

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

RECEIVED  
JUL 18 2014  
OFFICE OF INSPECTOR GENERAL  
CENTERS FOR MEDICARE FACILITIES AND SERVICES

PRINTED: 06/19/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/05/2014
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - HILLCREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
(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

A Recertification Survey was initiated on 06/03/14 and concluded on 06/05/14. The facility was found not meeting minimum requirements for recertification with deficiencies cited. The highest scope and severity was cited at an "F".

F 166 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES

SS=D

A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and review of the facility's Grievance Policy, it was determined the facility failed to resolve grievances for two (2) of twenty-four (24) sampled residents related to special food requests. (Resident #13 and #14).

The findings include:

Review of the facility's policy regarding Grievance Guidelines, revised 2013, revealed all employees were responsible for ensuring customer satisfaction. When concerns arise, a grievance system was in place to resolve the issues to the satisfaction of all parties involved. Response to the grievance should be as soon as possible. If the resident or family did not want to complete the Grievance Form, it was the responsibility of the employee hearing the grievance to complete the form and submit for follow-up and resolutions.

1 Observation of Resident #13, on initial tour of

F 000 Hillcreek

F 166 Nursing Center objects to the allegation of non-compliance in the statement of deficiency cited. Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Executive Director of any employees, agents or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission of agreement of any kind by the facility or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) ten days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admission by the facility. This plan of correction is submitted as the facility's credible allegation of compliance.

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

*Mary Adkins WED*

TITLE

*X Exec. Dir.*

(X6) DATE

*X 7-18-14*

56702 991 Previous Versions Obsolete

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F 166

07/18/14

the facility, on 06/03/14 at 9:30 AM, revealed the resident was sitting up in bed eating breakfast. Interview with Resident #13 revealed he/she had been trying to get hot tea or iced tea instead of coffee since admission, on 05/24/14. The resident was admitted with a closed wrist fracture and was receiving physical therapy. Review of the 06/01/14 Cognitive Assessment, revealed the resident had a BIMS Score of 15, which determined the resident was interviewable.

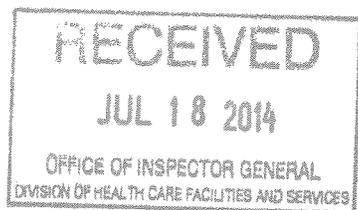
Further observation of the noon meal, on 06/03/14 at 11:45 AM, revealed the resident did not get hot tea as requested on the Tray Card. Additional observation of the noon meal, on 06/04/14 revealed the resident did not receive hot tea on her tray, even though it had been checked on the tray card.

Interview with Licensed Practical Nurse (LPN) # 4, on 06/04/14 at 11:45 AM, revealed residents on the 400 Hall do sometimes have long waits for Dietary to fill special food request. The LPN stated if dietary was called during the tray line, staff were told they would have to wait until the tray line was completed before sending the special request to the residents.

Interview with the Dietary Manager, on 06/05/14 at 10:35 AM, revealed the beverage carts should have tea bags on them for staff to make the hot tea; however, observation of the beverage cart revealed there were no tea bags available for residents.

2. Observation of Resident #14, on 06/04/14 at 12:05 PM, revealed the resident was sitting up in his/her wheelchair awaiting lunch. The resident was admitted, on 05/23/14, with a diagnosis of

1. Resident # 13 drink preference is on her tray card. She is now receiving her drink of choice. The diet ordering process for alternate foods was reviewed for Resident #14. She was receiving her food of choice. She is now Discharged (D/C'd).
2. All residents that express a desire for special food or drink from dietary have the potential to be affected. All residents resident diets and tray cards were reviewed by the Director of Dining Services (DDS) on 06-06-14. No other residents voiced grievances related to special food requests or diets.



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Hip Joint Replacement, and was receiving therapy. The facility assessed Resident #14, on 06/01/14, with a Brief Interview for Mental Status (BIMS) of 15, which indicated the resident was interviewable.

F 166

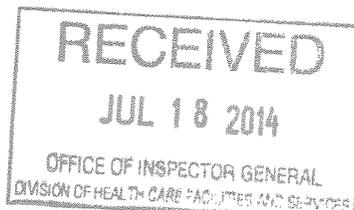
Interview with Resident #14, on 06/04/14 at 12:05 PM revealed the if he/she ordered anything from the kitchen, it may take up to an hour to get the food. The resident stated he/she spoke with the Dietary Manager, on 06/02/14, regarding the long periods of time resident's had to wait for special food requests, and revealed he/she had ordered something over the weekend, which took up to an hour to get.

3. A in-service is scheduled for 06-27-14 - 06-30-14 for all employees on the grievance policy and special food requests. The IDT team including the (Executive Director (ED), Unit Managers (UM), Staffing Coordinator, Assistant Director of Nursing (ADON) conducted this in-service. This in-service will also include a new communication to dietary 2 part form for special food requests to improve communication and ensure resident satisfaction. Resident Dietary Tray Cards were reviewed on 06-06-14 by the DDS and revised to reflect any changes needed. The DDS reviews all new admissions tray cards and special requests for accuracy with in 72 hours. The DDS will discuss with all new residents with in 72 hours, that if they feel like they have to wait too long for food requests to inform her and she will fill out a grievance form. She will then investigate the wait time, follow up with the resident and staff. DDS will then in-service the staff about that certain resident grievance and solution. The nursing and dietary staff will be in-serviced by the above Noted IDT team and the DDS on 06-27-14 - 06-30-14 regarding Communication to dietary 2 part form, Residents Rights including making choices about his or her drinks or food preferences and staff meeting those request. Dietary staff will also in-serviced by DDS on 06-27-14 -06-30-14 to follow preferences on tray cards. DDS in serviced dietary staff on wait time for food requests on 07-15-14 and 07-16-14.

