STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185238	A. BUILDING _____ B. WING _____	C 05/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - VANCEBURG	58 EASTHAM STREET VANCEBURG, KY 41179

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

AMENDED

A Recertification and Abbreviated Survey investigating KY#00020154 was conducted 05/22/13 through 05/26/13. KY#00020154 was unsubstantiated with no deficiencies cited. Immediate Jeopardy was identified on 05/24/13, and was determined to exist on 03/30/13 at 42 CFR 483.65 Infection Control, F-441 and 42 CFR 483.75 Administration, F-490. The facility was notified of the Immediate Jeopardy on 05/24/13.

The facility failed to have a system in place to monitor the disinfection of the facility's whirlpool (w/p) tub and failed to develop and implement effective policies and procedures for the disinfection of the w/p tub. Observation, on 05/23/13, revealed one (1) whirlpool tub was present in the facility. Record review revealed Resident #2 and Resident #4 both had infections and utilized the whirlpool tub. Resident #2 had a Decubitus Ulcer that was cultured and revealed the ulcer contained two (2) organisms, Pseudomonas Aeruginosa and Acinetobacter Species (these bacteria can cause infection in persons with weakened immune systems according to the Centers for Disease Control). Resident #4 had a history of Methicillin Resistant Staphylococcus Aureus (MRSA) and Vancomycin Resistant Enterococcus (VRE) and had Decubitus Ulcers on the buttocks. Resident #4 was admitted to the hospital on 03/15/13 and diagnosed with a Proteus Mirabilis Urinary Tract Infection (UTI) and Clostridium Difficile (C-diff) in his/her stool. Cultures performed on the Decubitus Ulcers were positive for Acinetobacter Species. Resident #4 received a w/p tub bath on

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	LNHA	7/10/13

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F 000	INITIAL COMMENTS	F 000		

AMENDED

A Recertification and Abbreviated Survey investigating KY#00020154 was conducted 05/22/13 through 05/26/13. KY#00020154 was unsubstantiated with no deficiencies cited. Immediate Jeopardy was identified on 05/24/13, and was determined to exist on 03/30/13 at 42 CFR 483.65 Infection Control, F-441 and 42 CFR 483.75 Administration, F-490. The facility was notified of the Immediate Jeopardy on 05/24/13.

The facility failed to have a system in place to monitor the disinfection of the facility's whirlpool (w/p) tub and failed to develop and implement effective policies and procedures for the disinfection of the w/p tub. Observation, on 05/23/13, revealed one (1) whirlpool tub was present in the facility. Record review revealed Resident #2 and Resident #4 both had infections and utilized the whirlpool tub. Resident #2 had a Decubitus Ulcer that was cultured and revealed the ulcer contained two (2) organisms, Pseudomonas Aeruginosa and Acinetobacter Species (these bacteria can cause infection in persons with weakened immune systems according to the Centers for Disease Control). Resident #4 had a history of Methicillin Resistant Staphylococcus Aureus (MRSA) and Vancomycin Resistant Enterococcus (VRE) and had Decubitus Ulcers on the buttocks. Resident #4 was admitted to the hospital on 03/15/13 and diagnosed with a Proteus Mirabilis Urinary Tract Infection (UTI) and Clostridium Difficile (C-diff) in his/her stool. Cultures performed on the Decubitus Ulcers were positive for Acinetobacter Species. Resident #4 received a w/p tub bath on

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F 000	Continued From page 1	F 000		

03/30/13; however, there was no documented evidence the facility ensured the resident was no longer infectious prior to receiving the w/p tub bath.

Observation of the facility's whirlpool tub disinfecting system, on 05/23/13, revealed no presence of a disinfecting solution in the system. Interview with facility staff revealed the Maintenance Director was responsible for maintaining the disinfection system. However, interview with the Maintenance Director revealed he had never refilled the disinfectant in the system in the three (3) years he had been employed by the facility. Interview with Certified Nursing Assistants (CNAs) revealed some used Citrus II disinfectant, diluted with water, to clean the whirlpool tub. However, review of the manufacturer's recommendations revealed this solution was not effective when diluted with water. Further interview with the CNAs revealed some used the whirlpool tub disinfecting system; however, the system contained no disinfectant.

Deficiencies cited were 42 CFR 483.65 Infection Control, F-441 and 42 CFR 483.75 Administration, F-490 at a S/S of a "K".

The facility provided an acceptable credible Allegation of Compliance (AoC) on 05/25/13 with the facility alleging removal of the Immediate Jeopardy on 05/25/13. The State Agency verified, on 05/26/13, the Immediate Jeopardy was removed as alleged on 05/25/13, prior to exiting the facility, with remaining non-compliance at 42 CFR 483.65 (F-441), Infection Control and 42 CFR 483.75 (F-490), Administration at a S/S of a "E", while the facility develops, implements,

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F 000	Continued From page 2 and monitors a Plan of Correction to prevent recurrence of the deficient practice.	F 000		
F 441 SS=K	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	F441, **Whirlpool:** All resident were reviewed during the survey that had received a whirlpool during the last year compared to any ATB or infection they may have had. Copies of this information was provided to Survey Team, there was no clinical correlation between whirlpool bathing and infections. The Medical Director also reviewed the file of whirlpools verses infections, for any negative outcomes. No negative outcomes was observed. No other residents were observed in the deficient practice. The whirlpool tub was placed out of service on 05/23/2013 by placing signs on the whirlpool tub. The water was turned off on the tub on 05/24/2013 and bands along with a sign was placed on the tub. The Central Supply Clerk contacted the ARJO representative to obtain a manual for the tub. A manual was sent to the facility and education of the manual began. The Central Supply Clerk and Maintenance Director ordered substition for dis-infection process an parts for the whirlpool tub to be repaired. A copy of the Whirlpool Manual was given to Administrator, DON, ADON, Maintenance Director, and Central Supply Clerk. The ED and DON, started immediate review of the manual and education. The Central Supply Clerk ordered appropriate chemicals for the tub, and Maintenance spoke with Brian Bloom, ARJO Representative to order parts for the tub. The tub was to remain out of service until complete repair of the tub was made.	

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F 441	Continued From page 3	F 441		

infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to have an effective Infection Control program designed to provide a safe, sanitary environment to help prevent the development and transmission of disease and infection as evidenced by failure to have a system in place to monitor the disinfection of the facility's whirlpool (w/p) tub and failure to develop and implement effective policies and procedures for the disinfection of the w/p tub.

