

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

PRINTED: 09/16/2015  
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  08/29/2015
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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F 323	<p>Continued From page 74 wheelchairs/safety belts were secured/fastened before moving the van.</p> <p>15. Interview, on 09/02/15 at 2:35 PM with the Activities Director, revealed on 07/28/15, she retrained the facility's authorized van drivers on safe resident transport and proper use of the van's wheelchair lock-down system.</p> <p>16. Review of the document titled, Quarterly Drivers Files Audit, No Date, revealed the drivers' files would be audited for re-training competencies on 10/28/15, 01/28/16, 04/28/16 and 07/28/16.</p> <p>17. Interview, on 08/29/15 at 2:50 PM with the Director of Resident Assessment/MDS revealed, on 08/28/15, the Activities Director consulted with the Director Of Assessment/Minimum Data Set Nurse prior to transporting a resident who had a lap tray affixed to his/her wheelchair. The Director of Resident Assessment/Minimum Data Set Nurse stated she referred the Activities Director to Therapy Department as she thought therapy staff could best answer the question related to the resident's wheel chair tray.</p> <p>18. Interview, on 08/29/15 at 3:22 PM with the Human Resources Generalist, revealed she reviewed the records for all authorized van drivers to ensure their drivers' licenses and Department of Transportation certifications were in-date, and for verification of re-training on the van's wheelchair restraint system. The Human Resources Generalist stated she was assigned to monitor the van drivers records for the required competencies and for verification of quarterly retraining for one year, and thereafter she would conduct an annual review of their records.</p>	F 323		



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F 323	Continued From page 75  19. Review of the document titled, Ad Hoc QAPI, dated 08/23/15, revealed the Executive Director, the Director of Nursing, the Assistant Director of Nursing, the facility's Social Worker, Unit Managers for four (4) of four (4) nursing units, the Director of Resident Assessment, the Human Resources Generalist, the Maintenance Director, the Corporate Director of Clinical Education, and the facility's Medical Director attended the QAPI meeting.  Interview with the ADON, on 08/29/15 at 3:42 PM, revealed she would oversee the monitoring that would occur by the Unit Managers and MDS Nurses, for the new admission process, complete all proper documentation, all new admissions will be discussed during the daily clinical meetings, twenty-four hour reports would be reviewed at the clinical meeting. The ADON stated she would also be attending the QA meetings and providing progress of the monitoring process for admissions and changes of condition.  Interview with the Administrator, on 08/29/15 at 4:30 PM, revealed nurses were assigned to monitor tasks described in the AOC to ensure that all residents newly admitted have been assessed and screened by the new process and interventions put in place. The Administrator stated she would have the AOC minder at each morning meeting to review and to check to ensure assigned staff were continuing to monitor for compliance with the plan.	F 323			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must -	F 371			



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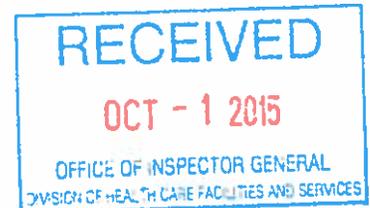
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F 371	Continued From page 76 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371  1. The wet dishes were not used for resident # 1 and #4 after they were determined to still be wet. New plates were gotten and used for resident # 1 and #4. The adaptive equipment for resident #4 was not used after it was determined that it was still wet. The equipment was dried and then used for resident #4. We did not use the wet plates or wet equipment for these 2 residents.  2. All Residents could potentially be at risk related to this practice. No others were affected because the RD immediately took the wet plates and equipment off the tray line on 08/12/15 and did not use.  3. All dietary staff, including the cook that made the mistake of placing the food on the wet plates, was in serviced on 08/13/15 by the Director of Dining Services (DDS) on the proper procedure for allowing dishes and utensils to air dry before use.  4. The kitchen will be monitored daily by the RD or DDS for following the proper procedure for allowing dishes and utensils to air dry and not be used until dry. The RD will do weekly audits of the tray line X 4 weeks to ensure that this process is being followed correctly. The monthly X 4 months. On a daily basis if this process is not followed correctly and the dietary staff are out of compliance the DDS or cook immediately will correct and in-service the dietary staff. She then will communicate these findings daily to the ED. The ED will then report these findings to QAPI monthly for 5 months.	09/30/15	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to distribute food under sanitary conditions when serving food, for two (2) of twenty-six (26) residents (Residents #1 and #4). Observations revealed the Cook placed Resident #1's food on a wet plate from a stack of plates delivered to the tray line from the dish washing room after the plate warmer ran out of plates. In addition, interview with Resident #4 revealed they received adapted equipment that was still wet.  The findings include:  Review of the facility's policy regarding Washing Dishes, not dated, revealed the dietary staff was to allow all items to thoroughly dry before unloading or storing and to store all items completely free of moisture.  Review of the facility's policy regarding Washing Flatware, not dated, revealed the dietary staff was to allow flatware to air-dry either by cylinder storage or bin storage.				



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F 371	<p>Continued From page 77</p> <p>Observation, on 08/12/15 at 10:45 AM, during the lunch tray line revealed the Dietary Cook took a wet plate from a stack of approximately 10 plates and placed food on the plate then placed the plate of food on a tray for Resident #1.</p> <p>Interview, on 08/13/15 at 2:35 PM, with Resident #4 revealed when his/her meal tray was delivered to his/her room, the adaptive equipment (foam handled fork and spoon) on the meal tray was sometimes wet to touch.</p> <p>Interview with the Dietary Cook, on 08/13/15 at 9:15 AM, revealed she had been trained on hire and at least once in the past year to allow the dishes and utensils to air dry before use. She stated by not letting the dishes air dry it could cause bacteria to grow on the dish and make the resident sick. She stated she realized she had plated food on a wet plate after she had already placed food on it. She stated she was nervous because a State and Federal surveyor were watching her and she had never used wet dishes or utensils in the past.</p> <p>Interview with the Dietary Manager, on 08/12/15 at 1:15 PM, revealed the facility policy stated to allow dishes and utensils to air dry before use. She stated the Dietary employees were trained upon hire and throughout each year on that policy which included air drying dishes and utensils. She also stated the potential harm for using wet dishes would be bacteria growing on the dishes and making the residents ill. She then stated this incident had never occurred in the past with any other Dietary staff member and the Dietary Cook was nervous because surveyors were observing her.</p>	F 371	<p>The RD findings from the audits will be reported to the DDS and ED. The RD will report the findings to the QAPI committee monthly for 5 months.</p>		



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F 431 SS=D	<p>483.60(b), (d), (a) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 431	<p>F431</p> <p>1. A locked med room was made on 08/13/15 and all treatment carts and med carts were stored in the med room.</p> <p>2. All residents have the potential to be affected by this practice. None were affected. All other med rooms were locked and med carts and treatment carts were stored in the locked med rooms.</p> <p>3. The nurses were in-serviced on 09/15/15 - 09/17/15 on keeping the med and treatment carts in the locked med rooms. The IDT team including the Executive Director (ED), Unit Managers (UM), Staffing Coordinator, Assistant Director of Nursing (ADON) conducted this in-service.</p> <p>4. The UM will randomly select 1 cart per week on their unit for 4 weeks, then monthly X 4 months to check that they are locked and placed in the locked med room when not in use. The UM will report their findings to QAPI committee monthly X 5 months. The QAPI team meets monthly. Each month, the team will review the results of these checks to ensure compliance of the staff, need for evaluation of any identified issues and need for developing an action plan (AP) for non-compliance. This will be completed for 5 months to ensure continued compliance.</p>	09/30/15	



