the resident to have an indwelling urinary catheter to bedside drainage.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated 05/15/15 revealed Resident #21 required an indwelling urinary catheter.</p>	F 279			

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F 279	Continued From page 8 Review of the comprehensive care plan for Resident #21 dated 04/08/11, revealed the resident had a care plan for an indwelling catheter; however, the care plan did not include interventions to address the risk for injury related to pulling/pressure of the resident's urinary catheter tubing. Observation of Resident #21 on 07/23/15 at 4:20 PM, revealed the resident was observed to be lying on his/her back in bed with the indwelling urinary catheter tubing draped over the resident's left leg. The indwelling urinary catheter tubing was not secured to the resident to prevent pulling of the catheter tubing. Interview with the Minimum Data Set (MDS) Coordinator on 07/23/15 at 5:40 PM, revealed she was responsible for developing resident care plans. The MDS Coordinator stated the facility did not routinely anchor urinary catheter tubing unless the resident had a specific physician's order for the tubing to be anchored, and had not developed interventions for residents who had indwelling urinary catheters related to securing the catheters to prevent trauma/injury. Interview with the DON on 07/02/15 at 3:45 PM revealed she had not been aware indwelling urinary catheters should be secured to prevent trauma, and therefore care plan interventions had not been developed for the residents to secure the urinary catheter tubing to prevent trauma/injury.	F 279			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281			

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F 281	<p>Continued From page 9</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and review of the facility policy it was determined the facility failed to ensure services provided by the facility met professional standards of quality for one (1) of twenty-four (24) sampled residents (Resident #1). A review of the medical records for Resident #1 revealed the doctor had ordered treatment for excoriation on 05/11/15. Record review revealed the facility failed to assure staff provided services ordered by the physician.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON) on 07/23/15 at 4:00 PM revealed the facility did not have a policy related to following physician orders.</p> <p>Review of the medical record for Resident #1 revealed the facility admitted the resident on 08/27/14 with diagnoses that included Cerebrovascular Disease, Urinary Tract Infection, Type 1 Diabetes, Hyperlipidemia, Dementia with Behavioral Disturbance, Depressive Disorder, Paralysis Agitans, Esophageal Reflux, and Hypertension.</p> <p>Review of the Physician Orders dated 05/11/15 for Resident #1 revealed an order for a foam dressing to be applied to the resident's coccyx for treatment of excoriation three times a week on Monday, Wednesday, and Friday. However, further review of the physician orders revealed</p>	F 281	<p><i>This Plan of Correction is the provider's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>F 281D</p> <p>1) <u>1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?</u></p> <p>Physician order for treatment to coccyx was re-entered on 7/23/15. Treatment was completed by treatment nurse on 7/23/15.</p> <p><u>2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken</u></p> <p>All residents have potential to be affected. Physician orders were reviewed for current residents to ensure accuracy and reflect resident's care needs as relates to treatments to skin concerns. Resident's physician orders were reviewed for accuracy and no concerns were noted. Review of residents with skin concerns indicated treatment orders were active and currently in place. Physician orders were transcribed to medication/treatment administration record.</p> <p><u>3. What action did the provider take to assure that the alleged deficient practice does not recur?</u></p> <p>In-service was conducted on 8/20/15 by DNS/ADNS/Designee to Charge Nurses as relates to physicians orders for treatments. Charge Nurses are responsible for entering physician orders in the computer (PCC). The orders then will be transcribed to the medication/treatment administration record. Residents with skin concerns will have current treatment orders and will be administered by the treatment nurse as per orders. DNS/ADNS/Designee will review new physician orders daily during clinical start up process and ensure all orders to be transcribed to the medication/treatment record for administration.</p> <p><u>4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?</u></p>		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484		
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F 281	Continued From page 10 the order for Resident #1's foam dressing had been entered into the computer and discontinued on 05/11/15 at 8:29 AM by Licensed Practical Nurse (LPN) #4. Further review of Resident #1's medical record revealed no evidence the physician ordered treatment was provided. An interview with LPN #4 could not be obtained. An interview with the Assistant Director of Nursing (ADON) on 07/23/15 at 7:35 AM revealed that when an order was entered in the computer, a stop date was not necessary for a routine order. The ADON stated the order "must have just got missed."	F 281	DNS/ADNS/Designee will monitor new physician orders daily during clinical start to ensure all orders are transcribed into the computer (PCC) accurately to include Skin concerns and orders for treatment. QAA committee will review monthly for concerns as relates to physician orders, transcription, or orders to MAR/TAR records for administration. AP's developed as indicated. Expected date of completion. 8/28/15		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to provide care in accordance with the Comprehensive Plan of Care for one (1) of twenty-four (24) sampled residents (Resident #6). Resident #6's Comprehensive Care Plan contained interventions for an indwelling urinary catheter that included "to secure the tubing appropriately." Observations on 07/22/15 revealed the catheter was attached to a bedside	F 282	This Plan of Correction is the provider'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. F282 D 1) <u>1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?</u> Resident #6- Leg band was placed to secure indwelling Catheter tubing to prevent injury. Care plan was reviewed/revise to reflect Risk Factors/Risk for injury as relates to indwelling catheter tubing. CNA care sheet reviewed/revise for use of leg band/cup to secure indwelling Catheter tubing.		

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F 282	<p>Continued From page 11 drainage bag; however, the tubing was not secured to the resident's leg.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON) on 07/23/15 at 5:50 PM revealed the facility did not have a policy related to following the resident's plan of care.</p> <p>Review of Resident #6's medical record revealed the facility admitted Resident #6 on 06/26/14 with diagnoses of Senile Dementia, Hypertension, Neurogenic Bladder, Anxiety, and Bipolar Disorder. Review of the annual Minimum Data Set (MDS) assessment dated 07/03/15 revealed Resident #6 required the use of an indwelling urinary catheter. Review of the comprehensive care plan dated 07/15/14 revealed catheter care was to be done daily and the catheter and tubing were to be secured appropriately.</p> <p>Observations of Resident #6 on 07/22/15 at 9:52 AM during wound care treatment revealed Resident #6's catheter was attached to a bedside drainage bag; however, the tubing was not secured to the resident's leg.</p> <p>Interview with Registered Nurse #1 revealed she had not identified any problems with staff not following the care plans. She further revealed she did rounds at least every two hours to ensure that staff was following the care plans.</p> <p>Interview with the MDS Coordinator on 07/23/15 at 5:40 PM revealed she was responsible for developing the care plans and updating the care plans as needed. However, the charge nurses were responsible to ensure staff was following the</p>	F 282	<p><u>2. How will the provider identify other residents who have the potential to be affected by the alleged deficient practice and what actions will be taken?</u></p> <p>All residents have potential to be affected by deficient practice. Audit completed for current residents with indwelling catheters and leg bands/clips were added to secure indwelling catheter tubing. Interdisciplinary Care Plan Team (RNAC, Social Services, Dietary Manager) reviewed/revised Care Plans for residents with indwelling catheters to include Risk Factors/Risk for injury as relates to securing tubing to prevent injury. The IDT reviewed CNA care sheets to ensure care provided as per care plans. CNA care sheets will reflect use of indwelling catheter to include use of leg bands/clips to secure tubing to prevent injury. CNA care sheets/Care Plans were reviewed/revised to ensure they reflect resident's current needs.</p> <p><u>3. What action did the provider take to assure that the alleged deficient practice does not recur?</u></p> <p>In-service conducted on 8/20/15 by DNS/ADNS/Designee to nursing staff as relates to following plan of care/care sheet for each resident. IDT will revise Care Plans daily to ensure residents care reflects current status to include risk factors, risk for injury. IDT will be responsible for updating CNA care sheets daily to reflect changes / current status for resident care. Charge nurse will provide CNA's with current updated care sheets each shift to reflect care needs daily. CNA's will provide care according to resident care sheets every shift daily.</p> <p><u>4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?</u></p> <p>Charge nurse is responsible for monitoring daily during rounds to ensure care provided according to resident care sheets/care plans. DNS/ADNS/Designee will conduct daily rounds to ensure care provided according to resident care sheets/care plans. QAA committee will meet monthly and discuss concerns noted with following care plans/ care sheets and AP developed as indicated.</p> <p>Expected date of completion: 08/28/2015</p>		