Interview with the RN Unit Manager (UM) #2 on the 400 Hall, on 06/04/14 at 11:50 AM, revealed recently she had been the only staff person on the 400 Hall due to low census of four (4) to eight (8) residents. The UM stated if she called the kitchen, she could not leave the floor unattended to get the special food requests from dietary upstairs. In addition, the UM stated many times she had been told by dietary staff that the resident would have to wait until all the carts were sent out, or the tray line was completed before sending a special request. The UM stated sometimes it could take an hour to get the request.

4. The Registered Dietician (RD) will randomly select 4 residents per week for 4 weeks with focus on their drink preference and any special food request with staff adherence to their choice, then monthly thereafter for 3 months. The RD will report any negative findings to QAPI committee monthly for 4 months.

Interview with the Dietary Manager (DM), on 06/05/14 at 10:35 AM, revealed she had been employed with the facility since January 2014. The DM stated if a resident had a special food request, a nurse aide would come to dietary and get it. The DM revealed at times they had someone take the food request to the unit if there was enough staff working in the kitchen. The DM



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F 166

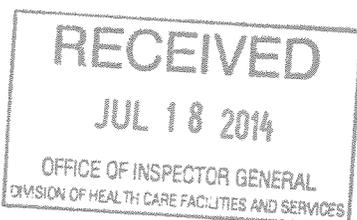
stated if the Unit Manager called and said they were working alone, they would take it to the floor. The Dietary Manager stated she spoke with Resident #14 after the Administrator had received a grievance from the resident, on 05/31/14, regarding special food requests taking long periods of time to get, and stated she had given the resident her business card; however, the DM had failed to complete a grievance form per facility policy. The Dietary Manager stated she had not had time to complete the grievance.

F 226 483.13(c) DEVELOP/IMPLMENT  
SS=D ABUSE/NEGLECT, ETC POLICIES  
F 226

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review, and review of the facility's policy Reporting Alleged Violations, it was determined the facility failed to follow their abuse policy in regard to reporting an allegation of resident to resident abuse for one (1) of twenty-four (24) sampled residents (Resident #8). The facility failed to report an alleged resident to resident altercation to the appropriate state agencies after Resident #8 reported the allegation on 05/28/14.

The findings include:  
Review of the facility's policy regarding Reporting Alleged Violation, revised 2013, defined abuse as



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F 226

07/18/14

the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The policy's definition of abuse also included the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being with the presumption that instances of abuse of all residents even those in a coma, cause physical harm, or pain or mental anguish.

Review of the facility's policy regarding Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property, dated 10/24/13, revealed any employee who suspected an alleged violation should immediately notify the Executive Director (ED) or Director of Rehabilitation (DOR). Further review revealed the ED or DOR should also notify the appropriate state agency, in accordance with state law, as well as notify immediate management. In addition, the policy revealed the results of all investigations must be reported by the ED or DOR to the appropriate state agency, as required by state law, within five (5) working days of the alleged violation.

Review of the clinical record for Resident #8 revealed the facility admitted the resident on 01/10/14 with diagnoses of Unspecified Disorder of Urethra & Urinary Tract, Neurogenic Bladder, Diabetes Type II, and Hypertension. Review of the Minimum Data Set (MDS) assessment, dated 04/04/14, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 indicating the resident was cognitively intact.

1. Resident # 8 incident and investigation was reviewed regarding the resident to resident altercation occurring on 05/26/14. No injuries were found. Ongoing any altercation will be reported to the appropriate state agencies timely and per policy. OIG notified during survey. OIG and APS notified by fax on 07-15-14. Initial and 5 day report sent on this day regarding this resident to resident altercation that occurred on 05/26/14

2. All residents have the potential to be effected by this deficient practice. A audit was conducted of all residents on 06-26-14 asking if they had been involved in any resident altercations. No other residents were found to have been in involved in any altercations.

3. All further incidents/altercations will be reviewed in morning Clinical meeting by the IDT team to ensure that all events that are required to be reported are reported timely per policy. The ED and DON will then ensure that OIG/APS is notified timely and that staff is immediately interviewed and trained. The nursing Staff will be in serviced by the IDT team on 06-27-14 - 06-30-14 regarding Abuse Policy including state reporting and event reporting all incidents to Director of Nursing(DON) or Assistant Director of Nursing (ADON) and the facility Executive Director (ED).

4. The DON/ADON or ED will review all events/incidents with focus on reporting as required by policy. DON/ADON or ED will report any negative findings to QAPI committee monthly for 4 months.

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F 226

Interview with Resident #8, on 06/04/14 at 9:50 AM, revealed the resident had reported an altercation with another resident to the nurse. The resident reported being hit by another resident and had hit the other resident back.

Review of the nursing progress note, dated 05/26/14 at 1:30 PM, revealed the resident reported being hit on the right arm a couple of days ago by another resident

Review of the facility's investigation, dated 05/26/14, revealed LPN #9 notified the facility ED, on 05/26/14 at 1:00 PM, of Resident #8's allegation. Further review of the report revealed the facility had not notified the state agency.

Interview with LPN #9, on 06/05/14 at 3:25 PM, revealed she had placed Resident #8's investigation report in the Director of Nursing (DON) mailbox on 05/26/14. She also revealed the ED had met with the resident on 05/27/14.

Interview with the Social Services Director (SSD), on 06/05/14 at 3:15 PM, revealed resident to resident altercations were considered abuse and should be reported to the state agencies as soon as possible. The SSD also revealed she was responsible for investigating Resident #8's allegations. She stated the incident was not reported to the state agencies because it was determined the resident was not clear about what really happened or who the perpetrator was.