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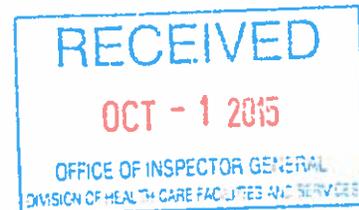
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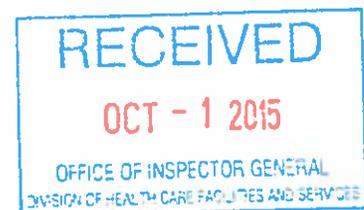
F 431	<p>Continued From page 79</p> <p>by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure one (1) of four (4) nursing units kept medications in a locked room. Three medication carts and one (1) treatment cart were stored in an unlocked room on the 300 Unit when not in use. In addition, the facility failed to ensure that one (1) emergency intravenous fluid for medication reconstitution was not expired and available for use.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Storage of Medication, dated 01/06/15, revealed in order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) would be allowed access to the medication carts. Medication rooms, cabinets and medication supplies were to be locked or attended by persons with authorized access. Continued review of this policy revealed outdated medications were to be immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order existed.</p> <p>1. Observation, on 08/13/15 at 3:15 PM, revealed three (3) medication carts and one (1) treatment cart on the 300 Hallway were not stored in a locked room when not in use. The medication carts and the treatment cart were stored in a vacant resident room (Room 303), and there was</p>	F 431		
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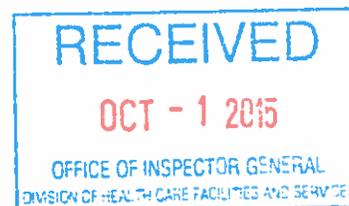
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F 431	<p>Continued From page 80</p> <p>no lock on the door. Resident Room 303 was near the end of the hallway away from the nurses' station which was located at the center of the 300 Hallway. In addition, this observation revealed one (1) of the three (3) medication carts stored in Room 303 was unlocked. Continued observation revealed the unlocked medication cart contained multiple doses of medications prescribed for residents in Rooms 300-310, and included, but was not limited to the following medications: Nitrostat 0.4 mg tablets; Glucagon Injection Pen (for treating hypoglycemia); Humulin R Insulin; Lasix 40 mg tablets; Fish Oil Capsules; Hydralazine 100 mg tablets; Warfarin 6 mg tablets; Namenda 10 mg tablets; Nystatin Oral Suspension; Senna Syrup 176 mg/5 milliliters (mLs); and Polyethylene Glycol Powder 255 GM Powder.</p> <p>Interview, on 08/13/15 at 3:15 PM, with the Unit Manager (UM) for the 300 Unit revealed she did not think the entry door to Room 303 was in full view of staff that worked at the nurses' station, and this prevented the nursing staff from being able to continuously monitor this unlocked room. The UM stated until about one (1) month ago, the medication and treatment carts were stored in a locked room next door to the nurses' station, but that room was converted to the Director of Nurse's (DON's) office, and the carts were then stored in whatever resident room happened to be vacant. The UM stated the carts were stored in Room 303 for about one (1) week. Prior to that, the medication carts and treatment cart had been stored in vacant Resident Room 326, which was also kept unlocked. The UM stated Room 326 was closer to the nurses' station. The UM stated the Administrator made the decision to use</p>	F 431			



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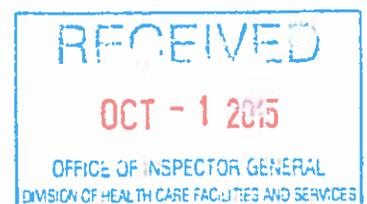
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F 431	Continued From page 81 vacant resident rooms as storage areas for the medication carts/treatment carts. Continued interview with the UM revealed there were typically two (2) licensed nurses on duty each shift. The UM stated all licensed nurses were trained to ensure medication and treatment carts were locked when they were not in direct sight of the nurses assigned to them, but she did not think the 300 Unit nurses received additional in-service education related to increased monitoring of the medication/treatment carts while they were stored in the vacant/unlocked resident rooms.  Interview, on 08/13/15 at 4:20 PM, with Incensed Practical Nurse LPN #5 revealed nurses were to ensure medication and treatment carts remained locked when not in use. LPN #5 stated she found her assigned medication cart in the vacant resident Room 303 today when she reported to work. LPN #5 stated she did not routinely work on the 300 Unit, but she had worked the unit a few times over the past two (2) weeks. LPN #5 stated she had not seen any residents attempt to enter vacant room 303 where the medication/treatment carts were stored.  Interview, on 08/13/15 at 4:50 PM, with Certified Nursing Assistant (CNA) #2, revealed he typically worked on the 300 Unit, and had not seen any residents enter vacant Room 303 where the medication/treatment carts were stored. CNA #2 stated a couple of residents from other hallways in the facility occasionally came to the 300 Unit looking for refreshments in the 300 Unit refrigerator, but he had not seen them attempt to enter vacant Room 303.	F 431			



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F 431	Continued From page 82  Observation, on 08/13/15 at 4:55 PM, revealed the medication carts and the treatment cart for the 300 Unit had been moved to the lockable room next to the nurses' station.  Interview, on 08/13/15 at 4:45 PM, with the Assistant Director of Nursing (ADON) revealed she was aware the medication carts and the treatment cart for the 300 Unit had been stored in various vacant resident rooms. The ADON stated she was also aware there was a plan to find a more secure space for the carts, but the storage of the carts in an unlocked space concerned her because residents, visitors, and staff not authorized to administer medications would have access to the contents of the medication/treatment carts if they were left unlocked. The ADON stated it could be potentially harmful if residents' obtained and ingested medications that were not prescribed for them. Continued interview with the ADON revealed, to date, there had not been any incidents where residents had obtained medications from unlocked medication carts or treatment carts.  2. Observation, on 08/12/15 at 9:51 AM, of the emergency medication supply stored in the medication room on the 200 Unit, revealed one (1) vial of Meropenem 500 milligram (expiration date January 2016) packaged with a 50 milliliter bag of Sodium Chloride 0.9%, with an expiration date of July 2015.  Interview, on 08/12/15 at 10:20 AM, with the Unit Manager (UM) for the 200 Unit revealed the 200	F 431			



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F 431	Continued From page 83 Unit medication room was the storage area for the emergency intravenous medications supply for all nursing units in the facility. The UM stated nursing staff for the 100, 300 and 400 Units would obtain emergency intravenous medications and fluids from the 200 Unit stock until the physician's order could be filled and delivered by the pharmacy. The UM stated the emergency medication supplies were audited every two (2) weeks by staff from the contracted pharmacy, but the UM could not identify any facility staff person assigned to perform audits of the emergency medications to ensure the supplies were not expired. The UM also stated that it was not good practice to use expired products for the administration of medications, and in-date products should always used to ensure effective administration of the medications.	F 431			
F 441 SS=E	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	F 441			



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F 441	Continued From page 84 (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 infection.  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 maintain an Infection Control Program for four (4) of twenty-six (26) sampled residents and one (1) of five (5) unsampled residents. Breaches in infection control were observed during wound care and dressing changes for Residents #2, #4, #5, #12 and #13 and Unsampled Resident E. In addition, nurses were observed not sanitizing their hands and not using proper handwashing technique during the medication pass observation, and five (5) of the ten (10) pill crushers on the medication carts were soiled. Staff was also observed obtaining disposable gloves from an unclean area for use	F 441	F 441  1. All resident room's paper towel dispensers in the facility were filled on 08/13/15 by the DOH and the housekeeping staff. All pill crushers in the facility were cleaned on 08/14/15 by the unit managers or the ADON.  2. All residents in the facility had the potential for being effected by the deficient practice. No other residents were affected because no other rooms were found to have empty paper towel dispensers upon rounds on 08/13/15 by the DOH and because all pill crushers were cleaned by the unit managers or the ADON on the 08/14/15 after the deficient practice was found.  3. The nursing staff were in-serviced on 09/15/15 - 09/17/15 on keeping the pill crushers clean by cleaning after each shift, the proper technique for hand washing, turning off the faucet, changing gloves and washing hands between procedures, washing hands in between residents when giving them medications, creating and maintaining a clean field for clean dressing changes, not returning any unused dressing supplies to the treatment carts, and only using gloves out of glove boxes. The IDT team including the Executive Director (ED), Unit Managers (UM), Staffing Coordinator, Assistant Director of Nursing (ADON) conducted this in-service. The UM or supervisor of each unit will provide oversight of these processes to ensure that they are done correctly by observing random med passes and treatments. When issues are identified the UM or supervisor will immediately educate the nurse on the correct process.	09/30/15	



