

MAY - 8 2015

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

OFFICE OF INSPECTOR GENERAL  
CENTERS FOR MEDICARE & MEDICAID SERVICES  
PRINTED: 04/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/16/2015
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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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F 000	INITIAL COMMENTS	F 000		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to develop a comprehensive care plan for one (1) of four (4) sampled residents (Resident #1) addressing the risk of dehydration</p>	F 279	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law.</p> <p>F 279 N 189</p> <p>1. Resident # 1 care plan (CP) was revised/updated on 04-14-15. Resident #1 has since been discharged (D/C'd).</p> <p>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 05/28/15 for accuracy.</p>	

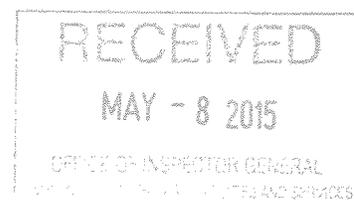
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*X [Signature]* TITLE *X Exec. Dir X* (X6) DATE *5-8-15*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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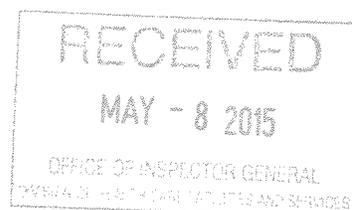
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F 279	<p>Continued From page 1 from the use of diuretics.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Hydration, dated 02/12/15, revealed the Dietician calculated daily fluid requirements for all residents annually or with changes in condition. Increased fluid needs may occur if the resident received diuretics. Each resident's fluid needs must be calculated based on objective data regarding the resident.</p> <p>Review of Resident #1's Nursing Notes, dated 04/09/15 at 6:02 PM, revealed the resident received a diuretic daily and had eaten and taken fluids poorly on 04/08/15 and 04/09/15 and was lethargic. The resident did arouse; however, after stimulation the resident fell back to sleep. The physician ordered, on 04/09/15, for the resident to be sent to the emergency room for evaluation.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/02/15, revealed the resident was not interviewable and had a cognitive deficit. The resident required the limited assistance of one person with eating meals, transfers, and hygiene. The resident required extensive assistance with dressing, and was nonambulatory and the resident was frequently incontinent.</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 07/09/14, revealed the resident required meal trays to be set-up and meal consumption was monitored daily. There was no evidence the facility developed a care plan to address the resident's risk for dehydration related to the daily administration of a diuretic. There was</p>	F 279	<p>3. All resident's daily orders will be reviewed in the daily morning clinical meeting by the Interdisciplinary (IDT) team. This team consists of the Director of Nursing (DON), Assistant Director of Nursing (ADON), Registered Dietitian (RD), Social Services, Unit Managers (UM) and MDS coordinators. Any residents with orders for a diuretic will have an accurate CP. The MDS coordinators will update the residents CP daily with any changes to reflect an accurate CP with use of a diuretic.</p> <p>4. The DON/ADON will randomly select 4 residents per week, that have an order for a diuretic, 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</p>	05-29-15	



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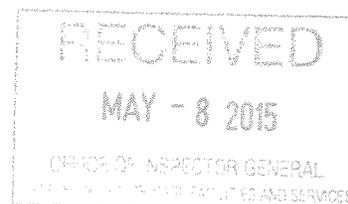
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F 279	<p>Continued From page 2</p> <p>no evidence the facility monitored fluids consumed or established fluid intake goals as assessed by the Dietician.</p> <p>Review of Resident #1's Meal Intake Record, dated 04/08/15 and 04/09/15, revealed the facility did not record the amount of fluids the resident drank for those days.</p> <p>Review of the Discharge Summary from the hospital, dated 04/13/15, revealed Resident #1 was admitted to the hospital, on 04/09/15, with diagnoses of Metabolic Encephelopathy, Urinary Tract Infection and Dehydration. Resident #1 was a patient in the hospital during part of the survey.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 04/14/15 at 10:40 AM, revealed Resident #1 was able to pick up a glass and drink; however, the resident had to have cues and reminders to drink. She stated she did not know how much the resident drank in a day or how much the resident needed to drink in a day. She stated fluid intake was not recorded for residents unless the nurses told them to record it. She stated the resident was very sleepy and did not eat or drink on 04/09/15 before she went to the hospital. She stated the Nurse Aide Care Plan did not provide any information on how much the resident needed to drink. She stated residents could get sick if they did not eat or drink fluids.</p> <p>Interview with CNA #2, on 04/14/15 at 11:06 AM, revealed Resident #1 would drink fluids; however, the resident was sick a week ago and was eating and drinking very little even when reminded. She stated the facility did not record resident fluid intake and there was nothing on the Nurse Aide Care Plan regarding the resident's fluid intake.</p>	F 279			