Observation, on 05/23/13, revealed one (1) whirlpool tub was present in the facility. Record review revealed Resident #2 and Resident #4 both had infections and utilized the whirlpool tub. Resident #2 had a Decubitus Ulcer that was cultured and revealed the ulcer contained two (2) organisms, Pseudomonas Aeruginosa and Acinetobacter Species (these bacteria can cause infection in persons with weakened immune systems according to the Centers for Disease Control). Resident #4 had a history of Methicillin Resistant Staphylococcus Aureus (MRSA) and Vancomycin Resistant Enterococcus (VRE) and had Decubitus Ulcers on the buttocks. Resident #4 was admitted to the hospital on 03/15/13 and diagnosed with a Proteus Mirabilis Urinary Tract Infection (UTI) and Clostridium Difficile (C-diff) in his/her stool. Cultures performed on the Decubitus Ulcers were positive for Acinetobacter Species. Resident #4 received a w/p tub bath on

The DON and ADON took the manual and made a complete check off sheet for whirlpool education. The Maintenance Director, Central Supply, Administrator, RNAC, Nurses, Nursing Assistants, and Housekeeping staff was educated on the Dis-infection process. A poster sign was placed next to whirlpool with directions. A complete in-house education of nursing staff, housekeeping staff, and maintenance director was completed, which entailed a demonstration on how to disinfect the whirlpool, with a return demonstration required. Audit was 100% completed on 05/31/2013. The demonstration and return demonstration form was placed

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F 441	Continued From page 4	F 441		

03/30/13; however, there was no documented evidence the facility ensured the resident was no longer infectious prior to receiving the w/p tub bath.

Observation of the facility's whirlpool tub disinfecting system, on 05/23/13, revealed no presence of a disinfecting solution in the system. Interview with facility staff revealed the Maintenance Director was responsible for maintaining the disinfection system. However, interview with the Maintenance Director revealed he had never refilled the disinfectant in the system in the three (3) years he had been employed by the facility. Interview with Certified Nursing Assistants (CNAs) revealed some used Citrus II disinfectant, diluted with water, to clean the whirlpool tub. However, review of the manufacturer's recommendations revealed this solution was not effective when diluted with water. Further interview with the CNAs revealed some used the whirlpool tub disinfecting system; however, the system contained no disinfectant.

Additionally, the facility failed to ensure staff followed the facility's policy and was knowledgeable in the transportation of soiled linens from rooms to the soiled linen cart, to prevent cross-contamination. Further the facility failed to ensure staff sanitized hands between residents while assisting with meals, as per the facility's policy.

Based on the above findings, it was determined the facility's failure to maintain an infection control program designed to provide a safe, sanitary and comfortable environment in order to prevent the development and transmission of disease and

in the orientation packet. A DVD also was ordered on the use of the Whirlpool Tub. The whirlpool disinfectant will be checked daily by Central Supply and if he/she is not available it is the responsibility of the 200 wing housekeeper. A sheet has been posted by the whirlpool for disinfectant cleaner fullness level.

Any resident with active infection, cultures pending, or wounds will no longer be permitted in the whirlpool during that time unless M.D. ordered.

Once the whirlpool is placed back into service a complete audit of the dis-infection process will be observed three times a week for four weeks, and one time weekly for four weeks, then once monthly ongoing. Any further issues will be presented to the Quality Assurance Process Improvement Committee.

Completed: May 25, 2013

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F 441	Continued From page 5	F 441	**Linen**	

infection has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 05/24/13 and determined to exist on 03/30/13.

The facility provided an acceptable credible Allegation of Compliance (AoC) on 05/25/13 with the facility alleging removal of the Immediate Jeopardy on 05/25/13. Immediate Jeopardy was verified removed on 05/26/13, as alleged on 05/25/13, prior to exiting with the facility, with remaining non-compliance at a scope and severity of an "E", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance continues to monitor to ensure a safe, sanitary and comfortable environment and to prevent the development and transmission of disease.

The findings include:

1. Review of the facility policies revealed no documented evidence of a policy for the use of the disinfecting system for the facility's whirlpool (w/p) tub. Further review of the facility's policies revealed an undated policy, which stated if the w/p tub disinfecting system was out of order, staff was to fill the w/p tub with water; add an unspecified amount of disinfectant (Citrus II); and, allow the w/p jets to run for twenty (20) to thirty (30) minutes.

Observation, on 05/23/13 at 3:45 PM, revealed one (1) whirlpool (w/p) tub present in the facility.

Review, of the facility's Group Bathing Report, dated May 2012 through May 26, 2013, revealed the facility provided a total of four hundred and

No negative resident outcomes were observed in the deficient practice

A in-service education was started on June 10, 2013 and will be completed by June 24, 2013, regarding handling of linen to prevent cross-contamination. In-service education does include a guideline on the transportation of linen and care of soiled linen. Education is being provided to Nursing, Housekeeping, and Therapy.

A daily audit to be completed 5x week by DNS, ADNS, and/or designee to assure practice of linen transpiration is being completed times two weeks, then weekly linen audits will be observed by DNS, ADNS or designee times four weeks. Linen transportation guideline will also be updated in the orientation packet for new employees. A annual in-service education will be provided on linen handling and transportation.

Any further concerns will be addressed through Quality Assurance Committee monthly.

Completed: June 24, 2013

OBS 7/23/13 BW

OBS 7/23/13 BW

-Cont

6/24/13

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F 441	Continued From page 6 eighty (480) baths in the w/p tub to include a total of thirty-three (33) current residents. Review of the Bathing Report revealed Resident #2 and Resident #4 received whirlpool tub baths. Record review revealed the facility admitted Resident #2 on 06/14/11, and readmitted the resident on 10/12/12, with Decubitus Ulcers to his/her sacrum, right and left buttocks, and right Trochanter (one of the bony prominences toward the near end of the thigh bone). Review of the laboratory reports revealed a culture was performed of the right Trochanter ulcer on 01/22/13. Review of the culture results revealed the ulcer contained two (2) organisms, Pseudomonas Aeruginosa and Acinetobacter Species (these bacteria can cause infection in persons with weakened immune systems according to the Centers for Disease Control). Review of the facility's Bathing Report revealed Resident #2 had received twenty-four (24) w/p tub baths since his/her admission, both prior to the culture of the Decubitus Ulcer and on 01/24/13 after the culture was completed. Record review revealed Resident #4 had an original admission date of 07/25/11, and was readmitted to the facility on 02/27/12, with chronic Decubitus Ulcers on his/her buttocks and bowel incontinence. Review revealed the resident was noted to have a history of Methicillin Resistant Staphylococcus Aureus (MRSA) and Vancomycin Resistant Enterococcus (VRE). Continued review revealed Resident #4 had been admitted to the hospital on 03/15/13 where he/she was diagnosed with a Proteus Mirabilis Urinary Tract Infection (UTI) and Clostridium Difficile (C-diff) in his/her stool. Additionally, cultures were	F 441	**Hand Hygiene** No negative resident outcomes were observed in the deficient practice A re-in-service education on hand hygiene was started on June 10, 2013 is being completed, including washing hands, hand sanitizer during care and feeding is being completed and will be completed by June 24, 2013. Including Nursing, Dietary, Therapy. The hand hygiene check off sheet is in the orientation packet. A hand washing audit will be completed observation audit will be completed, with demonstration will be completed five times weekly times 4 weeks, then weekly times four weeks, and bi-annual in-service education with periodic audits to be completed by DNS, ADNS, and/or designee. Any further concerns will be addressed in QA-A monthly. Completed: June 24, 2013	

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F 441	Continued From page 7	F 441	F441	

performed on the Decubitus Ulcers on the resident's buttocks during the hospitalization. Review of the hospital culture results, revealed the Decubiti to be positive for Acinetobacter Species. Record review revealed Resident #4 was discharged back to the facility on 03/28/13, and was still being treated for the C-diff infection. Review of the facility's Bathing Report revealed Resident #4 was noted to have received a total of fourteen (14) w/p tub baths to include a w/p tub bath on 03/30/13, however, record review revealed there was no documented evidence the facility ensured the resident was no longer infectious prior to receiving the w/p tub bath 03/30/13.