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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 441	<p>Continued From page 85 during a meal tray pass on the 300 Unit.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Handwashing/Hand Hygiene, revised August 2014, revealed all personnel would follow handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors. Staff was to wash their hands before preparing or handling medications, after contact with a resident's intact skin, and after contact with objects in the immediate vicinity of the resident. The steps for handwashing were also listed in the policy and included turning off the faucet handles with a clean paper towel as a final step in the handwashing procedure. In addition, when donning clean disposable gloves, the gloves were to be obtained from a dispensing box, one glove at a time, touching only the top of the cuff.</p> <p>1. Observation, on 08/12/15 at 9:07 AM, during the morning medication pass on the 200 Unit, revealed Licensed Practical Nurse (LPN) #3 did not wash her hands or use hand sanitizer after administering medication to Unsampled Resident B, but proceeded to set up medications at the medication cart for Unsampled Resident C, and then entered his/her room and administered the medication to that resident. LPN #3 did not sanitize her hands upon exiting Unsampled Resident C's and proceeded to knock on Resident Room 207, entered the room, and closed the door to that room.</p> <p>Observation, on 08/13/15 at 8:56 AM, during the morning medication pass on the 100 Unit, revealed LPN #1 administered medication to</p>	F 441	<p>4. The UM will randomly select one nurse weekly X 4 weeks, then monthly for 4 months to watch them do a treatment to make sure that they are creating a clean field and maintaining a clean field and changing gloves in between procedures and to watch them give meds to residents to ensure they are washing their hands in between giving meds to different residents. The UM will report the findings to QAPI committee monthly for 5 months. The QAPI team meets monthly. Each month, the team will review the results of these checks to ensure compliance of the staff, need for evaluation of any identified issues and need for developing an action plan (AP) for non-compliance. This will be completed for 5 months to ensure continued compliance.</p>		



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F 441	<p>Continued From page 86</p> <p>Unsampled Resident D, went to the sink in the resident's room to wash her hands, used soap and water to cleanse her hands, but turned off the faucet handles with her bare hands. Observation also revealed the paper towel dispenser over the sink was empty. After turning off the faucet handles with her bare hands, LPN #1 crossed the hall to Resident Room 102 and obtained a paper towel from the dispenser in that room to dry her hands.</p> <p>Observation, on 08/13/15 at 9:13 AM, during the morning medication pass on the 100 Unit, revealed LPN #2 assisted Resident #2 with a morning dose of his/her metered-dose inhaler. Before exiting the room, the nurse turned to wash her hands at the room's sink, realized the paper towel dispenser above the sink was empty, asked Resident #2's roommate if she could use some of his/her facial tissues to dry her hands, and used the tissues to dry her washed hands and turn off the sink's faucet handles.</p> <p>Interview, on 08/13/15 at 9:15 AM, with LPN# 2 revealed there was usually enough paper towels in resident rooms for use and was not sure why the paper towel dispenser was empty.</p> <p>Continued interview with LPN #2, on 08/14/15 at 8:40 AM, revealed the facility's Housekeeping Staff was responsible for ensuring resident rooms had paper towels, and she stated Housekeeping staff was on the unit throughout the day. LPN #2 stated she did use facial tissues obtained from Resident #2's roommate to dry her hands, but this was not ideal because of the increased risk of cross-contamination from using another resident's supplies.</p>	F 441			



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F 441	<p>Continued From page 87</p> <p>2. Review of the facility's policy regarding Crushed Medication Delivery, revised 02/01/11, revealed it was important to wipe down the inside of the pill crusher and removable grey overflow cup with a wet paper towel or other cleaning solution prior to use, and also before and after each med pass. The policy further stated this would help reduce static buildup, cross contamination, and ensure proper maintenance as required by the product's warranty.</p> <p>Observations, on 08/12/15 at 8:45 AM, of the medication cart marked 230-1 revealed a pill crusher located on top of the medication cart had a brown crusted substance around the lid, and tan colored stains down the sides of the crusher.</p> <p>Observation, on 08/13/15 at 8:42 AM, of the pill crusher on the 100 Unit medication cart for rooms 138-141, revealed a brown substance around the cup and ring area of the pill crusher.</p> <p>Observation, on 08/14/15 at 9:28 AM, of the medication cart on the 400 Unit, revealed a soiled pill crusher with a brown substance around the rim and in the interior of the device where the disposable cups would be placed.</p> <p>Observation, on 08/14/15 at 9:50 AM, on the 200 Unit revealed there was a soiled pill crusher with a brown substance on the medication cart for Rooms 200-229, and the pill crusher on the medication cart for Rooms 200-208 was also soiled with a brown substance.</p> <p>Interview, on 08/14/15 at 2:50 PM, with the Assistant Director of Nursing (ADON) revealed medication carts and all equipment used for medication preparation should be cleaned on an</p>	F 441			



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F 441	Continued From page 88 as needed basis by the nurses assigned to the carts. The ADON stated the Unit Managers were responsible for monitoring the medication and treatment carts for cleanliness, but there was no specific schedule for cleaning the carts. The ADON stated it was important for all medication preparation equipment to be cleaned regularly to prevent cross-contamination and the spread of infection, and that she would expect the pill crushers on every med cart to be cleaned often.  3. Review of the facility's policy regarding Dressing Change-Clean, dated 01/30/15, revealed the nurse was to create a clean field with paper towels or a towelette drape.  Review of the clinical record for Resident #4 revealed the facility admitted the resident on 01/21/15 with diagnoses of Diabetes Type 2, Hypo-potassium, Paraplegia, Decubitus Ulcers, Generalized Anxiety Disorder, Esophageal Reflux, and Neurogenic Bladder. Resident #4 had orders for wound care/dressing changes twice daily to a wound on the posterior side of his/her right thigh and to a wound at the Achilles area of his/her right leg.  Observation, on 08/14/15 at 9:55 AM, during the skin assessment for Resident #4 revealed LPN #4 did not create a clean field for placement of the supplies used for the dressing change. The nurse placed the medications (Silva Sorb, Santyl, and Bacitracin), some tongue depressors, and the paper tape dispenser on a stack of folded towels that were atop the resident's over bed table. A bottle of spray-on wound cleanser was placed on the resident's bedside table not protected by a barrier, and some of the packaged	F 441			



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F 441	<p>Continued From page 89</p> <p>dressings overlapped onto the resident's personal belongings that were also left on the overbed table. During the dressing changes, LPN #4 washed her hands three (3) times, but turned off the faucet handles each time using her bare hands, not with a clean paper towel.</p> <p>Interview, on 08/14/15 at 12:45 PM, with LPN #4 revealed she realized she did not use a paper towel to turn off the faucet handles when she washed her hands before and during the dressing changes for Resident #4, and stated this probably occurred because she was nervous. LPN #4 stated she thought the stack of folded towels on Resident #4's overbed table served as the clean field/barrier for placement of supplies for the resident's wound care/dressing changes. LPN #4 stated she placed the bottle of wound cleanser on the overbed table, and saw the resident's personal belongings on the table, as well. LPN #4 stated the wound care dressing change for Resident #4 was not a sterile procedure, but was considered a clean procedure for wound care.</p> <p>Interview, on 08/14/15 at 2:50 PM, with the ADON revealed nurses were to always use a clean paper towel to turn off faucet handles after washing their hands in order to prevent the risk of cross contamination to other residents, other staff, and themselves. The ADON stated the nurses should also keep hand sanitizer on their person for use when proper handwashing could not be completed immediately, and there were many hand sanitizer dispensers affixed to the walls on every hallway of the facility where direct care was performed.</p> <p>4. Review of the medical record for Resident #12, revealed the facility admitted the resident</p>	F 441			



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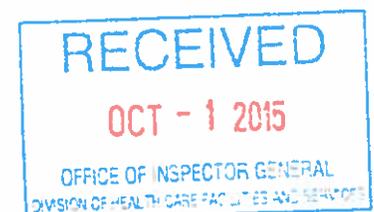
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F 441	<p>Continued From page 90</p> <p>most recently on 07/15/15 with diagnoses of Atrial Fibrillation, Dementia, and Kyphoplasty. Review of the Physician orders, dated 08/10/15, revealed staff was to clean incision sites to the lower back with peroxide and cover with a loose dressing two (2) times a day.</p> <p>Observation, on 08/12/15 at 9:19 AM, revealed LPN #7 obtained a sterile package of 4X4s, sterile Q-tips, and Peroxide and placed them on the resident's bedside table. A clean field was not established. After she cleaned the wound with the Q-tips, she changed her gloves, but did not wash her hands between glove changes. After she completed the treatment and skin assessment, LPN #7 proceeded to take unused left over supplies back to the treatment cart. She did not wipe down the Peroxide bottle before placing it back in the treatment cart.</p> <p>Interview, on 08/12/15 at 11:00 AM, with LPN #7 revealed she didn't think she had done anything wrong with the dressing change for Resident #12. She stated she did not remember if she needed to wash her hands between glove changes and could not remember if she had been trained on the dressing change policy. She stated she was not sure if it was okay to return unused supplies to the treatment cart.</p> <p>Interview, on 08/14/15 at 4:30 PM, with the ADON in regards to infection control revealed resident rooms were considered dirty. She stated taking supplies from a dirty area, with out disinfecting them, then placing them in the treatment cart was a risk for contamination and infection. She stated the disposable supplies should have been discarded and not brought back to the treatment cart.</p>	F 441			