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F 282	Continued From page 12 care plans.	F 282			
F 315 SS=E	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure appropriate treatment and services were provided to prevent injury of the urinary tract for five (5) of twenty-four (24) sampled residents (Residents #6, #16, #17, #19, and #21). The facility failed to assure the indwelling catheter for Resident #6 was secured according to the plan of care to prevent pulling/pressure/injury to the urinary tract. Furthermore, the facility failed to consider risk factors and develop a plan of care to address the risk for injury related to an indwelling urinary</p>	F 315	<p><i>This Plan of Correction is the provider's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>F315 E 1) <u>1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?</u></p> <p><i>Residents #6, #16, #17, #19, #21 all had Leg bands applied to secure indwelling catheter tubing to prevent pulling/pressure/injury to the urinary tract. Care plans were updated to reflect Risk Factors and Risk for Injury related to indwelling catheter. Care plan interventions include use of leg band/clip to secure tubing to prevent injury.</i></p> <p><u>2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken?</u> <i>All residents have the potential to be affected by this deficient practice. Current residents with indwelling catheters (10) were reviewed to ensure leg bands/clips were used to secure tubing. Leg bands/clips were added to 10 residents with indwelling catheters. Care plans were updated to reflect leg band/clips to secure indwelling catheter to prevent injury of pulling/pressure/injury to urinary tract. Certified nurse assistants care sheets were updated to ensure residents with indwelling catheters had leg band/clips used to secure to prevent injury. Residents with new orders for indwelling catheter will have a leg band/clip to secure tubing. Care plans/care sheets will be updated at that time to include Risk Factors/Risk for Injury to urinary tract. New admissions admitted to the facility with indwelling catheters will have leg band/clip in place to secure tubing. Care plans and Care Sheets will be updated at that time to include Risk Factors/Risk for Injury to urinary tract.</i></p>		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40464		
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F 315	<p>Continued From page 13 catheter for Residents #16, #17, #19, and #21.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Catheter Care, Indwelling Catheter," (dated January 2015) revealed the policy did not address securing indwelling urinary catheters.</p> <p>1. Review of Resident #6's medical record revealed the facility admitted the resident on 06/24/14 with diagnoses that included Neurogenic Bladder, Retention of Urine, Hypertension, Senile Dementia, and Bipolar Disorder. Further review of the medical record, which included the Annual Minimum Data Set (MDS) Assessment dated 07/03/15, revealed Resident #6 required the use of an indwelling urinary catheter. Review of Resident #6's care plan dated 07/15/14 revealed the facility would provide indwelling catheter care every shift and secure the catheter and tubing appropriately.</p> <p>Observation of Resident #6 on 07/22/15 at 10:20 AM during catheter care revealed the catheter drainage bag was attached to the bedside; however, the tubing was not secured to the resident's thigh to prevent pulling/injury.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 07/23/15 at 4:00 PM revealed if the intervention to anchor the tubing was on the care plan then it should have been followed. CNA #1 stated when catheter care was on the care plan that means to wash with soap and water. She further revealed that the urinary catheter tubing was not anchored unless a reason was added to the care plan for anchoring it.</p>	F 315	<p><u>3. What action did the provider take to assure that the allowed deficient practice does not recur?</u> An in-service will be conducted by the DNS/ADNS/Designee on 8/20/15 to nursing staff as relates to indwelling catheters to include Risk Factors/Risk for injury/Leg band/clip to secure tubing to prevent injury. Interdisciplinary Team (RNAC, Social Service, Dietary) developed care plans to address indwelling catheters as relates to Risk Factors and Risk for injury related to use of indwelling catheter to include leg band/clip use for securing catheter tubing.</p> <p><u>4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?</u> Charge nurses will monitor daily during rounds to ensure residents with indwelling catheters have leg band/clip to secure tubing to prevent injury. DNS/ADNS/Designee will monitor daily during rounds to ensure leg bands/clips are used to secure indwelling catheter tubing to prevent injury. IDT will monitor care plans to ensure Risk Factors/Risk for Injury and leg bands/clips are on residents care plans with indwelling catheters. IDT will also monitor for new orders/new admissions to ensure care plans reflect Risk Factors/Risk for Injury/leg bands/clips for all residents with indwelling catheters. QA&A committee will review residents monthly with indwelling catheters to ensure documentation supports use of indwelling catheters to include securing tubing to prevent injury. Action Plans will be developed as indicated.</p> <p>Expected date of completion: 8/28/2015</p>		

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F 315	<p>Continued From page 14</p> <p>2. Review of Resident #16's medical record revealed the facility admitted the resident on 11/12/07 with diagnoses that included History of Urinary Tract Infection, Alzheimer's, Neurogenic Bladder, Peripheral Vascular Disease, Dementia, and Dysphagia. Further review of the medical record, which included the Annual MDS Assessment dated 06/26/15, revealed Resident #16 required the use of an indwelling urinary catheter. Review of Resident #16's care plan dated 12/21/12 with a revision date of 07/08/14 revealed the facility would provide catheter care and perineal care daily and as needed. Further review of the care plan revealed the facility would check urinary catheter tubing for proper drainage and positioning.</p> <p>Observation of Resident #16 on 07/23/15 at 4:55 PM revealed the indwelling urinary catheter bag was anchored to the side of the resident's bed, but the indwelling urinary catheter tubing was not secured to the resident's leg.</p> <p>3. Review of Resident #17's medical record revealed the facility admitted the resident on 11/20/14, with diagnoses that included Neurogenic Bladder, Retention of Urine, Hypertension, Senile Dementia, and Depressive Disorder. Further review of the medical record, which included the Quarterly Minimum Data Set (MDS) Assessment dated 06/19/15, revealed Resident #17 required the use of an indwelling urinary catheter. Review of Resident #17's care plan dated 07/01/14 revealed the facility would provide indwelling catheter care daily with soap and water.</p> <p>Observation on 07/23/15 at 4:45 PM revealed Resident #17's urinary catheter bag was</p>	F 315			