Interview with the Executive Director, on 06/05/14 at 3:30 PM, revealed the SSD had completed an investigation of Resident #8's allegations. She stated Resident #8 kept changing the story and was not aware of who the other resident was or

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when the incident happened. The ED revealed  
the facility was unable to verify the circumstances  
of the incident and did not report the incident to  
the state agencies. She stated the incident  
should have been reported to the state agencies.  
F 253 483.15(h)(2) HOUSEKEEPING &  
SS=E MAINTENANCE SERVICES

F 226

F 253

The facility must provide housekeeping and  
maintenance services necessary to maintain a  
sanitary, orderly, and comfortable interior.

1. Resident room # 200/202 toilet was repaired  
and cleaned and the bathroom was cleaned on  
06/05/14. The 100 unit bathrooms from room  
#100 down the hall to room #116 were cleaned  
on 06/05/14.

07/18/14

2. All residents rooms have the potential to be  
affected for odors. All rooms were checked on  
06/05/14 for odors and no other rooms were  
found to have odors.

3. The Housekeeping daily schedule was  
reviewed by the Director Of Housekeeping  
(DOH) to clean the 100 and 200 hall bathrooms  
daily with a new enzyme cleaner. The DOH  
will in-service the housekeeping staff and the  
IDT team will in service the nursing staff.  
The Housekeeping and Nursing Staff will be  
in-serviced on 06-27-14 - 06-30-14 regarding  
keeping the bathroom clean and reporting any  
maintenance needs immediately by placing the  
concern/item to be fixed in the Building  
Engines System. Maintenance will then fix the  
items that are reported timely.

4. The ED will monitor the building engines  
system weekly for 4 weeks, then monthly to  
ensure that the repairs are fixed timely Any  
negative findings will be reported in QAPI  
monthly by the ED for 4 months.  
DOH or ED will randomly select 4 resident  
rooms on 100 or 200 hall, per week for 4  
weeks for checking of odors in rooms. Then  
monthly for 3 months. The ED will report any  
negative findings to QAPI committee monthly  
for 4 months.

This REQUIREMENT is not met as evidenced  
by:

Based on observation and interview, it was  
determined the facility failed to ensure the one (1)  
of four (4) units did not smell of urine and one (1)  
of four (4) units with shared toilets were clean and  
functional. Rooms 100 to 116 smelled heavily of  
urine. Room 200 and 202 shared commode  
would not flush and when repaired after 2 days,  
the solid waste remained attached to the inside of  
the commode.

The findings include:

The facility did not provide a policy regarding the  
sanitation of the facility or the resident's  
environment.

1. Observation of the shared bathroom between  
room 200 and 202 during tour, on 06/03/14 at  
8:55 AM, revealed the bathroom strongly smelled  
of urine. Upon entering the bathroom, the water  
in the commode was yellow in color and had toilet  
paper in the commode bowl. Unsampled  
Resident C stated to the touring Restorative

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Licensed Practical Nurse (LPN), that the toilet stopped up yesterday. Unsampled Resident C asked the LPN if the toilet was fixed. The Restorative LPN stated she would get someone to fix the commode. Upon exiting room 202, the Restorative LPN notified the 200 Unit Manager coming down the hallway about the clogged commode.

Observation of the shared bathroom in room 200/202, on 06/03/14 at 11:38 AM and at 3:25 PM, and on 06/04/14 at 7:30 AM and 9:05 AM, revealed the commode smelled strongly of stool. The commode bowl contained black stool and did not contain water.

Observation on the 200 Hall, on 06/04/14 at 8:55 AM, revealed a maintenance person pushing a maintenance type cart down the hall; however did not enter either room 200 or 202.

Interview with the maintenance employee on the 200 Hall, on 06/04/14 at 8:55 AM, stated he was from another facility and came to assist with the survey process. He stated, the facility had a system in place that provided a list of work orders. He stated he had obtained a list of items that needed attention on the 200 unit. However, review of the rooms listed did not include the bathroom for resident rooms 200 and 202.

Observation of the bathroom in room 200/202, on 06/04/14 at 12:50 PM, revealed the commode smelled of stool. The commode had been flushed; however, the commode bowl contained black stool residue on the commode.

Interview with Unsampled Resident C, on 06/04/14 at 9:05 AM, revealed the bathroom had

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(X3) DATE SURVEY  
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06/05/2014

NAME OF PROVIDER OR SUPPLIER  
  
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SUMMARY STATEMENT OF DEFICIENCIES  
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been plugged up for several days. He/she stated he/she told the staff the toilet was plugged up and told somebody again yesterday it was plugged up.

F 253

Interview with Director of Maintenance near the 200 Unit Nurses Station, on 06/04/14 at 9:20 AM, revealed he was the Interim Director of Maintenance. He stated the facility had a program for staff to enter information when there was something that needed to be fixed or taken care of. The system was called Building Engines and it generated a work order so they would know what needed to be fixed. He denied any plumbing concerns identified on the 200 unit this week. He stated, no one had reported any plumbing problems this week. He stated, the other maintenance employee was from another facility here to help him out. He stated, he had identified the areas in need of attention on the 200 hall and provided it to the other maintenance staff.

Interview and observation of Room 202's bathroom with LPN #2, the 200 Unit Manger, on 06/04/14 at 11:30 AM, revealed she had not been notified of any plumbing concerns this week on the 200 unit. Upon further interview, she did recall notification of a plugged toilet in a bathroom shared by rooms 200 and 202. She stated she called the Maintenance guy and asked him to fix the commode yesterday. She stated she came down later in the day and the commode was fixed. She stated the bathroom had a strong odor and should have been cleaned. She recanted her statement, saying she had sent an aide down to checked the rest room. However, she was unable to identify the staff member whom she had sent to check on the bathroom. She said she panicked when asked about the plugged toilet.

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Event ID: B9B311

Facility ID: 100212

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STATEMENT OF DEFICIENCIES  
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F 253 Continued From page 9

She stated a work order in the Building Engines program was appropriate; however, did not enter the plumbing concern in to the program.