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F 441	Continued From page 91  5. Review of the medical record for Resident #5 revealed the facility admitted the resident on 07/09/15 with diagnoses of Hemiplegia, Deformed Right foot, and a Pressure Ulcer. Review of the Physicians orders, dated 08/11/15, revealed the staff was to clean the right outer foot with wound cleaner then apply Bacitracin ointment and cover with a dry dressing every day.  Observation, on 08/12/15 at 9:39 AM, revealed Registered Nurse (RN) #2 completed the dressing change to the right foot of Resident #5. No clean field was prepared. After removing the old dressing from the right foot, RN #2 removed his gloves and replaced them with another pair without washing his hands. RN #2 proceeded to use wound cleaner to clean the wound, laid the bottle on the resident's bed, then picked the bottle up and placed it on the table.  6. Review of Resident #13's clinical record revealed the facility admitted the resident on 08/08/15 with a diagnosis of Right Tibia and Fibula Fracture.  Observation of a dressing change, on 08/11/15 at 2:35 PM, revealed Licensed Practical Nurse (LPN) #3 removed the old dressing; removed the gloves; washed her hands; and, donned new gloves. LPN #3 cleaned Resident #13's staples with soap and normal saline; dabbed the wound dry with a towel; removed her gloves; did not wash her hands; donned new gloves; and, applied the abdominal pad to the staples and wrapped with Kerlix.  Interview with LPN #3, on 08/11/15 at 2:45 PM, revealed when she cleaned the wound her gloves	F 441			



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F 441	<p>Continued From page 92</p> <p>were considered dirty and should have washed her hands when donning the new gloves.</p> <p>Interview, on 08/14/15 at 2:50 PM, with the ADON revealed normally the DON would oversee the infection control program for the facility, but as ADON, she would oversee the program in the DON's absence. The ADON stated the facility had a Corporate Director of Clinical Education who periodically monitored nurses' competencies for direct care tasks such as dressing changes, but this mostly occurred when there was an identified increase in infections within the facility. The ADON stated the facility did not currently have a specific nurse assigned to monitor wound/care dressing change technique of licensed nurses.</p> <p>7. Observation of the Tray pass on the 300 Unit, on 08/12/15 at 12:02 PM, revealed Certified Nursing Assistant (CNA) #8 was donning Personal Protective Equipment (PPE), before entering Unsampld Resident E's Room 327 which was an isolation room for C-Diff, to deliver a tray of food. CNA #8 removed a pair of gloves from LPN #7's pocket of her work uniform because there were no gloves in the isolation cart outside of Room 327.</p> <p>Interview with CNA #8, on 08/12/15 at 12:02 PM, revealed the PPE equipment was supposed to be in the isolation cart. CNA #8 stated anything that touched her body was not considered clean and thus the gloves she removed from LPN #7's body was not considered clean.</p> <p>Interview with LPN #7, on 08/12/15 at 12:10 PM, revealed the resident in Room 327 was on precautions for C-Diff. LPN #7 stated if the</p>	F 441			



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F 441	Continued From page 93 isolation cart was out of gloves the staff should get more gloves. LPN #7 stated she was aware her clothes were considered dirty and technically the gloves in her pocket were not considered clean either. LPN #7 stated her clothes were not considered clean because she frequently goes into resident rooms touching things. LPN #7 stated she could possibly contaminate other residents with the use of the dirty gloves.	F 441			
F 514 SS=J	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514			
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to have an effective system in place to maintain a complete and accurate clinical record, in accordance with professional standards, for one (1) of twenty-six (26) sampled residents (Resident #26).				



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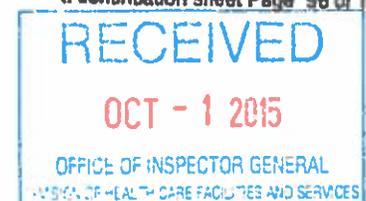
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F 514	<p>Continued From page 94</p> <p>On 07/17/15, Resident #26 fell from his/her wheelchair while riding in the facility's van, sustained a change in condition, and was transferred to an acute care hospital later that same day. Resident #26 was diagnosed with a subdural hematoma, and expired on 08/01/15 from complications. The facility's Assistant Director of Nursing (ADON), who assessed Resident #26 immediately after the fall, did not document her assessment in the resident's clinical record. The nurses failed to document any neuro-checks post incident and the nurses failed to document the Situation, Background, Assessment Report (SBAR).</p> <p>The facility's failure to have an effective system in place to accurately and completely document in the resident's clinical record has caused or is likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 07/17/15 and the facility was notified on 08/21/15.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/28/15, alleging the removal of Immediate Jeopardy on 08/27/15. The State Survey Agency (SSA) validated the Immediate Jeopardy was removed on 08/27/15 as alleged prior to exit on 08/29/15, which lowered the Scope and Severity to a "D" at 42 CFR 483.75 Administration (514) while the facility develops and implements the Plan of Correction (POC), and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>The facility did not provide a policy for</p>	F 514	<p>F 514</p> <p>Resident Immediately assessed by ADON at approximately 12:15pm (Assistant Director of Nursing) for any injuries/pain at time of incident. Her assessment included ROM, cognitive status, pupils, and grip. She also assessed her head for any abnormal areas and found none. Resident assessed at approximately 12:40 pm by ARNP upon arrival at facility on 7/17/15. His assessment included a Neurological assessment consisting of face and arm symmetry, muscle tone: upper and lower strength. An assessment of her head for any signs of trauma and found no signs of trauma.</p> <p>Executive Director (ED) notified of fall by ADON after arrival to facility and investigation initiated.</p> <p>The witnesses: Maintenance Director, ADON, and another resident riding in the bus) interviewed by ED.</p> <p>Clinical Health Status Assessment for resident was initiated by LPN charge nurse at 12:45 pm on 7/17/15.</p> <p>Medications - Promethazine HCL 12.5 mg, administered to resident per order on 7/17/15. RN charge nurse notified ARNP of change in condition at approximately 4:00pm and order received to send to Norton Audubon Hospital. This is noted in the medical record on the SBAR documentation in the chart. Resident transported by ambulance to Norton Audubon hospital at 4:30 pm. The same RN charge nurse that noticed the change in condition, called for ambulance after the order received.</p>	09/30/15	



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F 514	<p>Continued From page 95 documentation in residents' clinical records.</p> <p>Review of the clinical record for Resident #26 revealed the facility admitted the resident from another long term facility on 07/17/15. Resident #26 had diagnoses of Spina Bifida, Hydrocephalus with a shunt, Hypothyroidism, Nausea and Vomiting, Unspecified Essential Hypertension, and Chronic Headaches. Physician ordered medications were Plavix (to prevent blood clots) 75 mg daily, Aspirin (for pain, fever, and inflammation) 81 mg daily, and Maxalt 10 mg, as needed, for headache.</p> <p>Further review of the clinical record for Resident #26 revealed during transport to the facility staff failed to secure the resident via all available safety restraints prior to beginning the transportation. The resident's three (3) wheel scooter tipped over during transport and the resident fell from the scooter. The resident was subsequently transferred to the Emergency Room on 07/17/15 with a diagnosis of Subdural Hematoma and expired on 08/01/15 from complications.</p> <p>Record review revealed the ADON failed to follow the facility's policy and did not document the assessment completed after the fall. The facility also failed to complete and document the (SBAR) form for Resident #26 until the resident was sent to the hospital. Therefore, all nursing staff members were not aware of the fall or details related to the fall sustained by the resident.</p> <p>Interview with the ADON, on 08/13/15 at 10:00 AM, revealed she was in the van when the resident fell from the scooter and she assessed Resident #26's range of motion.</p>	F 514	<p>2. All residents have the potential to be affected by this practice. Falls for the last 6 months of current residents were reviewed by the ADON on 08/26/15, a total of 146, for a time frame of a fall occurrence within first 24 hours of admission. 4 falls were found to occur within the first 24 hours of admission. The residents identified as potentially affected within the 24 hour time frame records were reviewed by the ADON on 08/26/15, for timeliness of assessment completion to meet needs and Immediate Plan of Care (IPOC) developed. All 4 had an IPOC developed. All Care plans were reviewed by the RNAC, on 08/26/15 on the identified residents. Four residents were found to have a fall in this time frame. Their four careplans were reviewed. No updates were needed. The facility determines what interventions are needed to be put in place based upon the individual resident. The system we use is that the Interdisciplinary team, (IDT) (Consisting of the ADON or DON, the unit managers, the MDS nurse, the social services director, Therapy director and the RD), reviews each fall and the circumstances of the fall in the morning clinical meeting and they determine what intervention is best for that resident and the circumstances surrounding the fall to help prevent further falls.</p> <p>3. The facility fall policy does include completing a DQI and SBAR and noting the fall in report. ADON /Unit managers will ensure that SBAR is done and complete in the daily morning clinical meeting if a fall has occurred. The UM will also ensure that any new interventions are put on the care records and that they are physically in place on the resident if applicable. Training was initiated on 8/21/15 by DON and ADON to nurses regarding timely admission nursing notes assessment, clinical status assessment with IPOC, and SBAR with DQI. Training had</p>		