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F 315	<p>Continued From page 15</p> <p>anchored to the bed; however, the urinary catheter tubing was not secured to the resident's leg.</p> <p>4. Review of Resident #19's medical record revealed the facility admitted the resident on 04/30/12 with diagnoses that included History of Urinary Tract Infection, Neurogenic Bladder, and Retention of Urine. Further review of the medical record revealed an Annual MDS Assessment dated 05/01/15 that assessed Resident #19 to require the use of an indwelling urinary catheter. Review of Resident #19's care plan dated 01/07/15 revealed the facility would provide indwelling catheter care every shift and secure the catheter and tubing appropriately.</p> <p>Observation of Resident #19 on 07/23/15 at 4:15 PM during observations revealed the catheter drainage bag was attached to the bedside; however, the tubing was not secured to the resident's thigh to prevent pulling/injury.</p> <p>5. Review of the medical record for Resident #21 revealed the facility admitted the resident on 04/06/11, with diagnoses that included Dementia, Depression, and Neurogenic Bladder.</p> <p>Review of the physician's orders for Resident #21 revealed a physician's order dated 04/06/11, for the resident to have an indwelling urinary catheter to bedside drainage.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated 05/15/15 revealed Resident #21 required an indwelling urinary catheter.</p> <p>Observation of Resident #21 on 07/23/15, at 4:20 PM, revealed the resident was observed to be</p>	F 315			

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F 315	<p>Continued From page 16</p> <p>lying on his/her back in bed with the indwelling urinary catheter tubing draped over the resident's left leg. The indwelling urinary catheter was not secured to the resident to prevent pulling.</p> <p>Interview conducted on 07/23/15 at 4:30 PM with State Registered Nursing Assistant (SRNA) #4 revealed she was not required to secure residents' urinary catheters. The SRNA stated she had never been trained by the facility to secure a resident's urinary catheter to prevent injury to the urinary tract.</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #3 on 07/23/15 at 6:30 PM revealed she made rounds frequently throughout her shift to ensure residents were being provided the care they required. The LPN stated it was not a practice at the facility to secure urinary catheters, and she felt they should to prevent trauma/injury.</p> <p>Interview with Registered Nurse (RN) #1 on 07/23/15 at 4:05 PM revealed she checks all the residents with catheters on her floor daily to make sure all urinary catheters were secured. She further stated when a newly hired CNA came to her floor she instructed them on securing all the urinary catheters. She had not identified any problems with the urinary catheter tubing not being secured and thought they were being secured.</p> <p>Interview with RN #2 on 07/23/15 at 5:15 PM revealed that the charge nurse was responsible for making sure that catheters were secured. She also stated that CNAs and nurses checked catheters daily during routine care. RN #2 stated if staff needed anchors for indwelling urinary catheters, staff could get them at Central Supply.</p>	F 315			

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F 315	Continued From page 17	F 315			
F 371 SS=E	<p>Interview with the Director of Nursing on 07/23/15 at 5:50 PM revealed it is not the facility's policy to secure the urinary catheter tubing unless a resident had been identified to be pulling or tugging at the tubing.</p> <p>483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of facility policies, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions for one hundred fifteen (115) of one hundred nineteen (119) residents of the facility who received nutrition from the kitchen. Observations in the kitchen on 07/21/15 and 07/22/15 revealed the kitchen floor had built up grease and dirt-like substance throughout the kitchen that was especially heavy in the corners and loose dirt and debris on the floor throughout the kitchen. Observations on 07/21/15 revealed food transport carts that had dried food, liquid, and what appeared to be food particles and crumbs on the</p>	F 371	<p><i>This Plan of Correction is the provider's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>F371 E 1) <u>What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?</u></p> <p>All carts were cleaned and power washed. Stove vent hood was cleaned by maintenance department on 7/22/2015. All counter tops and floors were cleaned on 7/22/15. The cook was immediately re-in-serviced on proper food handling.</p> <p><u>2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken?</u></p> <p>All residents have potential to be affected by this deficient practice.</p> <p><u>3. What action did the provider take to assure that the alleged deficient practice does not recur?</u></p> <p>Dietary Services Manager (DSM) in-serviced dietary services employees on the completion of daily cleaning schedule which includes sweeping and mopping kitchen floors daily. In-service included wiping down all dietary areas. 8/12/2015. DSM and Administrator will monitor daily cleaning schedule weekly X 4 weeks then monthly X 4 months then random audits thereafter. DSM began in-servicing dining service employees on the handling of plates, cups, glasses, bowls, and utensils. DSM will monitor the tray line and between meals weekly X 4 weeks, then monthly x 4 months, then random audits thereafter. In-services - demonstrated how to clean food transportation carts per company policy. All carts were cleaned and power washed. Stove vent hood was cleaned by maintenance department on 7/22/2015.</p>		

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F 371	<p>Continued From page 18</p> <p>inside and outside of the carts. Observations on 07/22/15 revealed a cook touching the inside portion of the plate with her bare skin while serving, a knife rack with food particles on it, and the stove vent hood with an aluminum finish that was peeling and flaking off in close proximity to the serving line.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Dining Services Policies and Procedures," dated 2011, revealed no specific knife rack or floor cleaning procedures, but did define cleaning as the act of removing soil and buildup from a food or non-food contact surface. Clean was further defined as "free of visible soil."</p> <p>Review of the facility's policy, "Daily Cleaning Closed Meal Carts," dated 2011, revealed the following procedures: 1.) Wash inside and outside thoroughly using a mild-detergent solution and brush. 2.) Check shelves carefully for hidden debris, use soft-bristle brush as needed. 3.) Sanitize with appropriate-strength solution. 4.) Allow to air-dry and store with doors open. Further review of the policy revealed instruction for Weekly Cleaning of closed meal carts was as follows: 1.) Take the cart to the assigned cart wash area. 2.) Scrub the cart inside and outside (removing shelves if possible) with a mild-detergent solution and soft-bristle brush (Note - Do not use grease solvent or de-scaler on aluminum carts.). 3.) Scrub the wheels, assuring that all mop strings are removed. 4.) Rinse, using hose if available. 5.) Sanitize with appropriate-strength solution. 6.) Allow cart to air-dry.</p>	F 371	<p><u>4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?</u></p> <p><i>Dietary Services Manager (DSM) in-serviced dietary services employees on the completion of daily cleaning schedule which includes sweeping and mopping kitchen floors daily. In-service included wiping down all dietary areas. 8/12/2015. DSM and Administrator will monitor daily cleaning schedule weekly X 4 weeks then monthly X 4 months then random audits thereafter. DSM began in-servicing dining service employees on the handling of plates, cups, glasses, bowls, and utensils. DSM will monitor the tray line and between meals weekly X 4 weeks, then monthly x 4 months, then random audits thereafter. In-services - demonstrated how to clean food transportation carts per company policy. All carts were cleaned and power washed. Stove vent hood was cleaned by maintenance department on 7/22/2015. Executive Director will audit DSM progress daily for 2 weeks, 3 times a week for 4 weeks, and monthly for 4 months. As needed thereafter. Any defecance practices will be reviewed by IDT in QAPI.</i></p> <p>Expected date of completion: 8/28/15</p>		