F 253

Interview with the Administrator, on 06/04/14 at 12:50 PM, revealed the process was for staff to complete a work order in the Building Engines once a concern in the facility was identified. Once the repair was completed, then housekeeping would do the final clean. It was unacceptable for staff not to follow up with clogged drains. Once the commode was unclogged, it was unacceptable to leave the toilet with a black substance in the toilet bowl. The Unit Managers were responsible to ensure the bathrooms on assigned units were kept clean and functional.

2. Observation of the 100 Unit during the initial tour, on 06/03/14 at 8:50 AM, revealed there was a strong odor of urine throughout the unit.

Observation of the 100 Unit, on 06/04/14 at 2:30 PM, revealed the odor of urine continued to be noted from room 100 down the hall to room 116.

Interview with the Housekeeping Director, on 06/05/14 at 9:35 AM, revealed the housekeeping staff every morning cleaned and deodorized the hallway floors with a autosubber T3, which was a floor cleaner. He stated that the floor cleaner gave out a fresh smell and his staff cleaned and removed trash throughout the day. He stated that himself and staff try to keep it as fresh as they can in all hallways and throughout the facility. He stated that he was not aware of any odors in the 100 hallway.

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Interview with the Administer, on 6/5/14 at 10:00  
AM, revealed she was not aware there were  
odors in the 100 hallway.

F 253

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO  
SS=D PARTICIPATE PLANNING CARE-REVISE CP

F 280

The resident has the right, unless adjudged  
incompetent or otherwise found to be  
incapacitated under the laws of the State, to  
participate in planning care and treatment or  
changes in care and treatment.

A comprehensive care plan must be developed  
within 7 days after the completion of the  
comprehensive assessment; prepared by an  
interdisciplinary team, that includes the attending  
physician, a registered nurse with responsibility  
for the resident, and other appropriate staff in  
disciplines as determined by the resident's needs,  
and, to the extent practicable, the participation of  
the resident, the resident's family or the resident's  
legal representative; and periodically reviewed  
and revised by a team of qualified persons after  
each assessment.

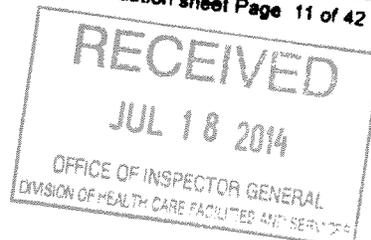
07/18/14

1. Resident # 2 care plan (CP) was  
updated/revised on 06/03/14 to reflect the  
changes that the Speech Therapist (ST) had  
recommended and the new MD orders.

2. All residents have the potential to be  
affected by this practice. All resident's CP will  
be reviewed by the our MDS coordinators by  
07/18/14 for accuracy.

This REQUIREMENT is not met as evidenced  
by:

Based on observation, interview, and record  
review, it was determined that the facility failed to  
revise the comprehensive care plan for one (1) of  
twenty-four (24) sampled residents (Resident #2)  
when the resident was no longer NPO (nothing by  
mouth), began to eat with specific precautions to  
prevent choking, and was placed on the Frazier



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F 280 Continued From page 11  
Water Protocol.

F 280

The findings include:

The facility did not provide a policy for revisions of the care plan.

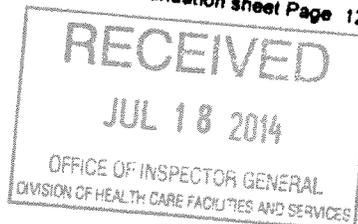
Observation of Resident #2, on 06/04/14 at 12:20 PM, revealed the resident was in the lounge area eating food of mechanical soft consistency. The resident was using chin tucks and multiple swallows while eating.

3. All resident's daily orders and any resident recommendations from the therapy department will be reviewed in the daily morning clinical meeting by the IDT team. The MDS coordinators will update the CP daily with any changes to reflect an accurate CP.

4. The DON/ADON will randomly select 4 residents per week for 4 weeks to audit the CP compared to the orders for accuracy. Then monthly for 3 months. The DON/ADON will report any negative findings to QAPI committee monthly for 4 months.

Review of the clinical record for Resident #2, revealed the facility admitted the resident with diagnoses of Diabetes, Pneumonia, Cardiomyopathy, Reynald's Disease and Chronic Obstructive Pulmonary Disease. The facility completed an admission Minimum Data Set (MDS) assessment, on 04/13/14, which revealed the resident was cognitively intact, required extensive assistance of one for locomotion, dressing, toileting and bathing. The resident required a tube feeding for nutrition. The Speech Therapist (ST) completed a swallow study for Resident #2, on 04/03/14, which indicated the resident was taking small single sips and was to be monitored. On 05/29/14, the ST reviewed a swallow study and recommended the resident take three to four swallows with each bite, perform chin tucks and be monitored. On 05/30/14, the ST documented the resident had made good progress over the week.

Review of the comprehensive care plan for Resident #2, dated 04/30/14, revealed the resident was NPO and received all nutrition by gastric tube.



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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - HILLCREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
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Interview with the Speech Therapist, on 06/04/14 at 11:23 AM, revealed she did not attend the care plan meetings; however, she did write notes and a care plan for the resident. She stated she did not share this information with the care plan team. She revealed she educated the resident regarding eating and precautions to take and since the resident was independent, she did not feel this information needed to be shared. She stated she should have shared the information with the care plan team since they played a part in monitoring the resident.

F 280

Interview with the MDS Coordinator, on 06/04/14 at 11:43 AM, revealed therapist were to provide her with information on the residents' treatment in order for the care plan to accurately reflect the residents' needs and treatment plan. She stated therapist normally did not participate in the care plan meetings for residents.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

F 282

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

1. Residents # 1, #3, #6 and resident B were interviewed by the unit managers regarding their bath and grooming choices and time preferences on 06/04/13. The Shower Schedule and CNA care sheets were revised to reflect the changes. They were all provided a shower, shaved and nail care on 06/03/14 or 06/05/14.