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F 514	<p>Continued From page 96</p> <p>However, review of the nurses' notes, dated 07/17/15, revealed the ADON failed to complete the Situation, Background, Assessment, Response (SBAR) note to document Resident #26's fall from his/her wheelchair while riding in the facility's van.</p> <p>Interview, on 09/03/15 at 4:35 PM, with the ADON revealed she did not document her observations and her assessment of Resident #26, as a first responder when the resident fell from his/her wheelchair on the van. The ADON further stated she probably should have documented her assessment in the resident's clinical record because it would have been important information for other staff as they conducted ongoing assessments, and planned subsequent care and made decisions for the necessary care after the resident's fall.</p> <p>Interview with the Director of Nursing (DON), on 08/21/15 at 2:29 PM, revealed she had not recognized there was not an SBAR completed on the fall sustained by Resident #26. The DON stated there should have been an SBAR added to the resident's clinical record.</p> <p>Interview with the Administrator, on 08/14/15 at 8:20 PM, revealed when a resident sustained a fall, the nurse was to assess the resident, and notify the physician and the family. The nurse would then complete an SBAR, a Verification of Investigation, and a Post Fall Analysis. Per interview, all of these forms were a permanent part of the resident's record.</p> <p>Further interview, on 09/03/15 at 2:20 PM, with the ADON revealed in addition to checking</p>	F 514	<p>been provided to DON and ADON by the corporate clinical services RN on March 26th and 27th, 2015 on the admission process, IPOC process, DQI process and SBAR process. They were determined to be knowledgeable in these facility practices that they trained staff on based on the fact that they had been trained by the corporate clinical services RN. Training of the facility nurses was concluded on 08/25/15. All full time and part time nurses trained, 49 in total. No agency nurses are used at this facility. No other nurses worked without first receiving training.</p> <p>All potential admissions are reviewed prior to coming to our facility by the clinical liaisons (CL). The clinical liaisons include RN's, or LPN's. Based upon these reviews of the potential residents we do our admission planning. Our system the facility uses is that the Admissions Director (AD) and ADON look for any special needs, interventions or equipment that the resident may need before arrival. If any interventions are needed the ADON communicates them with the unit managers to put into place. Upon arrival we will have all special needs, interventions or equipment in place.</p> <p>New resident admissions are reviewed in clinical morning meeting by unit managers, to ensure assessment, IPOC and documentation has been initiated timely and accurately.</p> <p>The unit managers ensure that the interventions, special needs or equipment are on the IPOC and that the staff is trained with these items, and have it in place. As we are auditing the IPOC, unit managers/nurse manager will do daily rounds to audit that the staff are following the interventions put into place on the IPOC. Initiated on 08/25/15.</p> <p>4. New admissions records will be audited by the DON/ ADON or the unit managers/Nurse</p>		



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F 514	<p>Continued From page 97</p> <p>Resident #26's range of motion, she also assessed the resident's pupils for equal size of reactivity to light stimulus, the resident's ability to grip with his/her hands, and his/her orientation to name and place. However, review of the clinical record revealed no documented evidence this assessment was conducted.</p> <p>Continued interview, on 09/03/15 at 4:35 PM, with the ADON, revealed she would not consider Resident #26's clinical record complete since she failed to document her immediate observations and assessments of the resident after the resident fell from his/her wheelchair.</p> <p>Further review of the clinical record revealed a nurse's note designated as a late entry, dated 07/17/15 at 1:30 PM, where the DON documented "resident was transferred to this facility from [another] Facility in bus when w/c tilted over enroute. Resident states that she did not hit her head but that she did have a migraine headache that she had prior to leaving [the other facility]. No other apparent injury noted. According to resident she has a h/o severe headaches/migraines."</p> <p>Interview with the DON, on 08/21/15 at 2:29 PM, revealed she wrote the first nurse's note, (designated as a late entry on 07/17/15 at 1:30 PM) based on the information that she believed was told to her by the Unit Manager. The DON then recanted and stated she wrote the statement based on what she assumed happened. The DON stated she was just helping the admitting nurse by writing the nurse's note on the same day the incident occurred. The DON stated she was not supposed to write inaccurate information in the resident's record. The DON stated she may</p>	F 514	<p>manager in clinical morning meeting every day to ensure timely assessment and IPOC to meet needs. This was initiated on 08/25/15. Audits will be completed daily x 3 weeks, then weekly x 4 weeks. Results will be reviewed in QAPI weekly x 4 weeks and then biweekly x 2 weeks. Then monthly X 3 months. Daily monitoring by ADON, DON, Nurse Managers, will continue in Clinical Start-up every morning after audits are completed as part of our normal daily clinical meeting. Further education of staff member will be initiated by the DON/ADON or UIM upon identification of untimely or omitted assessment/IPOC by a nurse.</p>		



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F 514	<p>Continued From page 98</p> <p>have used a poor choice of words by writing that Resident #26's wheelchair tilted over. The DON stated the Administrator confronted her and informed the DON that what she had documented was not what had happened to Resident #26, but that Resident #26 fell out of his/her wheelchair.</p> <p>Interview with the Administrator, on 08/14/15 at 3:20 PM, revealed she was not aware the DON had documented in the nurse's notes that Resident #26 fell while in wheelchair. However, the DON's documentation stated the resident's wheelchair tilted over not that the resident fell.</p> <p>Continued interview with the Administrator, on 08/14/15 at 3:20 PM, revealed the DON was wrong for documenting inaccurate information regarding the tilting of the three wheel scooter versus a fall from the scooter and she did not understand why the DON had documented in the nurse's note at all.</p> <p>Further review of the SBAR/nurses note on 07/17/15 at 4:29 PM, revealed Resident #26 requested to be sent to the hospital. However, review of the clinical record revealed there was no Physician order to transfer the resident to the hospital.</p> <p>Interview with Registered Nurse (RN) #5, on 08/14/15 at 9:40 AM, revealed she remembered talking to the APRN about Resident #26 requesting to go to the hospital and that the APRN gave the directive to send Resident #26 out to the Hospital for treatment. RN #5 stated she could not remember writing an order or not. Per interview, she should have completed a SBAR and Data for Quality Improvement (DQI) related to the resident's change in condition prior</p>	F 514			

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F 514	Continued From page 99 to discharge. However, review of the clinical record revealed these forms were not completed at the time of transfer.  Interview with the Unit Manager of the 100 Hall, on 08/21/15 at 3:30 PM, revealed she was told by the DON to complete a DQI, but was not asked to complete an SBAR. She completed a DQI on Monday 07/20/15, three (3) days after the resident was transferred to the Hospital.  Interview with the ADON, on 08/13/15 at 5:00 PM, revealed she did not review the clinical record to determine if there was a SBAR completed for Resident #26 or if an order was written to send Resident #26 out to the hospital for evaluation and treatment on 07/17/15.  Continued interview, on 09/08/15 at 10:55 AM with the Administrator, revealed newly employed nurses received training from the Corporate clinical staff regarding the facility's expectations for clinical record documentation. The Administrator stated the ADON did not document her assessment of Resident #26 in the clinical record, but that she should have, so that all staff caring for the resident prior to his/her transfer to the hospital would have had access to the ADON's immediate observations and findings directly after the resident fell. The Administrator stated the process was for the team, during the morning meeting, to ensure all forms (SBAR, DQI, post fall analysis, and nurses notes) were completed, orders were obtained, and new interventions were placed on the care plan, and physician and families were notified. However, she was not in attendance at that meeting for Resident #26, and did not review to ensure the record was complete and accurate.	F 514			