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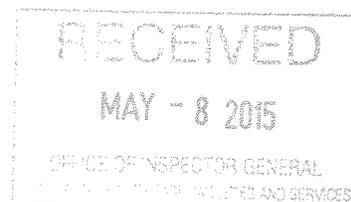
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F 279	Continued From page 3 She stated she did not know how much fluid the resident needed to drink. She stated the nurse did not tell the staff what to do while the resident was sick.  Interview with LPN #3, on 04/14/15 at 3:30 PM, revealed Resident #1 was lethargic and not drinking or eating much on the day before or the day the resident went to the hospital and could not estimate how much. She stated the physician visited the facility and ordered blood work done. She stated the physician then ordered the resident sent to the hospital for evaluation.  Interview with the Director of Nursing, on 04/14/15 at 4:15 PM, revealed residents on diuretics should have care plans to address the intake of fluids; however, the resident did not have a care plan for the risk of dehydration. She stated intakes of fluids and the amount the resident required were not addressed on the comprehensive care plan or on the nurse aide care plan. She stated the use of diuretics could cause dehydration and hospitalization.	F 279			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR 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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility's policy, it was determined	F 312			



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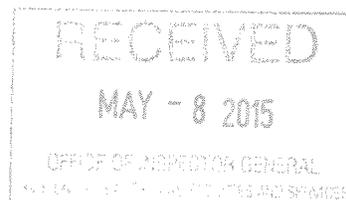
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F 312	<p>Continued From page 4</p> <p>the facility failed to provide two (2) of four (4) sampled dependent residents with oral care and nail care (Residents #2 and Resident #4).</p> <p>The findings include:</p> <p>Review of the facility's policy for Bath/Shower, dated 01/26/15, revealed a bath/shower cleansed the body, refreshed the resident, and provided increased circulation. The bath/shower included shampooing the residents' hair. There was no mention of oral care in the policy.</p> <p>Review of the facility's policy for Bed Bath, dated 01/26/15, revealed fingernail and toenail care were completed when a bed bath was received. There was no mention of oral care in the policy.</p> <p>1. Review of the clinical record for Resident #2, revealed the facility admitted the resident on 01/16/15 with diagnoses of Senile Dementia, Peripheral Vascular Disease, Frequent Falls and Stenosis of the Lumbar Spine.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #2, dated 03/04/15, revealed the resident had a BIMS score of ten (10) of a possible fifteen (15). The resident required extensive assistance from staff for bed mobility, transfer, dressing and hygiene. The resident was incontinent of bowel and bladder frequently.</p> <p>Review of the Care Plan for Resident #2, dated 01/19/15, revealed the resident was assisted by staff to bathe, nail care was completed by staff as needed, and the resident was assisted by staff in mobility as needed.</p>	F 312	<p>F 312 N 207</p> <p>1. Residents #2 and #4 were provided nail care and oral care immediately on 04-16-15 when found to be needed.</p> <p>2. All residents that need assistance in the facility have the potential for being affected by this deficient practice. An audit of all residents was conducted on 04-21-15 or 04-24-15 by the unit managers to ensure that all residents had nail care and oral care (unless they refused). The nail care and oral care was provided by the nursing staff as needed after the audit was conducted.</p> <p>3. The nursing staff was in serviced on 05-07-15 through 05-9-15 by the Interdisciplinary Team (IDT) on providing nail care and oral care to the residents everyday.</p> <p>4. The DON or ADON will randomly select 5 residents per week for 4 weeks, then monthly for 3 months, to check that each resident has had nail care and oral care. The Director of Nursing (DON) or Assistant Director of Nursing (ADON) will report any negative findings in QAPI committee monthly for 4 months. The DON or ADON will continue to do random checks monthly and report any negative findings, to ensure compliance greater than 4 months.</p>	05-29-15	