Staff interviews revealed inconsistencies on disinfecting the w/p tub and lack of knowledge related to procedures for the w/p tub disinfecting system.

Interview, on 05/23/13 at 5:45 PM, with Certified Nursing Assistants (CNAs) #15 and #24 revealed they used the disinfecting system on the w/p tub; however, they did not know how to tell if there was disinfectant in the system. They stated they were not sure who was responsible for refilling the disinfectant in the w/p tub disinfecting system. The CNAs stated they did not know who to ask to have the disinfectant refilled and did not know how to tell if it needed refilling.

Interview, on 05/24/13 at 10:15 PM, with CNA #5 revealed she used the w/p tub disinfecting system for disinfecting the tub after resident baths; however, she was unable to tell if there was disinfectant in the system. She stated she was not sure how to disinfect the w/p tub if the

The Facility DNS and ADNS will monitor the infection control program. The facility will review in-house infection control, and hospital returns with infections. The Infection Surveillance Report Form will be completed by ADNS which will give us the average new re-occurred infection rate it will list Infection Data, Culture information, and Antibiotic Treatment. A colored coded floor plan will be attached and colored for presence of the location of the infection. Documentation of Infection or Communicable Disease form will be completed on each individual resident. The facility will compile the reports and look for trending, root cause, and further prevention and re-education will be given. The ED, DNS and/or designee will make rounds three times weekly to assure infection control prevention measures are in place. Examples of rounds will include the Monitoring Compliance with Infection Control Checklist which includes various Surveillance Items such as: Environmental, Equipment and Nursing. If any breech in infection control observed in rounds, immediate

OBS 7/23/13

OBS 7/23/13

OBS QA 7/23/13

intervention and correction will occur, and continue with re-education. Any further problems observed will be forwarded to QA-A for further resolution.

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disinfecting system was broken.

Interview, on 05/25/13 at 10:50 AM, with CNA #1 revealed she had never used the w/p tub disinfecting system to disinfect the tub. She stated she "wiped it out". However, was unable to say what she "wiped it out" with. She stated she had never been shown how to disinfect the w/p tub and was unable to tell if there was disinfectant in the disinfecting system.

Interview, on 05/23/13 at 7:10 PM, CNA #6 revealed she disinfected the w/p tub with spray that was located in the linen closet. She stated she thought it was a bleach spray, however she was not sure.

Interview, on 05/25/13 at 9:40 AM, with CNA #12 revealed she had used the "cleaning stuff" in the supply room to disinfect the w/p tub; however, was unable to recall what the "cleaning stuff" was. She stated no one had ever shown her how to disinfect the w/p tub.

Interview, on 05/25/13 at 9:55 AM, with CNA #13 revealed she used the w/p tub disinfecting system for disinfecting the tub. She stated she could tell the disinfectant was coming out of the system by observing for a "mist". She stated she thought the Maintenance Director was responsible for refilling the disinfecting system. Per interview, CNA #13 stated she used the Citrus II disinfectant when the disinfecting system was out of disinfectant; however, was unable to tell how she knew when the disinfectant in the w/p tub disinfecting system was out.

Interview, on 05/23/13 at 3:45 PM, with CNA #3

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revealed she used the w/p disinfecting system after resident baths. She stated she would turn the w/p disinfecting system on, the water would bubble, and that's how she could tell the disinfectant was in the tub. She stated if there was no disinfectant in the disinfecting system it wouldn't bubble and she would tell a nurse, who would tell the Maintenance Director and he would refill the disinfectant. She indicated if the Maintenance Director was not present in the facility she would "guess" the nurse would refill the disinfectant in the w/p tub disinfecting system.

Interview, on 05/24/13 at 4:00 PM, with Licensed Practical Nurse (LPN) #4 revealed nurses were not aware of the disinfecting process for the w/p tub. She stated the CNAs were responsible for this, as they gave the baths. The LPN stated nurses did not monitor the w/p tub disinfection. According to the LPN, she thought the Maintenance Director was who the CNAs would tell if they needed anything related to the w/p tub.

Observation, on 05/23/13 at 6:15 PM, of the facility's locked w/p tub disinfecting system revealed no visual evidence of the presence of a disinfecting solution in the system. Interview, during the observation with the Maintenance Director, who staff indicated was responsible for refilling the disinfectant, revealed he occasionally sanitized the w/p tub himself with the disinfectant in the w/p tub disinfecting system.

Interview, on 05/23/13 at 4:50 PM, with the Assistant Director of Nursing (ADON), who was also the facility's Infection Control Nurse, revealed there was no system in place to monitor the w/p tub disinfectant. Additional interview, on

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05/23/13 at 6:10 PM, with the ADON revealed she did not know how staff could tell if there was disinfectant in the w/p tub disinfecting system. The ADON revealed she was unaware of what the disinfecting solution for the w/p tub disinfecting system looked like. She indicated it was the Maintenance Director's responsibility to refill the w/p tub disinfecting system with disinfectant.

However, further interview with the Maintenance Director on 05/23/13 at 6:30 PM, revealed he had never refilled the disinfectant in the w/p tub disinfecting system in the three (3) years he had been employed. He stated he did not know what the disinfectant container looked like and didn't know who would know.

Interview, on 05/23/13 at 6:10 PM, with the ADON revealed the disinfectant for the w/p tub disinfecting system was stored in the "cage" (facility's main supply area). However, observation during the interview of the facility's supply area, revealed no evidence of the disinfecting solution for the whirlpool disinfecting system.

Interview, on 05/23/13 at 6:45 PM, with the Central Supply Clerk, who was responsible for ordering products, revealed she was unaware the w/p tub had a disinfecting system. She stated she had never been asked to order the disinfectant solution for the disinfecting system on the w/p tub.

Further interview, on 05/25/13 at 4:37 PM, with the ADON revealed on 05/14/13 she was made aware that a piece on the w/p tub disinfecting

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system was broken. She developed a policy for disinfecting the w/p tub with a disinfectant used for disinfecting shower chairs and wheelchairs (Citrus II disinfectant). Per interview, an inservice was held and staff were instructed to fill the w/p tub with water; add an unspecified amount of disinfectant (Citrus II); and, allow the w/p jets to run for twenty (20) to thirty (30) minutes.