07/18/14

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review and review of the facility's shower schedule, it was determined the facility failed to follow the comprehensive care plan for three (3) of twenty-four (24) sampled residents (Resident #1, #3, #6) and one (1) of three (3) Unsampled Residents (Unsampled Resident B) for showering

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and grooming. The facility failed to provide nail care for Resident #1 with long and soiled nails, failed to provide nail care and remove facial hair for Resident #3, failed to provide nail care for Resident #6, and failed to shave Unsampled Resident B.

F 282

The findings include:

The facility did not provide policies on comprehensive care plans.

Review of the facility's first and second shift shower schedule for the 100 Unit, revised on 06/03/14, revealed nail care was to be done on all residents during showers, everyone must be shaved, and all refusals were to be reported to the staff nurse at that time, the shower sheets were to be turned in to the nurse after the resident's shower. This scheduled also revealed each nurse was responsible to make sure shower tasks were done. The shower schedule did address daily oral care for residents.

2. All residents have the potential to be affected by this practice. All residents were reviewed by the unit managers and their CNA care sheets were revised by the unit managers on 06/03/14 - 06/06/14. All the residents were provided with a shower, shaved and nail care.

3. The Shower Schedules, CNA care sheets and CP's were revised on 06/03/14 - 06/06/14 to reflect any changes that the resident may have wanted. (days, times, etc.) All residents will receive a shower as scheduled, nail care daily and shaved daily. If the resident does not want to be shaved daily, or nail care daily, the CP will be updated by the unit managers or the MDS coordinators immediately after they are notified, to reflect those choices. The nursing Staff will be in-serviced 06/27/14 - 06/30/14 regarding Residents Rights including making choices about his or her care, showers, nail care and shaving.

4. The Unit managers will randomly select 4 residents per week for 4 weeks, then monthly for 3 months, to check that the resident has had their showers, that they have had nail care and that they have been shaved. The DON/ADON will report any negative findings to QAPI committee. monthly for 4 months.

Review of the Certified Nursing Assistant (CNA) care plan for Unit 100, revealed Resident #1 required assist with oral care. Resident #3's CNA care plan stated the resident required assist with oral care and staff was to wash the resident's toes and make sure they were clean and dry.

1. Observation of Resident #1 during tour, on 06/03/14 at 8:15 AM to 9:40 AM, and 06/04/14 at 7:15 AM, 9:45 AM and 3:50 PM, and while escorted by CNA staff to the facility shower room, revealed the resident had long and soiled finger nails to both hands.

Review of the medical record for Resident #1

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F 282

revealed the facility admitted the resident on 06/30/04 with diagnoses of Multiple Sclerosis, Neurogenic Bladder, Muscle Weakness, and History of Pressure Wounds. Review of the quarterly Minimum Data Set Assessment completed on 04/25/14 revealed the facility completed a Brief Interview for Mental Status (BIMS) and assessed the resident as a four (4), severely impaired. The facility assessed the resident's mobility as requiring extensive assistance of one (1) assist for mobility, hygiene and bathing.

Review of the comprehensive care plan for Resident #1, revealed the resident was at risk for self-care deficit with a goal to remain clean, dry, odor free and appropriately dressed every day. Nursing staff were to assist Resident #1 with Activities of Daily Living (ADL's); monitor for any further ADL status decline; and facility staff was to assist with bathing as needed.

Interview with Resident #1, on 06/05/14 at 8:30 AM, revealed he/she disliked long soiled nails, but was unsure about his/her shower days or the last time he/she had a shower and got his/her nails cut.

Interview with CNA #8, on 06/05/14 at 3:05 PM, revealed she gave Resident #1 a shower on 06/04/14 and did not provide nail care because she was scared of cutting residents nails and was not sure if she notified the staff nurse.

Interview with License Practical Nurse (LPN) #8, on 06/05/14 at 2:30 PM to 2:40 PM, revealed she was aware Resident #1's nails were still long and needed to be trimmed because it was not done during the shower on second shift on 06/04/14.

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She further stated CNA's were aware nail care was to be done on shower days as listed on the bath and the skin-report sheets used by the CNA's. LPN #8 stated if the residents were not provided nail care and removal of facial hair during shower times the care plans were not being followed.

2. Observation during a wound evaluation with Advanced Registered Nurse Practitioner (ARNP) with Resident #3, on 06/03/14 at 1:45 PM, revealed the dressing to the resident's right lower leg was off and a foot bandage was removed by the ARNP. In between Resident #3's toes was a thick, dark yellow, putty like consistency, substance removed by the ARNP with a cotton tip applicator. She obtained a large amount between each toe on the right foot. The bottom of Resident #3's foot revealed the same substance with the color of brownish/black with a slightly green hue. The resident's foot had a strong musty odor. Resident #3 was unshaven with long nails with a brown substance underneath the nails. Resident #3 was observed while talking to have a buildup of plaque on his/her lower front teeth at the gum line. Continued observation, on 06/04/14 at 7:15 AM, 12:05 PM, and 3:50 PM, revealed Resident #3 remained unshaven, with long soiled nails and oral plaque buildup.

Review of the medical record for Resident #3 revealed the facility admitted the resident on 09/06/06 with diagnoses of Cerebral Palsy, Muscle Spasm with Contractures and splint use, Lack of Coordination, Left Leg Amputation, History of Cerebral Vascular Accident with Hemiplegia, Peripheral Vascular Disease, and Vascular wounds to the right lower leg. Review of the quarterly Minimum Data Set Assessment,

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completed on 04/25/14, revealed the facility completed a Brief Interview for Mental Status (BIMS) and assessed the resident at a fifteen (15), cognition intact. The facility assessed the resident's mobility as requiring supervisor with the assistance of one (1) staff for use of motorized wheelchair, hygiene was extensive assistance with one (1) staff, and bathing was total assist with two or more physical assistance. In addition the Wound Care Physician orders written on 05/13/14, revealed a reminder to facility staff to wash in between Resident #3's toes.