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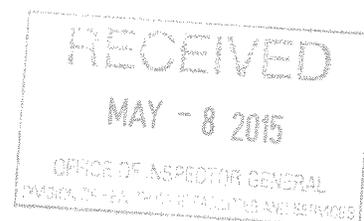
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F 312	<p>Continued From page 5</p> <p>Observation of Resident #2, on 04/14/15 at 2:10 PM, revealed the resident was sitting in a wheelchair in the room. The resident had long jagged fingernails with a black substance under the nails. In addition, the resident had a brown liquid substance coming from the mouth and spreading into the beard. The resident did not answer the question appropriately of what the liquid was.</p> <p>Interview with Certified Nurse Aide (CNA) #2, on 04/14/15 at 10:40 AM, revealed residents received nail care on bath day which was twice a week. She stated the diabetic residents and residents with thick nails were seen by the nurse or the podiatrist for toenail care. She stated residents received oral care in the morning and as needed. She stated she had provided Resident #2 with care and had received training to do oral care and nail care.</p> <p>Interview with CNA #4, on 04/14/15 at 2:29 PM, revealed residents were given nail care on bath days (twice a week). She stated Resident #2 would frequently refuse care; however, if you went back in a few minutes, the resident would agree to the care. She stated the resident had been bathed and dressed that morning. She stated she did not notice the state of the resident's nails nor did she see the blackish liquid coming from the resident's mouth down into the facial hair. She stated she provided care for Resident #2 today and had no explanation of the resident's condition. She stated she had received training on oral care and nail care.</p> <p>Interview with LPN #1, on 04/14/15 at 3:32 PM, revealed she did make rounds on residents to ensure they were clean and cared for. She</p>	F 312			



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F 312	<p>Continued From page 6</p> <p>stated she last made rounds earlier that morning. She stated the CNAs were trained on oral care and nail care and were to tell the nurse if there were problems completing the resident's care.</p> <p>2. Review of the clinical record for Resident #4, revealed the facility admitted the resident with diagnoses of Schizophrenia, Hypertension, and Congestive Heart Failure on 05/28/14.</p> <p>Review of the quarterly MDS assessment, dated 02/03/15, for Resident #4, revealed the facility assessed the resident as cognitively intact. The resident required extensive assistance with transfers, bed mobility, dressing, and hygiene. The resident required total assistance with bathing and the resident was occasionally incontinent.</p> <p>Review of Resident #4's Care Plan, dated 05/25/14, revealed the resident received assistance with bed mobility and positioning every shift. In addition, the resident required assistance with activities of daily living.</p> <p>Observation of Resident #4, on 04/14/15 at 11:15 AM and 2:20 PM, revealed the resident had crumbs and dandruff like particles all over the pants and shirt.</p> <p>Interview with Resident #4, on 04/14/15 at 2:20 PM, revealed the resident was not aware of the state of his/her clothing.</p> <p>Interview with CNA #1, on 04/14/15 at 2:29 PM, revealed residents were bathed twice a week and received a partial bath on other days. She stated nail care was provided on bath days. She stated oral care was provided daily and as needed.</p>	F 312			



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F 312	Continued From page 7  Interview with LPN #3, on 04/14/15 at 3:15 PM, revealed the nurses supervised the nurse aides to ensure resident care was completed; however, there were times when the unit was very busy.  Interview with the Assistant Director of Nursing, on 04/14/15 at 11:10 AM, revealed residents received a bath twice a week and a partial bed bath on the other days. She stated resident's were encouraged to wear pajamas to bed at night, and to receive baths on bath day along with nail care and grooming. She stated some residents refused and the nurses depended on the CNAs to notify them if the resident refused care.	F 312			