However, review of the Citrus II disinfectant label revealed the disinfectant was "ready to use". Review, of a facility e-mail dated 05/24/13, timed 9:12 AM, from the Customer Service Manager of the supplier of the Citrus II, revealed the Citrus II disinfectant would not be "an effective cleaner for a whirlpool system". The e-mail stated this product was designed to be used full strength, once it was diluted with water the "kill times" and claims could no longer be supported.

Further interview, on 05/25/13 at 4:37 PM, with the ADON revealed she was unaware the Citrus II disinfectant should not be diluted with water when she developed the policy on 05/14/13. However, the disinfectant label stated "ready to use".

Interview, on 05/23/13 at 6:35 PM, with the Director of Nursing (DON) revealed the Citrus II should be diluted with water. However, there were no instructions on the label to dilute the product. Further interview, on 05/26/13 at 3:54 PM, with the DON revealed she was not aware the Citrus II disinfectant should not be diluted until 05/24/13 when the facility received the email from the supplier of the Citrus II. Interview, on 05/24/13 at 9:53 AM, with the DON revealed the facility did not have a process in place to culture the w/p tub jets. Further interview, on 05/26/13 at

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3:54 PM, revealed the facility should have had policies and procedures in place for the disinfection of the w/p tub to promote resident safety and prevent cross-contamination. She stated there should have been a process in place for the monitoring of the disinfection of the w/p tub.

Interview, on 05/26/13 at 3:37 PM, with the Administrator revealed she came to the facility in September 2012. She stated she knew the w/p tub was purchased in 2008. Per interview, she was not aware the w/p had not been disinfected until 05/14/13 when staff indicated to her that they had never used the w/p tub disinfecting system since the purchase of the tub. Per interview, she was not aware the Citrus II disinfectant shouldn't be diluted with water when she had instructed the ADON to develop a policy for disinfecting the w/p tub with the Citrus II.

Interview, on 05/24/13 at 3:25 PM, with the Medical Director revealed she was not aware of there being no disinfectant in the w/p tub disinfecting system. She stated she would assume the w/p tub was being disinfected between residents. The Medical Director stated if there was no disinfectant used there would be potential for cross-contamination/transmission of organisms to other residents.

Interview, on 05/25/13 at 3:23 PM, with the representative of the company who supplied the w/p tub, revealed the w/p tub disinfecting system should always be used for disinfecting the w/p tub. He stated if the disinfecting system was broken then the w/p tub should not be used until the disinfecting system was fixed.

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2. A review of the facility's policy titled, "Handling Linens to Prevent and Control Infection Transmission" undated, revealed it was important that all potentially contaminated linen be handled with appropriate measures to prevent cross-transmission. The facility handled all used linen as potentially contaminated. Further review of the facility procedure for Direct Caregiver Infection Control, dated 01/13/12, revealed dirty linen carts were to be placed by the doorway when entering a room for resident care. Review revealed if linens were soiled they should be placed in a bag in the room, then into the dirty linen cart. Otherwise dirty bed linen could be placed in the dirty linen cart directly outside of resident doorways.

Observation on the initial tour, on 05/23/13 at 9:30 AM, revealed CNA #4 carried soiled linen against her clothing from Room #319 to the soiled linen cart across the hall in front of room #313.

Interview with CNA #4, on 05/23/13 at 9:30 AM, revealed she always carried the soiled linens out of the resident's room to the soiled cart. She stated she should not have carried soiled linens against her clothes because of the risk for cross contamination. Observation at the time of the interview revealed no evidence of bags in the room to place soiled linen in as per facility's policy.

Interview, on 05/25/13 at 4:37 PM, with the ADON, who also was the facility's Infection Control Nurse, revealed staff should not carry dirty linen against their clothing because that

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could contaminate their clothing and carry organisms to other residents. She stated staff should have a dirty linen cart outside the room and carry the linen to it. The ADON indicated staff should not carry dirty linen in the hallway. According to the ADON, the only time the facility had staff put dirty linen in a bag in the room, was when it was heavily soiled with bowel movement.

3. Review of the facility's policy titled, "Handwashing / Hand Hygiene", revised August 2012, revealed all personnel was to follow the established Handwashing/Hand Hygiene procedure to prevent the spread of infections and disease to other personnel, residents, and visitors. Further review revealed personnel was to wash hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water before and after assisting a resident with meals and after handling soiled equipment or utensils.

Observation of the meal service in the community's dining room, on 05/23/13 at 12:20 PM, revealed CNA #15 assisted Unsampled Resident A with eating during meals. After Unsampled Resident A stopped feeding himself/herself, CNA #15 picked up Unsampled Resident A's eating utensil, and helped the resident continue eating. CNA #15 then proceeded to assist Unsampled Resident B by grasping his/her eating utensil and encouraged him/her to continue eating. CNA #15 was observed not sanitizing or washing hands between residents.

Interview, on 05/23/13 at 12:30 PM, with CNA #15, revealed she should have sanitized her

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hands in between residents. CNA #15 further revealed that by not doing so, she could spread germs. CNA #15 stated,"it is unsanitary".

Interview, on 05/24/13 at 2:10 PM, DON revealed that personnel should sanitize their hands between providing assistance with each resident. The DON further revealed that staff should sanitize hands in-between resident care. The DON stated proper handwashing was important due to infection control.

Review of the facility's acceptable AoC, dated 05/25/13, revealed the following:

1. The whirlpool (w/p) tub was placed out of service on 05/23/13, by placing signs on the w/p tub and on the w/p disinfecting system.

2. The water to the w/p tub was turned off on 05/24/13 and "banding" was placed across the w/p tub to prevent further use.

3. On 05/24/13, the Central Supply Clerk notified the w/p tub representative to obtain a manual for the w/p, the disinfectant and the parts needed for the w/p tub disinfecting system were ordered. The manual was faxed that day to the facility and copies were given to the DON, ADON, Administrator, Maintenance Director, and Central Supply Clerk.

4. The w/p tub representative scheduled a date (05/29/13) to bring the parts for the disinfectant, if he could not come that day the w/p tub was to remain out of service until the representative arrived.

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5. All nursing staff, all housekeeping staff, the Central Supply Clerk and Maintenance Director were to be inserviced on how to properly disinfect the w/p tub by the DON, ADON, or Minimum Data Set (MDS) Nurse. They were then to perform a competency checkoff that was developed from the w/p tub manual on the disinfection process. This inservice with return demonstration was started on 05/24/13. Staff would not be allowed to work until they had completed the inservice and performed the checkoff.

6. A Master Staff List was being kept to ensure all nursing staff, all housekeeping staff, the Central Supply Clerk and Maintenance Director received the inservice education and performed the competency.