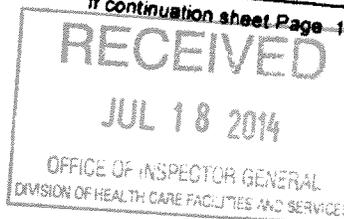
Interview with Resident #3, on 06/03/14 at 1:45 PM, revealed when the CNA's wrapped his dressing on his right foot with a plastic bag, his/her foot was not washed or in between the toes.

Interview with CNA #2, on 06/05/14 at 3:15 PM, revealed she did not shave Resident #3 on 06/04/14.

Interview with Assistant Director of Nursing (ADON), on 06/05/14 at 4:00 PM, revealed the nursing care plans were not being followed when residents were not provided nail and oral care, or complete showers for Resident #3's that included the right foot, and shaving of faces.

3. Observation of Unsampled Resident B, on 06/05/14 at 8:35 AM, revealed the resident was up in a wheelchair in the hallway outside the room. The resident was dressed and clean, however, the resident had facial hair present under the chin. The hair was long and curly.

Interview with Unsampled Resident B, on



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(X5) COMPLETION DATE

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F 282

06/05/14 at 8:35 AM, revealed the resident had been required to shave their face daily for many years. The resident stated daily shaving at home was completed to keep the hair under control. He/She stated staff had never offered to shave him/her.

Interview with LPN #7, on 06/05/14 at 2:55 PM, revealed she was responsible for monitoring the CNA's and the care that was provided during scheduled showers which included following the care plans.

Continued interview with the ADON, on 06/05/14, revealed if the CNA's were not reporting on resident skin and baths more education needs to be provided. The ADON stated the importance of good hygiene and if residents were not provided with ADL care residents could have a decline in their health.

4. Review of the clinical record for Resident #6 revealed the facility admitted the resident on 10/12/12 with diagnoses of Dementia with Behavioral Disturbance, Bipolar Disorder, Decubitus Ulcer, Hypertension, and Depressive Disorder. Review of the quarterly Minimum Data Set (MDS), dated 04/30/14, revealed the facility assessed the resident with short-term and long-term memory problems, and moderately impaired decision making. The facility assessed Resident #8 as totally dependent with one (1) assist for personal hygiene and, as requiring physical help with two plus (2+) assist for bathing.

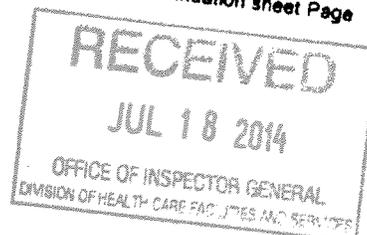
Review of Resident #6's Comprehensive Care Plan revealed the resident had a physical

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Event ID: B98311

Facility ID: 100212



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:  
**185095**

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING \_\_\_\_\_  
B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED  
**06/05/2014**

NAME OF PROVIDER OR SUPPLIER  
**GOLDEN LIVINGCENTER - HILLCREEK**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**3116 BRECKINRIDGE LANE  
LOUISVILLE, KY 40220**

(X4) ID  
PREFIX  
TAG

SUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
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PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
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DEFICIENCY)

(X5)  
COMPLETION  
DATE

F 282 Continued From page 18

functioning deficit requiring extensive assist with most activities of daily living (ADL) and total assist with bathing and dressing. Interventions on the care plan included staff assist to complete ADL's daily, including toileting and bathing.

F 282

Observation of Resident #6, on 06/05/14 at 1:15 PM, revealed a dark brown substance under the fingernails of both hands.

Review of the facility's Bath and Skin Report revealed an assessment of the resident's fingernails was to be completed on all residents receiving a shower or bath. The report indicated the Charge Nurse co-signed the report with the CNA verifying each assessment had been completed. According to the report, all wounds and findings were to be assessed immediately by the Charge Nurse. The Charge Nurse would then forward the report to the Unit Manager (UM).

Review of the Minimum Data Set (MDS) Activities of Daily Living (ADL) Report revealed Resident #6 had two (2) showers and one (1) full bed bath documented between 05/09/14 and 06/04/14.

Review of the 100 Unit shower schedule, revised 06/03/14, revealed nail care must be done on all residents during showers. In addition, the schedule indicated the shower sheet was to be turned in to the nurse after the resident's shower and all refusals must be reported to the nurse. Further review of the shower schedule for the 100 Unit revealed Resident #6 was not scheduled for routine showers.

Interview with LPN #6, on 06/05/14 at 4:10 PM, revealed the bath and skin report was to be completed by the CNA with each resident bath

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STATEMENT OF DEFICIENCIES,  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:  
  
185095

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING \_\_\_\_\_  
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(X3) DATE SURVEY  
COMPLETED  
  
06/05/2014

NAME OF PROVIDER OR SUPPLIER  
  
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STREET ADDRESS, CITY, STATE, ZIP CODE  
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F 282 Continued From page 19

and turned in to the assigned nurse. She stated  
the CNA's were responsible for performing  
resident nail care on bath days. She further  
stated the resident's nurse was responsible for  
ensuring care had been performed. LPN #6  
stated she was unable to find any CNA Bath and  
Skin Reports for Resident #6.

F 282

F 312 483.25(a)(3) ADL CARE PROVIDED FOR  
SS=E DEPENDENT RESIDENTS

A resident who is unable to carry out activities of  
daily living receives the necessary services to  
maintain good nutrition, grooming, and personal  
and oral hygiene.