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F 514	Continued From page 100  The facility alleged the removal of Immediate Jeopardy by implementing the following:  1. On 07/17/15 Resident #26 was assessed by the Assistant Director of Nursing at approximately 12:15 PM for any injuries/pain at the time of incident.  2. On 07/17/15 at 12:40 PM, the Advanced Registered Nurse Practitioner assessed Resident #26 for signs of trauma.  3. On 07/17/15, the Assistant Director of Nursing notified the Executive Director of the fall Resident #26 had sustained and that an investigation into the incident had started.  4. On 07/17/15, the Executive Director interviewed the Maintenance Director, the Assistant Director of Nursing and another resident riding on the bus.  5. On 07/17/15 at 12:45 PM, the Licensed Practical Charge Nurse conducted an assessment of Resident #26.  6. The Registered Charge Nurse notified the Advanced Registered Nurse Practitioner of Resident #26's change in condition, at 4:00 PM on 07/17/15, and received an order to transfer the resident to the hospital for an evaluation.  7. The Assistant Director of Nursing reviewed reports of falls that occurred within the first twenty-four hours of admission. The Assistant Director of Nursing's review of the reports determined four residents had sustained falls within twenty-four hours of admission.	F 514			



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F 514	Continued From page 101  8. The four resident's identified, that fell within twenty-four hours of admission, had their medical record reviewed by the Assistant Director of Nursing for timeliness of assessment and for the immediate development of the plan of care to meet the needs of the residents. The Assistant Director of Nursing determined the four resident's medical records contained a timely assessment and a plan of care.  9. The Director of Nursing and the Assistant Director of Nursing initiated an in-service education on, 08/21/15 and 08/25/15, for all full and part-time licensed nursing staff; 49 in total were trained. The training included: conducting resident admission assessments, creating the immediate Plan of Care, updating care plans and Certified Nursing Assistant assignment sheets. In addition, the in-service covered timely completion of incident reports and documentation of changes in a resident's condition via the Situation, Background, Assessment, and Response (SBAR) model for documenting, and Physician and Family Notifications. The facility noted no other nurses would be allowed to work without first receiving this training.  10. The Clinical Liaisons (CL), which included Registered Nurses or Licensed Practical Nurses, would review potential resident admissions' for special needs, interventions, or equipment. From the review the facility would plan the resident's admission to ensure the identified needs, interventions or equipment would be in place at the time of admission, which included communicating the resident's needs to the Unit Managers.	F 514			



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F 514	<p>Continued From page 102</p> <p>11. The Unit Managers would ensure that the interventions, special needs or equipment were in place on admission, the care plan would reflect this information, and staff would be trained on resident care needs.</p> <p>12. New resident admissions were reviewed in clinical morning meeting by the Unit Managers to ensure assessment, plan of care and documentation had been completed timely and accurately.</p> <p>13. The facility policies titled: Accident Investigation, dated 06/17/15; Accident Investigation, Cause(s) of Accidents, dated 07/07/15; Interdisciplinary Care Plan, dated 02/26/15, and Resident Transport Policy, dated 08/01/11, were reviewed by the Executive Director, the Assistant Director of Nursing, and the Activities Director on 08/23/15 and it was determined no policy changes were needed.</p> <p>14. After Resident #26's fall and before continuing to drive to the facility, the Maintenance Director verified the seatbelts and wheelchair restraint systems were in place for two (2) additional residents on the van with Resident #26.</p> <p>15. The Maintenance Director and all facility personnel authorized to transport residents in the facility's van received training on the facility van's wheelchair lock-down system and on the Resident Transport Policy on 07/28/15. The training was provided by the facility's Activities Director.</p> <p>16. Facility personnel authorized to transport residents would be retrained quarterly for four (4) quarters and annually, thereafter.</p>	F 514			



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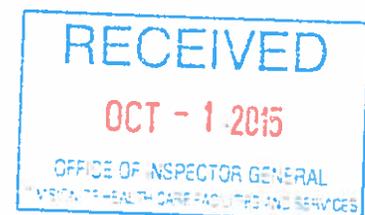
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F 514	Continued From page 103  17. Safe resident transport would be based on the residents' individual needs. The Activities Director would review a resident's assessments and have discussion with the resident's charge nurse regarding the best ways to safely transport the resident.  18. The Human Resources Generalist and the Executive Director reviewed the files of personnel authorized to transport residents in the facility's van to ensure training and competencies were completed. In addition, these employees' files would be audited quarterly for four (4) quarters and then annually.  19. The Quality Assurance Performance Improvement Committee met on 08/23/15 with the following staff persons in attendance: Executive Director, Director of Nursing Services, Assistant Director of Nursing Services, Social Worker, Unit Managers, Director of Resident Assessment, Human Resources Generalist, Maintenance Director, Corporate Director of Clinical Education, and the Medical Director to review assessments and monitoring tools.  The State Survey Agency validated the removal of Immediate Jeopardy on 08/29/15 as follows:  1. Interview, on 09/02/15 at 2:20 PM with the Assistant Director of Nursing, revealed Resident #26 was assessed immediately at the time of his/her fall in the van.  2. Review of the Advanced Registered Nurse Practitioner's documented assessment, dated 07/17/15, revealed Resident #26 was assessed by the ARNP.	F 514			



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(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 514	Continued From page 104  3. Interview with the Executive Director, on 09/02/15 at 2:00 PM, revealed the Executive Director was notified of the incident on 07/17/15 by the Assistant Director of Nursing. Review of the Verification of Investigation, revealed investigation of the incident was initiated on 07/17/15.	F 514			
	4. Interview with the Executive Director, on 09/02/15 at 2:00 PM, revealed on 07/17/15 the Executive Director interviewed the Maintenance Director, Assistant Director of Nursing and another resident who had been on the bus, as she initiated an investigation of the incident.  5. Review of the admission assessment titled Clinical Health Status, dated 07/17/15, revealed an assessment of Resident #26 was conducted.  6. Review of the Medication Administration Record and the Clinical Nursing Note for Resident #26, dated 07/17/15, timed 3:30 PM, revealed the resident received Promethazine 12.5 milligrams for nausea and vomiting. Further review of the clinical nursing note revealed the Registered Nurse in charge notified the Advanced Registered Nurse Practitioner of Resident #26's change in condition, at 4:00 PM on 07/17/15, and received an order to transfer the resident to the hospital for an evaluation.  7. Review of an aggregate list of resident falls, titled Total Events by Type, dated 02/22/15 to 08/22/15, revealed the facility's Assistant Director of Nursing identified four (4) residents, in addition to Resident #26, who had fallen within twenty-four (24) hours of their admission to the facility.				



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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 514	<p>Continued From page 105</p> <p>8. Interview, on 08/29/15 at 3:42 PM with the Assistant Director of Nursing, revealed upon review of the records of the four (4) residents who fell within 24-hours of admission, all were non-injury falls and none of the four (4) residents required transfer to the hospital for evaluation. The Assistant Director of Nursing stated she reviewed the time of day each resident was admitted to the facility and their diagnoses. The Assistant Director of Nursing stated she also reviewed the residents' physician orders/prescribed medications, and admission assessments.</p> <p>Interview, on 08/29/15 at 2:50 PM with the MDS Coordinator revealed she reviewed care plans of the four (4) residents identified with falls within twenty-four (24) hours of admission, and determined the residents' care plans did not need to be updated.</p> <p>9. Review of the document titled, Summary Report of Meeting: Nursing Lecture, Dated 08/21/15, revealed the facility's Director of Nursing and Assistant Director of Nursing initiated in-service education on 08/21/15 for the licensed nursing staff on resident admission assessments, creating the Immediate Plan of Care (IPOC), updating care plans and updating Certified Nursing Assistant assignment sheets. In addition, the in-service covered timely completion of incident reports and documentation of changes in a resident's condition using the Situation Background Assessment Response (SBAR) model for documentation, and on Physician/Family notifications.</p> <p>Review of the document titled, Summary Report of Meeting: Nursing Lecture, dated 08/21/15,</p>	F 514			



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F 514	Continued From page 106 revealed the training was provided to forty-nine (49) licensed nurses and had signed they received the training.  Interview, on 08/29/15 at 1:20 PM with the Executive Director, revealed there were 49 nurses employed by the facility who were currently authorized to work on the nursing units, and all had completed the required training.	F 514			
	Interview on 08/29/15 at 3:05 PM with the Corporate Director of Clinical Services revealed the facility's Director of Nursing and Assistant Director of Nursing had been trained on conducting Resident Admission Assessments, creating the IPOC, updating care plans and Certified Nursing Assistant assignment sheets. The Corporate Director of Clinical Services stated this training also included documentation using the SBAR method when there was a change in a resident's condition, and completion of incident reports.  Review, of the sign-in sheet for the training provided by the Corporate Director of Clinical Services revealed facility's Director of Nursing and Assistant Director of Nursing signed that they attended the training.				
	Interview, on 08/29/15 at 3:42 PM with the Assistant Director of Nursing, revealed newly hired licensed nurses would receive training on completing admission assessments, creating the IPOC, updating the Certified Nursing Assistant care assignments, documenting via the SBAR when there was a change in a resident's condition, and completing incident reports. Nurses would not work on the nursing units until they had completed the training.				