7. The inservice education and competency check list were added to the orientation packet for all new nursing staff and housekeeping staff.

8. Whirlpool tub cleaning instructions were posted by the w/p tub on 05/25/13.

9. A w/p check list was developed on 05/24/13. The Central Supply Clerk was to check the w/p disinfecting system for appropriate levels of disinfectant daily when on duty. The 200 wing Housekeeper was responsible for checking the w/p when the Central Supply Clerk was not on duty. If the disinfectant was low an order was to be placed into the facility's computer system for maintenance.

10. Observance of the proper use of w/p disinfecting process was to be audited three (3) times a week for four (4) weeks, then one (1)

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time weekly for four (4) weeks, then once a month ongoing. The audits were to be performed by the Administrator or her designee. Any issues were to be presented to the Quality Assurance/Process Improvement Committee.

The surveyors vatidated the corrective action taken by the facility, prior to exit on 05/26/13, as follows:

*Observation, on 05/26/13 at 2:40 PM, of the whirlpool tub room revealed a sign on the wall by the w/p tub with the disinfecting instructions. Observation revealed the w/p tub to have "banding" on the w/p tub to prevent use, out of order signs on the w/p tub, and the water to the w/p tub to be turned off. Further observation revealed two (2) staff persons receiving the inservice education with return demonstration.

*Review of an orientation packet revealed the inservice education and competency check list were present in the packet.

*Review of the materials submitted for review related to the abatement revealed a Master Staff List of all nursing staff, all housekeeping staff, the Central Supply Clerk and Maintenance Director who had received the inservice education and performed the competency, and of those who still required the education and competency check off.

*Interview, on 05/26/12 at 1:30 PM, with the Central Supply Clerk revealed she had obtained the manual and received a copy of it. She indicated the DON, ADON, and Maintenance Director had all received copies of the manual

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also. The Central Supply Clerk stated she had ordered the parts and disinfecting solution for the w/p tub. She stated she had received inservice education on the disinfection of the w/p tub with a return demonstration for competency. Further interview revealed it was now her responsibility to check the w/p tub disinfectant in the disinfecting system once per day when she's on duty. She stated there was now a clipboard with a checklist on it that she must fill out when observing the disinfectant. Continued interview revealed she works Monday through Friday and would be checking it on those days. The Central Supply Clerk stated she would refill the disinfectant if it was low and order a new supply to replace it.

*Interview, on 05/26/13 at 3:00 PM, with the DON revealed the facility had contacted the w/p tub representative for a copy of the w/p tub manual. She stated she had received a copy of the manual, as well as, the ADON, Maintenance Director, and Central Supply Clerk. She stated she had developed her inservice and competency check list material from the disinfection process in the manual. The DON stated she had trained the ADON, MDS Coordinator, Central Supply Clerk, and Maintenance Director. In addition, she stated staff was being trained by herself, the ADON, and the MDS Coordinator. She stated staff would not be allowed to work until they had received the inservice training and performed a return demonstration for competency. The DON indicated the w/p tub representative had scheduled a date (05/29/13) to bring the parts, the disinfectant, and to provide education to her, the ADON, Maintenance Director, and Central Supply Clerk on any updates related to the w/p tub and disinfection process. According to the

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DON, if the w/p tub representative could not come that day, the w/p tub was to remain out of service until the representative arrived.

*Interview, on 05/26/13 at 2:00 PM, with the 200 Hall Housekeeping Supervisor revealed she had been inserviced on the w/p tub disinfecting system on 05/25/13. She stated if the Central Supply Clerk was not present to conduct the daily checking of the w/p tub disinfectant the 200 Hall Housekeeper would be responsible for checking.

*Interview, on 05/26/13 at 12:10 PM, with Housekeeper #3 who worked on the 200 Hall; at 11:25 AM with Housekeeper #2, who was working on the 100 Hall; and, at 11:30 AM with Housekeeper #1, who was working on the 100 Hall, revealed they had all been inserviced on 05/24/13 and 05/25/13 related to the w/p tub disinfecting system and had performed a return demonstration for competency. They stated the w/p disinfecting system was to be checked daily by the Central Supply Clerk if she was on duty and if she wasn't, the Housekeeper on the 200 Hall would be responsible for performing the check to ensure there was disinfectant in the system.

*Interview, on 05/26/13 at 1:30 PM, with the Maintenance Director revealed he had turned the water off to the w/p tub and it would remain turned off until the w/p tub part was fixed and the disinfectant for the w/p disinfecting system was received. He stated he had been given a copy of the w/p tub manual. The Maintenance Director stated he had been inserviced on the w/p tub disinfecting system and had completed a return demonstration for competency.

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*Interview, on 05/26/13 at 3:40 PM, with the MDS Coordinator revealed she had received an inservice given by the DON on the w/p tub disinfecting system and had performed a return demonstration for competency. She stated she had provided inservices to staff and observed return demonstrations for competency since being trained. She stated staff would not be allowed to work until they had received the inservice training and performed a return demonstration for competency.

*Interviews were conducted on 05/26/13 to verify that staff had received education, performed a return demonstration for competency, and verify staffs' knowledge of the disinfection of the w/p tub as follows: Licensed Practical Nurse (LPN) #2 at 2:00 PM, LPN #1 at 2:10 PM, LPN #3 at 2:45 PM, LPN #5 at 3:20 PM, CNA #5 at 11:40 AM, CNA #21 at 1:40 PM, CNA #1 at 1:42 PM, CNA #6 at 2:00 PM, CNA #22 at 2:15 PM, CNA #13 at 2:30 PM, CNA #20 at 2:40 PM, CNA #16 at 2:15 PM, CNA #19 at 2:20 PM, CNA #18 at 2:25 PM, CNA #17 at 2:30 PM, CNA #25 at 2:37 PM, CNA #23 at 4:45 PM, and Registered Nurse (RN) #1 at 2:50 PM. All staff verbalized having received the inservice training on 05/24/13 or 05/25/13 related to the w/p tub disinfection process, and performance of return demonstration for competency, and were aware the w/p tub would remain out of use until the tub was repaired and the disinfecting solution for the disinfecting system was obtained. Record review validated the training was provided on 05/24/13 and 05/25/13.

*Interview, on 05/26/13 at 3:47 PM, with the

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F 441	Continued From page 21 Administrator revealed the w/p tub was placed out of order on 05/23/13 in the evening. She stated the w/p representative was contacted, a copy of the w/p tub manual was requested and the part for the w/p tub was ordered. She also stated the disinfectant for the w/p tub disinfecting system was ordered, and the representative made an appointment to come on 05/29/13 to bring the part and disinfectant solution and provide training on any updates to the w/p tub and disinfecting system. The Administrator stated a copy of the w/p tub manual was received and copies were given to her, the DON, the ADON, the Maintenance Director, and the Central Supply Clerk. She stated inservice training had been developed with a competency check list. According to the Administrator, staff was being trained and required to do a return demonstration for competency prior to being allowed to work. The Administrator stated the w/p tub would remain out of service until the part and disinfecting solution came in. Further interview revealed observation of disinfecting process would be audited three (3) times a week for four (4) weeks, one (1) time a week for four (4) weeks, then once monthly and ongoing.	F 441		
F 490 SS=K	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - VANCEBURG	58 EASTHAM STREET VANCEBURG, KY 41179

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 490 Continued From page 22

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review and review of the facility's policy, it was determined the facility's Administration failed to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable, physical, or psychosocial well-being of each resident. The facility failed to have a system in place to ensure disinfection of the facility's whirlpool (w/p) tub and failed to ensure effective policies and procedures were developed and implemented for the disinfection of the w/p tub.