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F 371	<p>Continued From page 19</p> <p>Review of the facility's policy, "Handling Clean Equipment and Utensils," dated 2011, revealed staff was to observe the following guidelines for handling clean equipment and utensils: Pick up and touch clean spoons, knives, and forks by the handles only. Handle clean cups, glasses and bowls so that fingers and thumbs do not contact inside surfaces.</p> <p>Interview with the facility Administrator on 07/23/15 at 5:54 PM revealed there was not a policy that addressed the stove vent hood.</p> <p>1. Observations on 07/21/15 at 11:30 AM during the initial tour of the kitchen revealed the following: the kitchen floor had built up grease and dirt-like substance throughout the kitchen, especially heavy in the corners. There was also loose dirt and debris on the floor throughout the kitchen on 07/21/15. The same debris was observed on the floor on 07/22/15 beside the white reach-in refrigerator.</p> <p>Review of the facility's Daily Cleaning Schedule for July 2015 revealed no documentation that the kitchen floors had been swept or mopped for the entire month of July.</p> <p>Interview with the Dietary Manager on 07/22/15 at 4:00 PM and with the Registered Dietitian on 07/22/15 at 4:15 PM revealed that the dirt should not have been on the floor, and the cleaning schedule should have been signed.</p> <p>2. Observations on 07/21/15 from 5:53 PM to 6:44 PM during the dinner meal revealed six food tray delivery carts delivering food trays to the floors. All six carts had dried food, liquid, and what appeared to be food particles and crumbs</p>	F 371		

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F 371	<p>Continued From page 20</p> <p>on the inside and outside of the carts. A white film-like coating was also observed on the inside and outside of all six carts.</p> <p>Review of the Daily Cleaning Schedule for July 2015 revealed the closed food transport carts were not on the Daily Cleaning Schedule.</p> <p>Review of the facility's Weekly Cleaning Schedule for July 2015 revealed the closed tray carts were on the schedule, but there was no documentation that the carts were cleaned for the entire month of July.</p> <p>Interview with the Dietary Manager on 07/22/15 at 4:00 PM revealed that the food transport carts should not have what appeared to be food particles and crumbs on the inside and outside of the carts, and the cleaning schedule should have been signed. She stated the staff was changing the procedures of cleaning the transport carts to be more in line with the current facility policy.</p> <p>Interview with the Registered Dietitian on 07/22/15 at 4:15 PM revealed that the food transport carts should not have what appeared to be food particles and crumbs on the inside and outside of the carts, and the cleaning schedule should have been signed.</p> <p>3. Observation on 07/22/15 at 11:40 AM revealed that Cook #1 was touching the rim and inside portion of plates with her bare skin at least 10 times during the noon meal service preparation.</p> <p>Interview with the Dietary Manager on 07/22/15 at 4:00 PM and with the Registered Dietitian on 07/22/15 at 4:15 PM revealed that Cook #1 should not have touched the rim or inside portion</p>	F 371			

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F 371	Continued From page 21 of the plates with her bare skin. 4. Observation on 07/22/15 at 12:26 PM revealed a knife rack that had visible food particles on the top portion where the knives were inserted into the rack and inside the knife rack. Review of the Daily Cleaning Schedule for July 2015 revealed the last day the knife rack was cleaned was 07/18/15. Interview with the Dietary Manager on 07/22/15 at 4:00 PM and with the Registered Dietitian on 07/22/15 at 4:15 PM revealed that the knife rack should not have food particles on the top or inside of it. 5. Observation on 07/22/15 at 12:30 PM revealed that the stove vent hood's aluminum finish was peeling and flaking off in close proximity to the serving line. Interview with the Dietary Manager on 07/22/15 at 4:00 PM and with the Registered Dietitian on 07/22/15 at 4:15 PM revealed that the stove vent hood should not have the finish peeling and flaking off, and they were not aware of it. Interview with the Administrator on 07/23/15 at 5:54 PM revealed he was unaware of any concerns in the kitchen and further stated that kitchen staff should be following facility policies, procedures, and cleaning schedules.	F 371			
F 412 SS=E	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with	F 412			

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F 412	<p>Continued From page 22</p> <p>§483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</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 assure dental services were provided for fourteen (14) of twenty-four (24) sampled residents to meet the needs of each resident. Review of the records for Residents #2, #3, #5, #6, #8, #9, #10, #12, #15, #16, #18, #19, #20, and #21 revealed no evidence the residents were examined by a dentist.</p> <p>The findings include:</p> <p>Interview with the Administrator on 07/23/15 at 5:54 PM revealed the facility did not have a policy related to dental care.</p> <p>1. Review of the medical record for Resident #19 revealed the facility admitted the resident on 04/30/12 with diagnoses that included Hypertension, Hyperlipidemia, Congestive Heart Failure, Cerebrovascular Disease, and Lupus. Further review of the medical record revealed no evidence Resident #19 had received an oral evaluation by a dentist since the resident was admitted to the facility.</p>	F 412	<p><i>This Plan of Correction is the provider's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>F412 E</p> <p>1) <u>1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?</u></p> <p>Resident #2, 3, 5, 6, 8, 9, 10, 12, 15, 16, 18, 19, 20, and 21 assessed for immediate dental care needs and found no urgent need at this time for dental care. However, dental services has been scheduled for 8/25/15 with the Dentist for oral exams for residents listed above.</p> <p><u>2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken?</u></p> <p>All residents have potential to be affected by this deficient practice. Current residents assessed for urgent dental needs and 2 residents were identified which needed dental care at this time. Social Services made dental appointments for services. Both residents received dental services. Dental Services has been scheduled for 8/25/15 to come to facility and provide oral exams for all current residents at facility.</p> <p><u>3. What action did the provider take to assure that the alleged deficient practice does not recur?</u></p> <p>In-service will be conducted 08/20/2015 by DNS/ADNS/Designee as relates to dental needs for residents. Nursing staff will report dental needs to SS when needed.</p> <p>SS will be responsible for contacting dentist whether local or other contract services for dental care for residents as needed to include F/U visits. Dental care visits will be documented in each resident's medical record. Residents will receive routine Annual exams by the Dentist.</p> <p><u>4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?</u></p> <p>Nursing Staff will monitor daily for oral/dental care needs during bathing and document care needs on bath sheets when oral/dental</p>		