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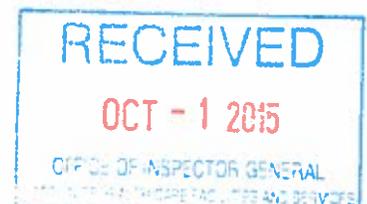
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F 514	Continued From page 107  Interview, on 08/29/15 at 2:32 PM with Licensed Practical Nurse #14, revealed she received training within the past week on admission assessments, completing incident reports and documenting using the SBAR method when there was a change in a resident's condition. Licensed Practical Nurse #14 stated, when she admitted a resident, her responsibilities included obtaining necessary authorizations from the resident or his/her legal representative, conducting a resident assessment, and initiating the resident's IPOC.  Interview, on 08/29/15 at 1:15 PM with the 400 Hallway Unit Manager (UM), revealed she received in-service education in the past week on admission assessments, completing incident reports and documenting using the SBAR method when there was a change in a resident's condition. The 400 Unit Manager stated when a resident was admitted to the 400 Hallway, she reviewed all admission paperwork received from other facilities and reviewed and in-put the orders obtained from the resident's physician. The 400 Hallway Unit Manager stated if not on duty at the time of an admission, she reviewed the resident's paper work and orders, and personally visited the resident upon her return to work.  Interview, on 08/29/15 at 3:13 PM with the 200 Unit Manager, revealed she received recent in-service education on conducting admission assessments, completing SBARs and incident reports. In addition, the 200 Hallway Unit Manager stated the 24-hour shift report was the mechanism used for recording and communicating information about a resident's status, any new care areas, and any changes in a resident's condition over the 24-hour period. The	F 514			



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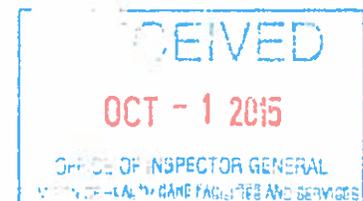
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F 514	Continued From page 108 200 Hallway Unit Manager stated she reviewed the 200 Hallway 24-hour report every morning to ensure continuity of reporting of the residents' status across all shifts.  Interview, on 08/29/15 at 2:50 PM with the MDS Coordinator revealed she received recent in-service education on care planning for newly admitted residents, and on how nurses were to complete the initial admission assessment packet. The Director of Resident Assessment stated she was also trained on completing incident reports and documenting using the SBAR method in clinical notes. The Director of Resident Assessment/Minimum Data Set Nurse stated if a resident experienced a change in condition, such as a fall, a licensed nurse should assess the resident, put immediate interventions in place to protect and/or treat the resident's injury, if any. The care plan should be updated and the documentation should also include the SBAR and a completed incident report. The Director of Resident Assessment/Minimum Data Set Nurse stated the incident report(s) were later reviewed by the Quality Assurance Committee.  10. Interview, on 08/29/15 at 4:30 PM with the facility's Executive Director, revealed the corporation's clinical liaisons conducted pre-admission assessments for potential residents. The Executive Director stated the clinical liaisons forwarded the assessments to her, and along with the Director of Nursing and/or Assistant Director of Nursing, and the Admissions Director, she reviewed the data to determine the level care the potential resident would require, and any special equipment or arrangements the facility would need to secure prior to the resident's admission.	F 514			



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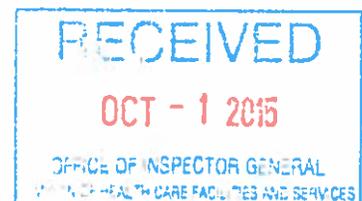
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F 514	Continued From page 109  11. Interview, on 08/29/15 at 1:15 PM with the 400 Unit Manager, revealed when a resident was admitted to the 400 Hallway, she reviewed all admission paperwork received from other facilities and reviewed and in-put the orders obtained from the resident's physician. She stated the residents' clinical records were reviewed ensure the care plan was initiated, and that the Certified Nursing Assistant Care Record assignments, and the care interventions were communicated to the staff. The 400 Hallway Unit Manager stated if not on duty at the time of an admission, she reviewed the resident's paper work and orders, and personally visited the resident upon her return to work.  12. Review, on 08/29/15 of the Resident Admission Monitoring Tool, revealed the facility had admitted eight (8) residents since 08/26/15. The residents' clinical records were reviewed by the facility's Unit Managers, who signed/dated when they reviewed the residents' records for plan of care, Certified Nursing Assistant Care Record assignments, and for implementation of the care interventions, as planned. According to the Unit Manager's signatures with dates, all eight (8) records had been reviewed for the required components within one (1) day of each resident's admission to the facility.  Interview, on 08/29/15 at 3:42 PM, with the Assistant Director of Nursing revealed she would be responsible for ensuring all components of the admission documentation was completed for newly admitted residents. The Assistant Director of Nursing stated the Unit Managers and the Minimum Data Set Nurses were also responsible for ensuring all necessary admission	F 514			



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F 514	Continued From page 110 documentation was completed. In addition, the Assistant Director of Nursing stated she would review the new admission audits conducted by the Unit Managers, and these documents would be discussed daily in clinical morning meetings. The Assistant Director of Nursing stated, to date, no corrective action had not been necessary as the admission documentation has been completed for new admissions as required.  13. Interview, on 08/29/15 at 1:20 PM with the Executive Director, revealed she and the Assistant Director of Nursing reviewed following policies 08/23/15: Accident Investigation, dated 06/17/15; Accident Investigation, Cause (s) of Accidents, dated 07/07/15; and Interdisciplinary Care Plan, dated 02/26/15, no changes to the policies were made.  Interview, on 09/02/15 at 2:35 PM, with the Activities Director revealed she reviewed the Resident Transport Policy with the facility's Executive Director, and recently retrained the staff authorized to drive the facility's van.  14. Interview, on 09/02/15 at 3:20 PM with the facility's Maintenance Director, revealed once the Assistant Director of Nursing assessed Resident #26 after his/her fall on the van, he ensured Resident #26's wheelchair lock-down system and seatbelts were secured and fastened. In addition, the Maintenance Director stated he also observed the other two residents on the van to ensure their wheelchairs/safety belts were secured/fastened before moving the van.  15. Interview, on 09/02/15 at 2:35 PM with the Activities Director, revealed on 07/28/15, she retrained the facility's authorized van drivers on	F 514			



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F 514	<p>Continued From page 111</p> <p>safe resident transport and proper use of the van's wheelchair lock-down system.</p> <p>16. Review of the document titled, Quarterly Drivers Files Audit, No Date, revealed the drivers' files would be audited for re-training competencies on 10/28/15, 01/28/16, 04/28/16 and 07/28/16.</p> <p>17. Interview, on 08/29/15 at 2:50 PM with the Director of Resident Assessment/MDS revealed, on 08/28/15, the Activities Director consulted with the Director Of Assessment/Minimum Data Set Nurse prior to transporting a resident who had a lap tray affixed to his/her wheelchair. The Director of Resident Assessment/Minimum Data Set Nurse stated she referred the Activities Director to Therapy Department as she thought therapy staff could best answer the question related to the resident's wheel chair tray.</p> <p>18. Interview, on 08/29/15 at 3:22 PM with the Human Resources Generalist, revealed she reviewed the records for all authorized van drivers to ensure their drivers' licenses and Department of Transportation certifications were in-date, and for verification of re-training on the van's wheelchair restraint system. The Human Resources Generalist stated she was assigned to monitor the van drivers records for the required competencies and for verification of quarterly retraining for one year, and thereafter she would conduct an annual review of their records.</p> <p>19. Review of the document titled, Ad Hoc QAPI, dated 08/23/15, revealed the Executive Director, the Director of Nursing, the Assistant Director of Nursing, the facility's Social Worker, Unit Managers for four (4) of four (4) nursing units, the</p>	F 514			