Observation, on 05/23/13, revealed one (1) whirlpool tub was present in the facility. Resident #2 and Resident #4 both had infections and utilized the whirlpool tub. Resident #2, who utilized the w/p tub, had a Decubitus Ulcer that was cultured and revealed the ulcer contained two (2) organisms, Pseudomonas Aeruginosa and Acinetobacter Species (these bacteria can cause infection in persons with weakened immune systems according to the Centers for Disease Control). Resident #4 was noted to have a history of Methicillin Resistant Staphylococcus Aureus (MRSA) and Vancomycin Resistant Enterococcus (VRE). Resident #4 was admitted to the hospital on 03/15/13 and diagnosed with a Proteus Mirabilis Urinary Tract Infection (UTI) and Clostridium Difficile (C-diff) in his/her stool. Cultures were performed on the Decubitus Ulcers on Resident #4's buttocks and were positive for Acinetobacter Species. Resident #4 was noted to have received a w/p tub bath on 03/30/13, however there was no

F 490

F490
Infection Control Program:

The facility ED and DNS will ensure to administer a effective Infection program, and utilize its resources effectively and efficiently to attain or maintain the highest practicable, physical, or psychosocial well being of each resident. A review of the infection control program (policy and procedure) was completed by the ED, DNS, with review of systems, including infection control manual, cleaning of equipment, and education on dis-infection of medical equipment i.e. shower chairs, wheelchairs. The ADNS has been re-educated regarding the infection control policy and the procedure, and the program will be overseen by the ED and DNS. The ED and DNS will assure the effective policy and or procedure is in place for dis-infection of the whirlpool tub. Will require monthly reporting from the ADNS of infections and intervention utilized.

The ED, DNS and ADNS will be responsible for the Infection Control Policy and Procedure including: Tracking, Monitoring, Surveillance, Trending, and Action plan related to infection control along with education and auditing, however this will be monitored with a monthly report submitted by the ADNS to the ED and DNS.

Completed: May 25, 2013

7/23/13 DNS

7/23/13 ED

7/23/13 ADNS

5/24/13

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F 490	Continued From page 23 documented evidence the facility ensured the resident was no longer infectious prior to receiving the w/p tub bath. Observation of the facility's whirlpool tub disinfecting system, on 05/23/13, revealed no presence of a disinfecting solution in the system. Interview with facility staff revealed the Maintenance Director was responsible for maintaining the disinfection system. However, interview with the Maintenance Director revealed he had never refilled the disinfectant in the system in the three (3) years he had been employed by the facility. Interview with Certified Nursing Assistants (CNAs) revealed some used Citrus II disinfectant, diluted with water, to clean the whirlpool tub. However, review of the manufacturer's recommendations revealed this solution was not effective when diluted with water. Further interview with the CNAs revealed some used the whirlpool tub disinfecting system; however, the system contained no disinfectant. Based on the findings, it was determined the facility's Administration failed to ensure policies and procedures were developed and staff was educated related to the disinfection of the w/p tub to ensure the prevention, development and transmission of diseases and infection is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 05/24/13 and determined to exist on 03/30/13. The facility provided an acceptable credible Allegation of Compliance (AoC) on 05/25/13 with the facility alleging removal of the IJ on 05/25/13. On 05/26/13 the State Agency verified removal of	F 490	The nursing staff is being re-educated on hand washing, hand sanitizing, feeding (including feeding total dependent, assist and cue residents), and linen transportation before and after care the education will be completed by June 24, 2013. The education was started on June 10, 2013. A yearly review of Policy and Procedures will be completed during the QA-A process with the Interdisciplinary Team. This will be monitored monthly during the Quality Assurance Process Improvement Committee. Completed: June 24, 2013	

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F 490 Continued From page 24

the IJ as the facility alleged on 05/25/13 prior to exiting with the facility, with remaining non-compliance at a scope and severity of an "E", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance along with Administration continues to monitor to ensure a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection.

(Refer to F-441)

The findings include:

Review of the facility's policies and procedures revealed no documented evidence of policies and procedures for the disinfecting system for the facility's w/p tub.

Observation, on 05/23/13 at 3:45 PM, revealed one (1) whirlpool (w/p) tub present in the facility. Review of the facility's Group Bathing Report and record review revealed two of the residents utilizing the w/p tub had infections, Resident #2 and Resident #4. However, observation of the facility's locked w/p tub disinfecting system revealed no visual evidence of the presence of a disinfecting solution in the system and staff interviews revealed lack of knowledge on how to disinfect the w/p tub. Observation revealed the disinfecting solution for the w/p tub disinfecting system was not located in the facility and interview with the Central Supply Clerk revealed Administration had never instructed her to order the disinfectant solution for the w/p tub disinfecting system.

Interview, on 05/26/13 at 3:37 PM, with the

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F490

The Facility DNS and ADNS will monitor the infection control program. The facility will review in-house infection control, and hospital returns with infections. The Infection Surveillance Report Form will be completed by ADNS which will give us the average new no-socomial infection rate it will list Infection Data, Culture information, and Antibiotic Treatment. A colored coded floor plan will be attached and colored for presence of the location of the infection. Documentation of Infection or Communicable Disease form will be completed on each individual resident. The facility will compile the reports and look for trending, root cause, and further prevention and re-education will be given. The ED, DNS and/or designee will make rounds three times weekly to assure infection control policy and procedure, and prevention measures are in place to ensure proper infection control guidelines are being observed. Examples of rounds will include the Monitoring Compliance with Infection Control Checklist which includes various Surveillance Items such as: Environmental, Equipment and Nursing. If any breech in infection control observed in rounds, immediate intervention and correction will occur, and continue with re-education. Any further problems observed will be forwarded to QA-A for further resolution.

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Administrator revealed she was hired in September 2012 and was not aware there was no system in place to monitor the disinfection of the w/p tub. She stated there should be a policy and procedure for everything and staff should have been educated on the procedure for the disinfecting system for the w/p tub. Per interview, on 05/14/13, she was told the disinfecting system for the w/p tub was broken and a piece was missing on the w/p tub. The Administrator stated she talked to staff to see how they were disinfecting the w/p tub since the piece was missing. She stated staff told her they were using the "Citrus cleaner" and she then asked the Director of Nursing (DON) and Assistant Director of Nursing (ADON) to "write up" the procedure the CNAs were using for disinfection of the w/p tub. However, interviews on 05/23/13 with CNAs #7, #15, and #24 revealed they did not use the Citrus II disinfectant for disinfecting the w/p tub. According to the CNAs, the Citrus II disinfectant was to be used for disinfecting wheelchairs and shower chairs.