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F 412	<p>Continued From page 23</p> <p>Observation of Resident #19's oral cavity on 07/23/15 at 4:15 PM revealed Resident #19's oral cavity had several missing and broken teeth.</p> <p>2. Review of the medical record for Resident #2 revealed the facility admitted the resident on 01/30/14 with diagnoses that included Senile Dementia and Chronic Airway Obstruction. Further review of the medical record revealed no evidence Resident #2 had received an oral evaluation by a dentist since the resident was admitted to the facility.</p> <p>Review of a significant change Minimum Data Set (MDS) assessment dated 04/10/15 revealed the facility had assessed the resident to have severely impaired cognition; the dental portion of the MDS indicated the facility identified no concerns with the resident's teeth or gums.</p> <p>3. Review of the medical record for Resident #3 revealed the facility admitted the resident on 05/27/05 with diagnoses that included Anxiety State Unspecified, Bipolar Disorder, and Depressive Disorder. Further review of Resident #3's medical record revealed no evidence the resident had an oral evaluation completed by a dentist since the resident was admitted to the facility.</p> <p>Review of a quarterly MDS assessment dated 08/19/15 for Resident #3 revealed the facility assessed the resident to be cognitively intact; the dental portion of the MDS indicated the facility identified no concerns with the resident's teeth or gums.</p> <p>4. Review of Resident #8's medical record revealed the facility admitted the resident on</p>	F 412	<p>care services are needed.</p> <p>DNS/ADNS/Designee will monitor both sheets for oral/dental care needs and notify SS for F/U. SS will contact dentist for dental visit for evaluation according to residents oral/dental needs. Residents will receive routine Annual exams by the Dentist.</p> <p>QAA committee will review Dental Care Services monthly for concerns with oral care/dental needs that require dental services. Action Plans will be developed as indicated.</p> <p>Expected date of completion: 8/28/15</p>		

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F 412	<p>Continued From page 24</p> <p>06/28/14 with diagnoses that included Senile Dementia, Hypertension, Neurogenic Bladder, Anxiety, and Bipolar Disorder. Review of the Minimum Data Set (MDS) assessment dated 07/03/15 revealed Resident #6 did not have any natural teeth, broken, or loose fitting dentures. Review of the comprehensive care plan dated 07/02/14 revealed Resident #6 received a mechanical altered diet. Review of the medical record revealed no evidence that Resident #6 had received any dental services by a dentist.</p> <p>5. Review of Resident #8's medical record revealed the facility admitted the resident on 04/04/14, with diagnoses that included Neurogenic Bladder, End Stage Renal Disease, Hypothyroidism, Disorganized Schizophrenia, and Arthropathy. Further review of the medical record, which included the annual MDS assessment dated 04/09/15, revealed Resident #8 did not have any natural teeth, broken, or loose fitting dentures. Review of the comprehensive care plan dated 04/08/14 revealed Resident #8 received a therapeutic diet. Review of the medical record revealed no evidence that Resident #8 had received any dental services by a dentist.</p> <p>6. Review of the medical record for Resident #9 revealed the resident was admitted to the facility on 09/19/12 with diagnoses that included Dementia and Anxiety. Further review of the medical record revealed no evidence Resident #9 had received an oral evaluation by a dentist since the resident was admitted to the facility.</p> <p>Review of a significant change Minimum Data Set (MDS) assessment dated 12/28/14 revealed the facility had assessed the resident to have</p>	F 412			

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F 412	<p>Continued From page 25</p> <p>severely impaired cognition and to have no natural teeth.</p> <p>Observation of Resident #9's oral cavity on 07/22/15 at 3:30 PM during a skin assessment by Licensed Practical Nurse (LPN) #4 revealed Resident #9's oral cavity was observed to be clean and edentulous.</p> <p>7. Review of the medical record for Resident #10 revealed the resident was admitted to the facility on 04/11/14 with diagnoses that included Dementia, Cachexia, and Adult Failure to Thrive. Further review of Resident #10's medical record revealed no evidence the resident had an oral evaluation completed by a dentist since the resident was admitted to the facility.</p> <p>Review of an annual MDS assessment dated 03/13/15 for Resident #10 revealed the facility had assessed the resident to have severely impaired cognition and to have broken teeth.</p> <p>Observation of Resident #10's oral cavity on 07/23/15, at 9:20 AM, during a skin assessment observation with LPN #4, revealed Resident #10 had several broken and missing teeth.</p> <p>8. Review of Resident #12's medical record revealed the facility admitted the resident on 03/18/14, with diagnoses that included Alzheimer's Disease, Hypertension, Hypothyroidism, Macular Degeneration of Retina, and Anemia. Further review of the medical record, which included the significant change MDS assessment dated 10/03/14, revealed Resident #12 did not have any natural teeth or tooth fragments. Review of the comprehensive care plan dated 03/24/14 revealed Resident #12</p>	F 412			

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F 412	<p>Continued From page 26</p> <p>wore upper and lower dentures and received a regular diet. Review of the medical record revealed no evidence that Resident #12 had received any dental services by a dentist.</p> <p>9. Review of the medical record for Resident #15 revealed the facility admitted the resident on 11/11/13 with diagnoses that included Cerebral Vascular Accident, Diabetes Mellitus, and Alzheimer's Dementia. Further review of Resident #15's medical record revealed no evidence Resident #15 had an oral evaluation by a dentist since the resident was admitted to the facility.</p> <p>Review of a significant change MDS assessment dated 01/23/15 for Resident #15 revealed the facility had assessed the resident to have severely impaired cognition, to be edentulous, and to have dentures.</p> <p>Observation of Resident #15 on 07/23/15 at 4:10 PM revealed the resident was observed to be edentulous and to have no dentures in his/her mouth.</p> <p>10. Review of Resident #16's medical record revealed the facility admitted the resident on 11/12/07 with diagnoses that included Alzheimer's Disease, Dysphagia, Depressive Disorder, Nutritional Deficiency, Reflux Esophagitis, Osteoporosis, and Dyspnea. Review of the annual MDS assessment dated 06/26/15 revealed Resident #16 did not have any natural teeth or tooth fragments. Review of the comprehensive care plan dated 09/17/10 with a revision date of 10/09/14 revealed that Resident #16 received enteral tube feedings, was on a regular pureed diet, and could receive one</p>	F 412			

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F 412	<p>Continued From page 27</p> <p>pureed item and one honey-thick liquid at lunch for oral gratification. Further review of the medical record revealed no evidence that Resident #16 had received any dental services by a dentist.</p> <p>11. Review of the medical record for Resident #5 revealed the facility admitted the resident on 06/20/14 with diagnoses that included Alzheimer's Disease, Anxiety State, and Esophageal Reflux. Further review of Resident #5's medical record revealed no evidence Resident #5 had an oral evaluation by a dentist since the resident was admitted to the facility.</p> <p>Review of an annual MDS assessment dated 06/05/15 for Resident #5 revealed the facility had assessed the resident to have moderately impaired cognition; the dental portion of the MDS indicated the facility identified no concerns with the resident's teeth or gums.</p> <p>12. Review of the medical record for Resident #18 revealed the facility admitted the resident on 07/07/08 with diagnoses that included Senile Dementia and Lower Limb Amputation above the knee. Further review of Resident #18's medical record revealed no evidence Resident #18 had an oral examination by a dentist since being admitted by the facility.</p> <p>Review of an annual MDS assessment dated 06/05/15, revealed Resident #18 had been assessed by the facility to be interviewable with a Brief Interview for Mental Status (BIMS) score of 11 which indicated the resident was moderately impaired. The dental portion of the MDS indicated the facility identified no concerns with the resident's teeth or gums.</p>	F 412			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484		
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F 412	<p>Continued From page 28</p> <p>Interview conducted with Resident #18 on 07/23/15, at 6:08 PM revealed he/she had not been seen by a dentist in the last couple of years.</p> <p>13. Review of Resident #20's medical record revealed the facility admitted the resident on 10/14/11 with diagnoses that included Osteoporosis, Depressive Disorder, Hypothyroidism, Chronic Airway Obstruction, and Anemia. Further review of the medical record, which included the annual MDS assessment dated 04/10/15 revealed Resident #20 did not have any natural teeth or tooth fragments. Review of the comprehensive care plan dated 04/28/14 revealed Resident #20 received a therapeutic diet. Review of the medical record revealed no evidence that Resident #20 had received any dental services by a dentist.</p> <p>Interview with the Social Services Director on 07/23/15 at 7:20 PM revealed she was responsible for assisting the residents with their dental appointments. She further revealed that residents only see the dentist if they have a dental issue/complaint.</p> <p>14. Review of the medical record for Resident #21 revealed the facility admitted the resident on 04/06/11 with diagnoses that included Dementia and Depression. Further review of Resident #21's medical record revealed no evidence Resident #21 had an oral examination by a dentist since being admitted to the facility.</p> <p>Review of an annual MDS assessment dated 11/14/14, revealed Resident #21 had been assessed by the facility to be interviewable with a Brief Interview for Mental Status (BIMS) score of</p>	F 412			