F 312

07/18/14

This REQUIREMENT is not met as evidenced  
by:

Based on interview, record review and review of  
the facility shower schedule, it was determined  
the facility failed to provide Activities of Daily  
Living for eight (8) of twenty-four (24) sampled  
residents, (Residents #1, #3, #6, #10, #15, #18,  
#20) and one (1) of three (3) unsampled  
residents, (Unsampled Resident B). The facility  
failed to provide: nail and oral care for Resident  
#1; nail, oral care and a shave for Resident #3;  
nail care with missing showers for Resident #6;  
showers and shampoo for Resident #10; showers  
for Resident #1; daily oral care for Resident #18;  
showers for Resident #20; and shaves for  
Unsampled Resident #B.

1. Residents #1, #3, #6, #10, #15, #18, #20, #B  
were provided nail care, shaving and oral care  
immediately when found to be needed.  
Showers (unless they refused), were provided  
on 06/03/14 or 06/05/14.

2. All dependent residents in the facility have  
the potential for being affected by this deficient  
practice. An audit of all residents was  
conducted on 06/05/14 - 06/06/14 by the unit  
mangers too ensure that all residents had been  
shaved, had nail care, oral care and a shower  
(unless they refused a shower). The showers,  
nail care, shaving and oral care was provided  
by the nursing staff as needed after the audit  
was conducted.

The findings include:

The facility did not provide policies on resident  
showers, shaving, oral and nail care or staff

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OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/05/2014
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - HILLCREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
(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)

F 312 Continued From page 20  
assistance with Activities of Daily Living. F 312

Review of the facility's first and second shift shower schedule for the 100 Unit, revised on 06/03/14, revealed nail care was to be done on all residents during showers, everyone must be shaved, and all refusals were to be reported to the staff nurse at that time. The shower sheets were to be turned in to the nurse after the resident's shower. This schedule also revealed each nurse was responsible to make sure shower tasks were done. The shower schedule did address daily oral care for the residents.

3. The nursing staff will be in-serviced on 06/27/14 - 06/30/14 by the IDT team regarding ADL care. Focusing on showers, nail care, shaving and oral care for all dependant residents.

1. Observation during tour, on 06/03/14 at 8:15 AM to 9:40 AM, revealed Resident #1 was found with long fingernails on both hands that had a brown substance underneath.

4. The Unit managers will randomly select 4 residents per week for 4 weeks, then monthly for 3 months, to check that the resident has had their showers, that they have had nail care, that they have been shaved and oral care has been provided. The DON/ADON will report any negative findings to QAPI committee monthly for 4 months.

Observation during a skin assessment for Resident #1 with LPN# 8, on 06/04/14 at 9:45 AM, revealed the resident continued to have long fingernails on both hands with a brown substance underneath. In addition the resident continued to have a buildup of plaque at the gum line of his/her natural teeth.

Review of the medical record for Resident #1 revealed the facility admitted the resident on 06/30/04 with diagnoses of Multiple Sclerosis, Neurogenic Bladder, Muscle Weakness, and History of Pressure Wounds. Review of the quarterly Minimum Data Set Assessment, completed on 04/25/14, revealed the facility completed a Brief Interview for Mental Status (BIMS) and assessed the resident at a four (4), severely impaired. The facility assessed the resident's mobility as requiring extensive assistance of one (1) assist with mobility, hygiene

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Event ID: 898311

Facility ID: 100212

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STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

185095

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

06/05/2014

NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - HILLCREEK

STREET ADDRESS, CITY, STATE, ZIP CODE

3116 BRECKINRIDGE LANE  
LOUISVILLE, KY 40220

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(X5)  
COMPLETION  
DATE

F 312 Continued From page 21  
and bathing.

F 312

Review of the facility shower schedule revealed Resident #1 was to receive a shower on Wednesdays and Saturdays on the second shift.

Review of the CNA Bath and Skin Report sheet for Resident #1, dated 06/04/14, revealed his/her fingernails were clean and short.

Interview with Licensed Practical Nurse (LPN) #8 during Resident #1 skin assessment, on 06/04/14 at 9:45 AM revealed the resident's nails were long and dirty.

Interview with CNA #8, on 06/05/14 at 3:05 PM, revealed she had given Resident #1 a shower on 06/04/14 and she had not provided nail care to the resident and was not sure if she notified the staff nurse.

Interview with LPN #8, on 06/05/14 at 2:30 PM, revealed she was aware Resident #1's nails were still long and needed to be trimmed and instructed the CNA on 06/05/14 in the AM to cut the residents nails because it was not done during his shower second shift on 06/04/14.

Interview with Resident #1, on 06/05/14 at 8:30 AM, revealed he/she liked his/her fingernails trimmed short; however, he/she was not sure when the last shower was before last night or when his/her nails were last trimmed before this morning.

2. Observation during wound evaluation with Advanced Registered Nurse Practitioner (ARNP) with Resident #3, on 06/03/14 at 1:45 PM, revealed the dressing to the residents' right lower

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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - HILLCREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
(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)

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F 312

leg was off and a foot bandage was removed by the ARNP. In between Resident #3's toes was a thick, dark yellow, putty like consistency, substance that was removed by the ARNP with a cotton tip applicator. She obtained a large amount between each toe on the right foot. The bottom of Resident #3's foot revealed the same substance with the color of brownish/black with a slightly green hue. The resident's foot had a strong musty odor. Resident #3 was unshaven, had long nails with a brown substance underneath. Resident #3 was observed while talking to have a buildup of plaque on his/her lower front teeth at the gum line.

Review of the medical record for Resident #3 revealed the facility admitted the resident on 09/06/06 with diagnoses of Cerebral Palsy, Muscle Spasm with Contractures and splint use, Lack of Coordination, Left Leg Amputation, History of Cerebral Vascular Accident with Hemiplegia, Peripheral Vascular Disease, and Vascular wounds to the right lower leg. Review of the quarterly Minimum Data Set Assessment, completed on 04/25/14, revealed the facility completed a Brief Interview for Mental Status (BIMS) and assessed the resident at a fifteen (15), cognition intact. The facility assessed the resident's mobility as requiring supervision with the assistance of one (1) staff for use of a motorized wheelchair; hygiene was extensive assistance with one (1) staff, and bathing was total assist with two or more physical assistance. In addition the Wound Care Physician orders written on 05/13/14, revealed a reminder to facility staff to wash in between Resident #3's toes.