Review of this undated policy, describing how to disinfect the w/p tub if the disinfecting system was out of order, revealed staff was to use the disinfectant used to sanitize showers and wheelchairs (Citrus II disinfectant). The policy instructed staff to fill the w/p tub with water, add an unspecified amount of disinfectant (Citrus II), and, run the w/p jets for twenty (20) to thirty (30) minutes. However, review of the Citrus II disinfectant label revealed the disinfectant was "ready to use" and an e-mail dated 05/24/13, timed 9:12 AM, from the Customer Service Manager stated the product was designed to be used full strength. The e-mail stated once the

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product was diluted with water the "kill times" and claims could no longer be supported.

Interview, on 05/23/13 at 6:35 PM, with the DON revealed she thought the Citrus II should be diluted with water. Interview, on 05/25/13 at 4:37 PM, with the ADON who developed the undated policy, revealed she was not aware the Citrus II disinfectant should not be diluted with water until 05/24/13, when they received the e-mail from the product's Customer Service Manager.

Additional interview with the Administrator, on 05/26/13 at 3:37 PM, revealed she reviewed the undated policy; however, she was not aware the Citrus II disinfectant, indicated for use in the undated policy, should not be diluted with water until 05/24/13.

Review of the facility's acceptable AoC, dated 05/25/13, revealed the following:

1. The whirlpool (w/p) tub was placed out of service on 05/23/13, by placing signs on the w/p tub and on the w/p disinfecting system.

2. The water to the w/p tub was turned off on 05/24/13 and "banding" was placed across the w/p tub to prevent further use.

3. On 05/24/13, the Central Supply Clerk notified the w/p tub representative to obtain a manual for the w/p, the disinfectant and the parts needed for the w/p tub disinfecting system were ordered. The manual was faxed that day to the facility and copies were given to the DON, ADON, Administrator, Maintenance Director, and Central Supply Clerk.

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4. The w/p tub representative scheduled a date (05/29/13) to bring the parts for the disinfectant, if he could not come that day the w/p tub was to remain out of service until the representative arrived.

5. All nursing staff, all housekeeping staff, the Central Supply Clerk and Maintenance Director were to be inserviced on how to properly disinfect the w/p tub by the DON, ADON, or Minimum Data Set (MDS) Nurse. They were then to perform a competency checkoff that was developed from the w/p tub manual on the disinfection process. This inservice with return demonstration was started on 05/24/13. Staff would not be allowed to work until they had completed the inservice and performed the checkoff.

6. A Master Staff List was being kept to ensure all nursing staff, all housekeeping staff, the Central Supply Clerk and Maintenance Director received the inservice education and performed the competency.

7. The inservice education and competency check list were added to the orientation packet for all new nursing staff and housekeeping staff.

8. Whirlpool tub cleaning instructions were posted by the w/p tub on 05/25/13.

9. A w/p check list was developed on 05/24/13. The Central Supply Clerk was to check the w/p disinfecting system for appropriate levels of disinfectant daily when on duty. The 200 wing Housekeeper was responsible for checking the w/p when the Central Supply Clerk was not on

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duty. If the disinfectant was low an order was to be placed into the facility's computer system for maintenance.

10. Observance of the proper use of w/p disinfecting process was to be audited three (3) times a week for four (4) weeks, then one (1) time weekly for four (4) weeks, then once a month ongoing. The audits were to be performed by the Administrator or her designee. Any issues were to be presented to the Quality Assurance/Process Improvement Committee.

The surveyors validated the corrective action taken by the facility, prior to exit on 05/26/13, as follows:

*Observation, on 05/26/13 at 2:40 PM, of the whirlpool tub room revealed a sign on the wall by the w/p tub with the disinfecting instructions. Observation revealed the w/p tub to have "banding" on the w/p tub to prevent use, out of order signs on the w/p tub, and the water to the w/p tub to be turned off. Further observation revealed two (2) staff persons receiving the inservice education with return demonstration.

*Review of an orientation packet revealed the inservice education and competency check list were present in the packet.

*Review of the materials submitted for review related to the abatement revealed a Master Staff List of all nursing staff, all housekeeping staff, the Central Supply Clerk and Maintenance Director who had received the inservice education and performed the competency; and of those who still required the education and competency check

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off.

'Interview, on 05/26/12 at 1:30 PM, with the Central Supply Clerk revealed she had obtained the manual and received a copy of it. She indicated the DON, ADON, and Maintenance Director had all received copies of the manual also. The Central Supply Clerk stated she had ordered the parts and disinfecting solution for the w/p tub. She stated she had received inservice education on the disinfection of the w/p tub with a return demonstration for competency. Further interview revealed it was now her responsibility to check the w/p tub disinfectant in the disinfecting system once per day when she's on duty. She stated there was now a clipboard with a checklist on it that she must fill out when observing the disinfectant. Continued interview revealed she works Monday through Friday and would be checking it on those days. The Central Supply Clerk stated she would refill the disinfectant if it was low and order a new supply to replace it.

'Interview, on 05/26/13 at 3:00 PM, with the DON revealed the facility had contacted the w/p tub representative for a copy of the w/p tub manual. She stated she had received a copy of the manual, as well as, the ADON, Maintenance Director, and Central Supply Clerk. She stated she had developed her inservice and competency check list material from the disinfection process in the manual. The DON stated she had trained the ADON, MDS Coordinator, Central Supply Clerk, and Maintenance Director. In addition, she stated staff was being trained by herself, the ADON, and the MDS Coordinator. She stated staff would not be allowed to work until they had received the inservice training and performed a

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return demonstration for competency. The DON indicated the w/p tub representative had scheduled a date (05/29/13) to bring the parts, the disinfectant, and to provide education to her, the ADON, Maintenance Director, and Central Supply Clerk on any updates related to the w/p tub and disinfection process. According to the DON, if the w/p tub representative could not come that day, the w/p tub was to remain out of service until the representative arrived.

"Interview, on 05/26/13 at 2:00 PM, with the 200 Hall Housekeeping Supervisor revealed she had been inserviced on the w/p tub disinfecting system on 05/25/13. She stated if the Central Supply Clerk was not present to conduct the daily checking of the w/p tub disinfectant the 200 Hall Housekeeper would be responsible for checking.