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F 412	Continued From page 29 14 which indicated the resident was cognitively intact. The MDS also revealed Resident #21 had no natural teeth. Interview conducted with Resident #21 on 07/23/15 at 4:25 PM revealed he/she had not been seen by a dentist since his/her admission to the facility.	F 412			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature 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	F 431	<i>This Plan of Correction is the provider's credible allegation of compliance.</i> <i>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.</i> F431 E 1) <u>What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?</u> Medication carts (6 in facility) were audited on 7/23/15 and expired medications and non-packaged medications were removed immediately from the carts. Pharmacy was contacted to replace all expired medications. No resident was affected by this deficient practice. <u>2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken</u> All residents have potential to be affected by this deficient practice. Audits as mentioned in #1 were conducted and expired medications were removed immediately and pharmacy contacted to replace if current order exists. <u>3. What action did the provider take to assure that the alleged deficient practice does not recur?</u>		

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F 431	<p>Continued From page 30</p> <p>abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure drugs and biologicals were stored with currently acceptable professional principles. Observations on 07/23/15 of medication carts revealed three (3) of five (5) medication carts had expired medications that were available for resident use. Furthermore, a medication was observed to be in an opened package lying in a resident's medication box available for resident use.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Storage of Medication," with a review date of 01/06/15, revealed medications and biologicals were to be stored properly, following manufacturer's recommendations, or those of the supplier to maintain their integrity and to support safe administration. The policy also stated outdated, contaminated, discontinued, or deteriorated medications, and those in containers that were cracked, soiled, or without secure closures were immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order existed.</p>	F 431	<p>Re- inservice conducted on 8/20/15 as relates to policy for outdated, contaminated, discontinued, or deteriorated medications to include inappropriate storage of medications. Expired medications and medications improperly stored will be removed from carts immediately and replaced by pharmacy if current order exists. Charge nurses are responsible to ensure medications are checked according to policy to include checking for expired medications prior to administering. Charge nurses will note any discrepancies according to policy. Charge Nurses will note improper storage of medications or expired medications and if noted will be removed from cart immediately and disposed of according to policy. Pharmacy will be contacted to replace medications as needed.</p> <p><u>4 What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?</u></p> <p>DNS/ADNS/Decignee will conduct medication cart audits weekly for four weeks and then monthly. Audits will consist of monitoring improper storage/ expiration of medications. Pharmacy Consultant will conduct random audits for expired medications/ storage of medications during monthly visits. QAA Committee will review results of monthly audits conducted. Action Plans will be developed as indicated.</p> <p>Expected date of completion: 8/28/2015</p>		

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F 431	<p>Continued From page 31</p> <p>Observation of medication cart #1 on the 200 Unit on 07/23/15 at 8:25 PM revealed six expired medications that were available for resident use. The expired medications were as follows: Ondansetron HCL 4 milligrams (mg) expired on 06/25/15, Ondansetron HCL 4 mg expired on 06/16/15, Chlorthalidone 50 mg expired on 10/24/14, Docusate Sodium 100 mg expired April 2015, Phenazopyridine HCL 100 mg expired on 04/17/15, and Clonazepam 0.5 mg expired May 2015. Observations of medication cart #2 on the 200 Unit revealed five expired medications that were available for resident use. The expired medications were as follows: Diphenhydramine 25 mg expired on 04/07/15, Diphenhydramine 25 mg expired on 11/26/13, Spiriva 18 micrograms (mcg) Inhaler expired March 2015, MI-Acid Gas Relief 80 mg chewable tablets expired on 06/23/15, and Mapap 325 mg tablets expired on 07/07/14.</p> <p>Observation of the 300 Unit medication cart on 07/23/15 revealed a medication, Docusate Calcium 240 mg, to be opened and lying in the resident's medication box.</p> <p>Observation of the 100 Unit medication cart on 07/23/15 revealed five expired medications that were available for resident use. The expired medications were as follows: Two boxes of Relistor that expired on 03/31/15, Gas Relief 125 mg tablets with no expiration date listed, Benzonatate 100 mg expired on 03/31/15, Bisacodyl 5 mg expired on 07/06/15, and Mucinex ER 600 mg expired on 07/21/15.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 07/23/15 at 8:40 PM revealed, "We (nurses)</p>	F 431			