Review of the Certified Nursing Assistant (CNA) Bath and Skin Report sheet for Resident #3.

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Facility ID: 100212

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STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:  
  
185095

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING \_\_\_\_\_  
B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED  
  
06/05/2014

NAME OF PROVIDER OR SUPPLIER  
  
GOLDEN LIVINGCENTER - HILLCREEK

STREET ADDRESS, CITY, STATE, ZIP CODE  
3116 BRECKINRIDGE LANE  
LOUISVILLE, KY 40220

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COMPLETION  
DATE

F 312 Continued From page 23  
dated for 06/04/04, revealed his/her finger nails  
were clean and short. No documentation was  
listed for a shave.

F 312

Review of the facility shower schedule revealed  
Resident #3 was to receive a shower every other  
day on day shift starting 06/04/14.

Interview with Resident #3 during the wound  
evaluation, on 06/03/14 at 1:45-2:00 PM,  
revealed facility staff was not removing the  
dressing to the right lower leg including the foot,  
nor was staff washing his foot and between the  
toes. The resident further stated the dressing  
was left on his leg/foot and wrapped in a plastic  
bag during his/her showers. In addition the  
resident stated he/she can't hardly get a shower  
here.

Observation, on 06/04/14 at 7:15 AM, revealed  
Resident #3 remained unshaven with long nails.  
During the shower provided by CNA #2 at 12:05  
PM, in the 100 unit shower room, revealed  
Resident #3 was not shaved during a scheduled  
shower nor were his nails cut. During this  
observation the resident asked the CNA #2 if she  
could shave him/her today, and the CNA #2 told  
the resident yes, but did not have a razor and  
offered to shave the resident in his/her room after  
getting dressed.

Observation, on 06/04/14 at 3:50 PM, revealed  
Resident #3 was unshaven with long nails.

Interview with Resident #3, on 06/05/14 at 9:40  
AM, revealed the facility staff had just shaved  
his/her face today.

Review of CNA #2 completed Bath and Skin

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STATEMENT OF DEFICIENCIES  
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IDENTIFICATION NUMBER

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(X2) MULTIPLE CONSTRUCTION  
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06/05/2014

NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - HILLCREEK

STREET ADDRESS, CITY, STATE, ZIP CODE

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DATE

F 312 Continued From page 24

Report sheet for Resident # 3, dated for 06/04/14,  
revealed his/her fingernails were clean and short,  
in addition the document did not indicate if a  
shave was provided.

F 312

Interview with CNA #2, on 06/05/14 at 3:15 PM,  
revealed she did not go back and shave Resident  
#3 after the scheduled shower.

Interview with LPN #7, on 06/05/14 at 2:55 PM,  
revealed she was responsible for monitoring the  
CNA's for her residents and stated she usually  
cuts Resident #3's nails because he/she was a  
Diabetic and she had cut them two weeks ago.  
She further stated she did not get any reports  
from CNA #2 regarding Resident #3's need for  
nail care or being shaved.

3. Observation of Resident #10, on 06/03/14 at  
9:15 AM during facility tour, revealed the resident  
remained in the bed. The resident's hair was  
separated into clumps and did not appear to be  
combed.

Clinical record review for Resident #10 revealed  
the facility admitted the resident on 06/08/12, with  
diagnoses of Atrial Fibrillation, Essential  
Hypertension, Schizoaffective Disorder, and  
Presenile Dementia with Depressive Disorder.  
The facility assessed the resident, on 03/13/14,  
using a quarterly Minimal Data Set (MDS), and a  
Brief Interview for Mental Status (BIMS) and  
determined Resident #10 was cognitively intact  
with a BIMS score of fifteen (15) of fifteen (15).  
The facility assessed the resident's functional  
status as requiring one (1) person physical assist

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Event ID: B98311

Facility ID: 100212

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STATEMENT OF DEFICIENCIES  
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(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:  
  
185096

(X2) MULTIPLE CONSTRUCTION  
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STREET ADDRESS, CITY, STATE, ZIP CODE  
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F 312 Continued From page 25  
during personal hygiene and bathing.

F 312

Review of the facility's shower schedule, dated 05/21/14, revealed Resident #10 was scheduled for showers on Tuesday and Friday of each week. Review of the MDS report, section for activities of daily living (ADL), dated 04/25/14 through 06/05/14 revealed three (3) showers were documented, none of which were provided on a scheduled shower day. The reports revealed the resident received three (3) of twelve (12) shower opportunities. There were eleven (11) days between the shower completed on 05/01/14 and shower provided on 05/12/14. The next shower was provided ten (10) days later, on 05/22/14. There were no showers documented after 05/22/14 through 06/05/14.

Interview with Resident #10, on 06/05/14 at 2:20 PM, revealed this place was not what it used to be when it comes to assisting the residents. He/She stated, it was sometimes a month between his/her hair being shampooed. Often times it was a couple of weeks between his/her showers. He/She stated they get to feeling pretty dirty over that time frame.

4. Observation of Resident #15 from the corridor into the resident's room, on 06/4/14 at 8:20 AM, revealed the resident's privacy curtain was pulled nearly to the foot of the bed. The resident was laying in the bed with the covers pulled up to the chest and the eyes were closed. The curtains to the window were closed and the lights were off.

Observation of Resident #15, on 06/05/14 at 8:10 AM, revealed the resident was self propelling towards his/her room on the 200 Hall. He/She commented in an excited tone of voice to another

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