"Interview, on 05/26/13 at 12:10 PM, with Housekeeper #3 who worked on the 200 Hall, at 11:25 AM with Housekeeper #2, who was working on the 100 Hall; and, at 11:30 AM with Housekeeper #1, who was working on the 100 Hall, revealed they had all been inserviced on 05/24/13 and 05/25/13 related to the w/p tub disinfecting system and had performed a return demonstration for competency. They stated the w/p disinfecting system was to be checked daily by the Central Supply Clerk if she was on duty and if she wasn't, the Housekeeper on the 200 Hall would be responsible for performing the check to ensure there was disinfectant in the system.

"Interview, on 05/26/13 at 1:30 PM, with the Maintenance Director revealed he had turned the water off to the w/p tub and it would remain

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turned off until the w/p tub part was fixed and the disinfectant for the w/p disinfecting system was received. He stated he had been given a copy of the w/p tub manual. The Maintenance Director stated he had been inserviced on the w/p tub disinfecting system and had completed a return demonstration for competency.

'Interview, on 05/26/13 at 3:40 PM, with the MDS Coordinator revealed she had received an inservice given by the DON on the w/p tub disinfecting system and had performed a return demonstration for competency. She stated she had provided inservices to staff and observed return demonstrations for competency since being trained. She stated staff would not be allowed to work until they had received the inservice training and performed a return demonstration for competency.

'Interviews were conducted on 05/26/13 to verify that staff had received education, performed a return demonstration for competency, and verify staffs' knowledge of the disinfection of the w/p tub as follows:

Licensed Practical Nurse (LPN) #2 at 2:00 PM, LPN #1 at 2:10 PM, LPN #3 at 2:45 PM, LPN #5 at 3:20 PM, CNA #5 at 11:40 AM, CNA #21 at 1:40 PM, CNA #1 at 1:42 PM, CNA #6 at 2:00 PM, CNA #22 at 2:15 PM, CNA #13 at 2:30 PM, CNA #20 at 2:40 PM, CNA #16 at 2:15 PM, CNA #19 at 2:20 PM, CNA #18 at 2:25 PM, CNA #17 at 2:30 PM, CNA #25 at 2:37 PM, CNA #23 at 4:45 PM, and Registered Nurse (RN) #1 at 2:50 PM. All staff verbalized having received the inservice training on 05/24/13 or 05/25/13 related to the w/p tub disinfection process, and performance of

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return demonstration for competency, and were aware the w/p tub would remain out of use until the tub was repaired and the disinfecting solution for the disinfecting system was obtained. Record review validated the training was provided on 05/24/13 and 05/25/13.

*Interview, on 05/26/13 at 3:47 PM, with the Administrator revealed the w/p tub was placed out of order on 05/23/13 in the evening. She stated the w/p representative was contacted, a copy of the w/p tub manual was requested and the part for the w/p tub was ordered. She also stated the disinfectant for the w/p tub disinfecting system was ordered, and the representative made an appointment to come on 05/29/13 to bring the part and disinfectant solution and provide training on any updates to the w/p tub and disinfecting system. The Administrator stated a copy of the w/p tub manual was received and copies were given to her, the DON, the ADON, the Maintenance Director, and the Central Supply Clerk. She stated inservice training had been developed with a competency check list. According to the Administrator, staff was being trained and required to do a return demonstration for competency prior to being allowed to work. The Administrator stated the w/p tub would remain out of service until the part and disinfecting solution came in. Further interview revealed observation of disinfecting process would be audited three (3) times a week for four (4) weeks, one (1) time a week for four (4) weeks, then once monthly and ongoing.

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K 000	INITIAL COMMENTS	K 000		

CFR: 42 CFR 483.70(a)

Building: 01

Survey under: NFPA 101 (2000 Edition)

Plan approval: 1978

Facility type: SNF/NF

Type of structure: One story, Type III (unprotected)

Smoke Compartment: Five (5)

Fire Alarm: Complete fire alarm with smoke detectors installed in corridor, heat detectorsin mechanical rooms, laundry, kitchen, and sprinkler riser room. Upgraded 05/21/08.

Sprinkler System: Complete sprinkler system (dry). Upgraded in 2006 with new main control valve and in 2008 with new dry valve.

Generator: Type 2 generator powered by diesel installed May 2011.

A Standard Life Safety Code Survey was conducted on 05/22-23/13. Golden Living Center Vanceburg was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was eighty nine (89). The facility is licensed for ninety four (94) beds.

The Highest Scope and Severity deficiency was an "F" level.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	LNHA	6/21/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185238	A. BUILDING 01 - MAIN B. WING	05/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - VANCEBURG	58 EASTHAM STREET VANCEBURG, KY 41179

(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 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire extinguishers were installed according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, twenty three (23) residents, staff and visitors. The findings include: Observation, on 05/22/13 between 3:15 PM and 3:25 PM, revealed the fire extinguishers mounted in the Kitchen, Short 300 Hall and 300 Front Hall, was mounted greater than five (5) feet in height. Fire extinguishers cannot be mounted greater than five (5) feet in height to ensure the fire extinguishers can be reached during a fire. The observations were confirmed with the Maintenance Director. Interview, on 05/22/13 at 3:15 PM, with the Maintenance Director revealed he was not aware fire extinguishers could not be mounted greater than five (5) feet in height. NFPA 10 (1998 edition) 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed	K 064	K064 SS=D The fire Extinguishers located Kitchen, Short 300 hall, and 300 Front hall have been removed and remounted according to National Fire protection Association (NFPA), so that the top of the extinguisher are not more than 5 feet (1.5m) above the floor and not less that 4 inches (101.6) above the floor. to ensure the fire extinguisher can be easily reached during a fire. Maintenance Director was educated on the standard from the National Fire Protection Association (NFPA) Completed May 31, 2013	5/31/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185238	A. BUILDING 01 - MAIN B. WING	05/23/2013

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K 064	Continued From page 2 so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064		
K 211 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure Alcohol Based Hand Rub (ABHR) dispensers were	K 211	K211 SS=F ABHR dispensers have been removed from resident room108 and every resident room in the facility and re-mounted according to National Fire Protection Association (NFPA). Maintenance Director was educated on this standard from the National Protection Association (NFPA) Completed May 31, 2013	5/31/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185238	A. BUILDING 01 - MAIN B. WING	05/23/2013

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K 211	Continued From page 3 mounted according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, ninety four (94) residents, staff and visitors. The findings include: Observation, on 05/23/13 at 10:58 AM, revealed an ABHR dispenser was mounted above the light switch in resident room 108. Further observations revealed the same for every resident room in the facility. ABHR dispensers cannot be mounted above an ignition source due to increasing the risk of fire. The observations were confirmed with the Maintenance Director. Interview, on 05/23/13 at 10:58 AM, with the Maintenance Director revealed he had installed the ABHR dispensers in the resident rooms sometime in February 2013. Further interview revealed he had not identified the ABHR dispensers as being installed near an ignition source. Reference: NFPA 101 (2000 edition) 19.3.2.7 Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source.	K 211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 211	Continued From page 4 o If the floor is carpeted, the building is fully sprinklered. CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211		