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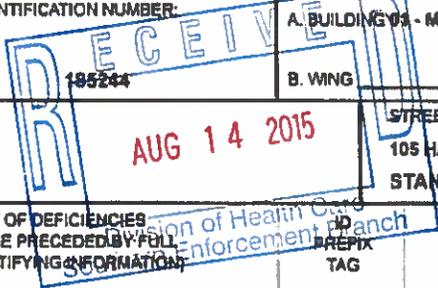
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F 431	<p>Continued From page 32</p> <p>are supposed to look at the expiration dates on the medications before we give them, but sometimes we get too busy." LPN #1 further stated she had not identified any problems with expired medications. LPN #1 stated expired medications were to be sent to the pharmacy and thought it was the pharmacist's job to check the expiration dates on medications.</p> <p>Interview with the Director of Nursing (DON) on 07/23/15 at 9:35 PM revealed the nurses were supposed to check the expiration dates on medications before giving to residents. The DON stated the facility conducts audits at least once a month on medications. The DON stated the pharmacy consultant comes in monthly and conducts medication cart reviews, medication room reviews, and medical record reviews. The DON stated she had not identified any expired medications in the medication carts and staff was to place expired medications in a tote and send back to Pharmacy.</p> <p>Interview with the Pharmacy Consultant on 07/23/15 at 10:30 PM revealed that the nurses were responsible for checking for expired medications.</p>	F 431			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484
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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: 1988</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 111(200)</p> <p>SMOKE COMPARTMENTS: Five</p> <p>FIRE ALARM: Complete automatic fire alarm system</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system</p> <p>GENERATOR: Type II natural gas generator</p> <p>A life safety code survey was initiated and concluded on 07/21/15. 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 to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p>	K 000		
K 018 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or</p>	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 8/14/15
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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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K 018	<p>Continued From page 1</p> <p>hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor doors were maintained according to National Fire Protection Association (NFPA) standards. This deficient practice affected one (1) of five (5) smoke compartments, staff, and approximately eight (8) residents. The facility has the capacity for 128 beds with a census of 116 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 07/21/15 at 12:15 PM with the Director of Maintenance (DOM), a mechanical room corridor door in Zone 1 of the facility was observed not to self-close due</p>	K 018	<p><i>This Plan of Correction is the provider's credible allegation of compliance.</i></p> <p><i>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.</i></p> <hr/> <p>K-018</p> <p><u>1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?</u></p> <ol style="list-style-type: none"> Mechanical room corridor door in Zone 1 has been corrected door and is self closing Linex cart corridor door has been corrected and will latch when close. Biohazard door repairs are underway and will be completed by compliance dated to ensure that the gap is not at the top of door. <p><u>2. How will the provider identify other residents who have the potential to be affected by the alleged deficient practice and what actions will be taken</u></p> <p>All residents have the potential to be affected. Facility Maintenance Director will conduct facility wide door check to identify any problem areas related to the findings.</p> <p><u>3. What action did the provider take to ensure that the alleged deficient practice does not recur?</u></p> <p>Maintenance Director will conduct facility audit to identify any doors that may have deficient practices. Maintenance Director will conduct in-services on using building engines (systems for reporting maintenance issues) to help report any doors that are not working according to the regulations. In addition Maintenance Director will continue to monitor the facility door to ensure that all doors are operating according to regulation. Quarterly environmental walking rounds by maintenance department will continue and be monitored by Executive Director.</p> <p><u>4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?</u></p> <p>Executive Director will monitor quarterly environmental rounds by Maintenance Director. Daily environmental rounds will be reviewed in morning stand up meeting by IDT team.</p> <p>Expected date of completion: 8-28-2015</p>	

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K 018	Continued From page 2 to the bottom of the door rubbing against the floor. The linen cart corridor door was observed not to latch when closed as required. The Biohazard corridor room door was observed to have an excessive gap at the top of the door. Corridor doors must close, latch, and seal to help resist the passage of smoke in a fire situation. An interview on 07/21/15 at 12:20 PM with the DOM revealed he was slowly working on doors to get them in working order. The findings were revealed to the Administrator upon exit. Reference: NFPA 101 (2000 Edition). 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lb (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.	K 018		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 045		

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K 045	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain emergency lighting at exits according to National Fire Protection Association (NFPA) standards. This deficient practice affected one (1) of five (5) smoke compartments, staff, and approximately thirteen (13) residents. The facility has the capacity for 128 beds with a census of 118 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 07/21/15 at 1:35 PM with the Director of Maintenance (DOM) an exterior exit light fixture located in Zone 4 of the facility was observed to be a single bulb lighting fixture. An exterior light fixture is required to have more than one bulb in case one bulb burns out and leaves the area in darkness.</p> <p>An interview with the DOM on 07/21/15 at 1:35 PM revealed he recently changed the lighting fixture and was not aware that exterior exit lighting fixtures should contain more than one bulb.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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 of less than 0.2 ft-candle (2 lux) in any designated area.</p>	K 045	<p><i>This Plan of Correction is the provider's credible allegation of compliance.</i></p> <p><i>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.</i></p> <hr/> <p>K 045</p> <p><u>1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?</u></p> <p>Maintenance Director (DOM) will conduct a facility audit to identify any exterior light fixtures that require more than a single bulb. DOM will correct deficient practice by installing an exterior light that has more than one bulb.</p> <p><u>2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken?</u></p> <p>All residents could be potential affected because in emergency lighting used for exiting in darkness.</p> <p><u>3. What action did the provider take to assure that the alleged deficient practice does not recur?</u></p> <p>Maintenance Director will conduct facility audit to identify any exterior lights that are requiring more than one bulb. In addition Maintenance Director will continue to monitor all lights in the facility. Quarterly environmental walk through by maintenance department will continue and be monitored by Executive Director.</p> <p><u>4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?</u></p> <p>Executive Director will continue to monitor quarterly environmental rounds by Maintenance Director. Daily environmental rounds by department heads will be reviewed in morning stand up meeting.</p> <p>Expected date of completion: 8-28-2015</p>

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K 045	Continued From page 4 A.7.8.1.4 An example of the failure of any single lighting unit is the burning out of an electric bulb.	K 045			
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct fire drills to ensure that staff was prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness. This failure affected all residents and staff in the facility. The facility has the capacity for 128 beds with a census of 116 on the day of the survey. The findings include: During the Life Safety Code survey on 07/21/15 at 2:00 PM an interview and record review with the Director of Maintenance (DOM) revealed the facility had not been performing fire drills at unexpected times and varying conditions on the first, second, and third shifts as follows:	K 050	<i>This Plan of Correction is the provider's credible allegation of compliance.</i> <i>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.</i> K 050 <u>1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?</u> Maintenance Director (DOM) was in-serviced on proper fire drill techniques <u>2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken</u> All residents and staff were identified for potential harm. DOM will follow NFPA 101 Life Safety Code Standards when conducting facility fire drills. <u>3. What action did the provider take to assure that the alleged deficient practice does not recur?</u> Maintenance Director will follow the NFPA 101 Life Safety Code Standard for conducting fire drills. DOM will report fire drill times and outcomes to the Executive Director after drills are conducted to ensure that times are being alternated according to Life Safety Code standards. <u>4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?</u> DOM will bring fire drill results to QAPI for IDT team review and Executive Director will continue to monitor fire drills information as DOM completes for 120 days. Expected date of completion: 8-28-2015		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484	
(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 050	Continued From page 5 Three fire drills on the first shift from 09/30/14 through 06/30/15 were conducted between 1:47 PM and 2:30 PM. Three fire drills on the second shift from 07/31/14 through 04/29/15 were conducted between 2:30 PM and 3:15 PM. Four fire drills on the third shift from 08/13/14 through 05/13/15 were conducted between 6:00 AM and 6:15 AM. An interview with the DOM on 07/21/15 at 2:00 PM revealed he was not aware fire drills should be conducted at unexpected times and under varying conditions. The findings were revealed to the Administrator upon exit.	K 050		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 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 by National Fire Protection Association (NFPA) standards. This deficient practice affected three (3) of five (5) smoke compartments, staff, and approximately fifty-five (55) residents. The facility has the capacity for 128 beds with a census of 116 on the	K 062	<i>This Plan of Correction is the provider's credible allegation of compliance.</i> <i>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.</i> K 062 <u>1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?</u> Maintenance Director (DOM) communicated with contracted sprinkler company and the sprinkler heads we changed to reflect the same response heads in Zone 1, 3, and 5. The exit sign was removed from Zone 3. <u>2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken?</u>	

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K 062	<p>Continued From page 6 day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 07/21/15 at 12:20 PM with the Director of Maintenance (DOM), quick response and standard response rated sprinkler heads were observed in the same compartmented space in Zone 1 of the facility. Sprinkler heads located in the same compartmented space usually are required to be of the same type. This condition may adversely affect the way the sprinkler system reacts in a fire situation. During the survey quick and standard response rated sprinkler heads were observed in Zones 3 and 5 of the facility. An exit sign was also observed to be blocking a sprinkler head in Zone 3 of the facility.</p> <p>The facility was cited on 06/03/14 for quick response and standard response sprinkler heads being in the same compartmented space.</p> <p>An interview with the DOM on 07/21/15 at 12:20 PM revealed he thought the sprinkler contractors fixed the issue.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 13 (1999 Edition).</p> <p>5-3.1.5.2 When existing light hazard systems are converted to use quick-response or residential sprinklers, all sprinklers in a compartmented space shall be changed.</p> <p>Reference: NFPA 13 (1999 Edition).</p>	K 062	<p>All residents and staff were identified for potential harm. DOM will follow NFPA 101 Life Safety Code Standards.</p> <p><u>3. What action did the provider take to assure that the alleged deficient practice does not recur?</u></p> <p>Maintenance Director will follow the NFPA 101 Life Safety Code Standards. DOM will follow up with fire safety contractor to ensure that projects are being properly completed according to NFPA 101 Life Safety Code Standards. DOM will maintain a binder that will have all fire safety projects starts and completions.</p> <p><u>4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?</u></p> <p>DOM will continue to monitor sprinkler system using building engines (in-house environmental rounds tracker) protocols. DOM will inform Executive Director of any fire system upgrades and or repairs and the outcomes. Executive Director will oversee the DOM with all fire systems projects ongoing.</p> <p>Expected date of completion: 8-28-2015</p>	

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K 062	Continued From page 7 5-6.5.3* Obstructions that Prevent Sprinkler Discharge from Reaching the Hazard. Continuous or noncontinuous obstructions that interrupt the water discharge in a horizontal plane more than 18 in. (457 mm) below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with this section.	K 062			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 168 HARMON HEIGHTS STANFORD, KY 40484	

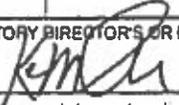
RECEIVED
 AUG 14 2015
 Division of Health Care
 Enforcement Branch

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 02 PLAN APPROVAL: 2007 SURVEY UNDER: 2000 New FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 11(000) SMOKE COMPARTMENTS: Three FIRE ALARM: Complete automatic fire alarm system SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system GENERATOR: Type II natural gas generator A life safety code survey was initiated and concluded on 07/21/15. 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 to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily	K 038		

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

TITLE

(X6) DATE



Administrator

8/14/15

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.

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K 038	<p>Continued From page 1</p> <p>accessible at all times in accordance with section 7.1. 18.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that access to exits was readily accessible at all times by National Fire Protection Association (NFPA) standards. This deficient practice affected one (1) of three (3) smoke compartments, staff, and occupants of the Therapy room. The facility has the capacity for 128 beds with a census of 116 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 07/21/15 at 1:20 PM with the Director of Maintenance (DOM), a test of the cross-corridor doors leading out of the Therapy room revealed the doors would automatically lock by way of a pair of magnetic locking devices located at the top of the door assembly. Any occupants of the Therapy room would have to know the combination of a coded keypad located adjacent to the doors to release the locks for exiting purposes. Access to exits is required to be maintained for emergency purposes. Occupants should be able to leave this room with no special knowledge or effort to operate the door assembly. A set of double doors leading from the other exit of the Therapy room were arranged in the same manner.</p> <p>An interview with the DOM on 07/21/15 at 1:20 PM revealed he did not know the combination to release the doors and was having a programming</p>	K 038	<p><i>This Plan of Correction is the provider's credible allegation of compliance.</i></p> <p><i>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.</i></p> <hr/> <p>K 038</p> <p><u>1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?</u></p> <p>Maintenance Director (DOM) has notified alarm contractor to set up time for reprogramming of doors. The doors will be programmed to follow NFPA 101 Life Safety Code Standards.</p> <p><u>2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken?</u></p> <p>All residents and staff were identified for potential harm. Doors will be corrected to will follow NFPA 101 Life Safety Code Standards</p> <p><u>3. What action did the provider take to assure that the alleged deficient practice does not recur?</u></p> <p>Maintenance Director will follow the NFPA 101 Life Safety Code Standards will all doors and emergency doors/exits. DOM will follow up with alarm contractor to ensure that doors are working according to NFPA 101 Life Safety Code Standards. DOM will continue daily environmental rounds which, includes door checks to ensure all doors are working according to NFPA 101 Life Safety Code Standards</p> <p><u>4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?</u></p> <p>DOM will continue environmental rounds using building engines (in-house environmental rounds tracker) protocols. DOM will provide Executive Director with building engines information for review quarterly for 90 days.</p> <p>Expected date of completion: 8-28-2015</p>	

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K 038	Continued From page 2 issue with the magnetic locking devices. The findings were revealed to the Administrator upon exit. Reference: NFPA 101 (2000 Edition). 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.	K 038	<i>This Plan of Correction is the provider's credible allegation of compliance.</i> <i>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.</i>	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct fire drills to ensure that staff was prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness. This failure affected all residents and staff in the facility. The facility has the capacity for 128 beds with a census of 116 on the day of the survey.	K 050	<u>K 050</u> <u>1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?</u> Maintenance Director (DOM) was in-serviced on proper fire drill techniques. <u>2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken?</u> All residents and staff were identified for potential harm. DOM will follow NFPA 101 Life Safety Code Standards when conducting facility fire drills. <u>3. What action did the provider take to assure that the alleged deficient practice does not recur?</u> Maintenance Director will follow the NFPA 101 Life Safety Code Standard for conducting fire drills. DOM will report fire drill times and outcomes to the Executive Director after drills are conducted to ensure that times are being alternated according to Life Safety Code standards. <u>4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?</u> DOM will bring fire drill results to QAPI for IDT team review and Executive Director will continue to monitor fire drills information as DOM completes for 120 days. Expected date of completion: 8-28-2015	

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K 050	<p>Continued From page 3</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 07/21/15 at 2:00 PM an interview and record review with the Director of Maintenance (DOM) revealed the facility had not been performing fire drills at unexpected times and varying conditions on the first, second, and third shifts as follows:</p> <p>Three fire drills on the first shift from 09/30/14 through 06/30/15 were conducted between 1:47 PM and 2:30 PM.</p> <p>Three fire drills on the second shift from 07/31/14 through 04/29/15 were conducted between 2:30 PM and 3:15 PM.</p> <p>Four fire drills on the third shift from 08/13/14 through 05/13/15 were conducted between 6:00 AM and 6:15 AM.</p> <p>An interview with the DOM on 07/21/15 at 2:00 PM revealed he was not aware fire drills should be conducted at unexpected times and under varying conditions.</p> <p>The findings were revealed to the Administrator upon exit.</p>	K 050			