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F 514	<p>Continued From page 112</p> <p>Director of Resident Assessment, the Human Resources Generalist, the Maintenance Director, the Corporate Director of Clinical Education, and the facility's Medical Director attended the QAPI meeting.</p> <p>Interview with the ADON, on 08/29/15 at 3:42 PM, revealed she would oversee the monitoring that would occur by the Unit Managers and MDS Nurses, for the new admission process, complete all proper documentation, all new admissions will be discussed during the daily clinical meetings, twenty-four hour reports would be reviewed at the clinical meeting. The ADON stated she would also be attending the QA meetings and providing progress of the monitoring process for admissions and changes of condition.</p> <p>Interview with the Administrator, on 08/29/15 at 4:30 PM, revealed nurses were assigned to monitor tasks described in the AOC to ensure that all residents newly admitted have been assessed and screened by the new process and interventions put in place. The Administrator stated she would have the AOC minder at each morning meeting to review and to check to ensure assigned staff were continuing to monitor for compliance with the plan.</p>	F 514			





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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - HILLCREEK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220</b>	
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{K 000}	<p><b>INITIAL COMMENTS</b></p> <p>An Onsite Life Safety Code Revisit was conducted on 11/12/15, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this revisit.</p> <p>The facility alleged compliance effective 10/02/15, for deficiencies cited on 08/13/15 for K-18, K-27, K-38, K-46, K-52, K-72, K-76 and K-144.</p>	{K 000}		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

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

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185095	(Y2) Multiple Construction A. Building B. Wing 01 - GOLDEN LIVING CENTER HILLCREEK	(Y3) Date of Revisit 11/12/2015
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Name of Facility GOLDEN LIVINGCENTER - HILLCREEK	Street Address, City, State, Zip Code 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0018	Correction Completed 09/30/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0027	Correction Completed 09/30/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0038	Correction Completed 09/30/2015
ID Prefix _____ Reg. # NFPA 101 LSC K0046	Correction Completed 09/30/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0052	Correction Completed 09/30/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0072	Correction Completed 10/01/2015
ID Prefix _____ Reg. # NFPA 101 LSC K0076	Correction Completed 09/30/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0144	Correction Completed 10/02/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <i>mz</i>	Reviewed By <i>KR</i>	Date: <i>11/16/15</i>	Signature of Surveyor: <i>[Signature]</i>	Date: <i>11/16/2015</i>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 8/13/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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DEPARTMENT OF HEALTH CARE FACILITIES AND SERVICES

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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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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1970, 1984</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNE/NF</p> <p>TYPE OF STRUCTURE: Two (2) levels, Type III Protected.</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments in the Upper Level and three (3) in the Lower Level.</p> <p>FIRE ALARM: Complete fire alarm system.</p> <p>SPRINKLER SYSTEM: Complete automatic, dry sprinkler system; pipe schedule design.</p> <p>GENERATOR: Type II, 350 KW generator; fuel source is diesel, installed new in 2007.</p> <p>A Recertification Life Safety Code Survey was conducted on 08/13/15 using the 2786S, short form. The facility was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility has the capacity for one-hundred seventy-two (172) beds and at the time of the survey, the census was one-hundred fifty (150).</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<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>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Exec. Dir.* (X6) DATE *revised 9-30-15*

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.

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

PRINTED: 09/15/2015  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GOLDEN LIVING CENTER HILLCREEK B. WING _____	(X3) DATE SURVEY COMPLETED  08/13/2015
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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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K 000  K 018 SS=D	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire)  Deficiencies were cited with the highest scope and severity of an F level. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.	K 000  K 018		
			K 018  1. The corridor door to resident room 205 was adjusted by an outside vendor, to close completely and latch with no gaps on 08/27/15.  2. An audit of all facility resident doors was completed on 08/14/15. All the other resident doors did close completely and latch with no gaps.  3. Maintenance Director or maintenance assistant will complete once a month checks on all resident doors to ensure that they close completely.  4. Maintenance will report the findings of the monthly checks to the QAPI team. The QAPI team meets monthly. Each month, the team will review the results of these checks to ensure that the doors close completely. This will be completed for 5 months to ensure compliance and resident safety.	09/30/15
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms would latch properly in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eleven (11)			



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K 018	<p>Continued From page 2</p> <p>smoke compartments, two (2) residents, staff and visitors. The facility has the capacity for one-hundred seventy-two (172) beds and at the time of the survey, the census was one-hundred fifty (150).</p> <p>The findings include:</p> <p>Observation, on 08/13/15 at 10:39 AM, with the Maintenance Director revealed the corridor door to resident room #205 would not latch when tested and had a gap at the top that would not resist the passage of smoke.</p> <p>Interview, on 08/13/15 at 10:39 AM, with the Maintenance Director revealed he was unaware the door would not latch and had too large of a gap.</p> <p>The census of one-hundred fifty (150) was verified by the Administrator on 08/13/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/13/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in</p>	K 018		
	<p>other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding</p>			



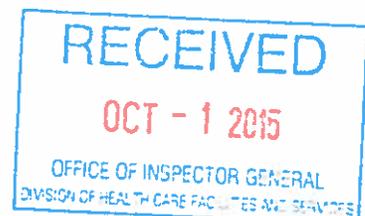
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K 018	Continued From page 3 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with	K 018		
K 027 SS=D	19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.  19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.  Reference: CMS: S&C-07-18 NFPA 101 LIFE SAFETY CODE STANDARD	K 027		
	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive			



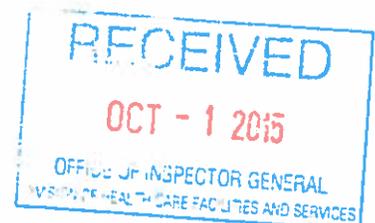
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K 027	Continued From page 4 latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficient practice has the potential to affect three (3) of eleven (11) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred seventy-two (172) beds and at the time of the survey, the census was one-hundred fifty (150).  The findings include:  1. Observation, on 08/13/15 at 10:32 AM, with the Maintenance Director revealed the cross-corridor doors located by Room #216 would not close completely when tested. This was due to the doors not having a coordinating device installed so the door without the astragal could close first.  Interview, on 08/13/15 at 10:33 AM, with the Maintenance Director revealed he was not aware the coordinating device was required for doors with an astragal.  2. Observation, on 08/13/15 at 10:41 AM, with the Maintenance Director revealed the cross-corridor doors heading to the 200 Hall would not close completely when tested. This was due to the doors not being adjusted properly.	K 027	K 027  1. The cross-corridor doors located by room 216 were adjusted by the maintenance director and the astragal was removed by the maintenance director to make doors close completely on 08/13/15. The cross-corridor doors located heading to the 200 hall were adjusted by an outside vendor, to close completely 09/01/15.  2. An audit of all facility corridor doors was completed on 08/14/15. All the other corridor doors did close completely with no gaps.  3. Maintenance Director or maintenance assistant will complete once a month checks on all corridor doors to ensure that they close completely.  4. Maintenance will report the findings of the monthly door checks to the QAPI team. The QAPI team meets monthly. Each month, the team will review the results of these checks to ensure that the doors close completely. This will be completed for 5 months to ensure compliance and resident safety.	09/30/15



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K 027	<p>Continued From page 5</p> <p>Interview, on 08/13/15 at 10:42 AM, with the Maintenance Director revealed he was not aware the doors were not adjusted properly.</p> <p>The census of one-hundred fifty (150) was verified by the Administrator on 08/13/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/13/15.</p>	K 027		
	<p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 18.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems.</p> <p>Reference NFPA 101 (2000 Edition) 18.3.7.6* Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 18.2.2.2.6.</p>			
	<p>Reference NFPA 101 (2000 Edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation</p>			



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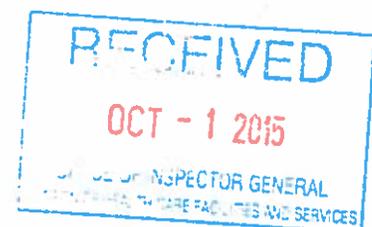
NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - HILLCREEK

STREET ADDRESS, CITY, STATE, ZIP CODE

3116 BRECKINRIDGE LANE  
LOUISVILLE, KY 40220

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K 027	Continued From page 6 and shall be without undercuts, louvers, or grilles.  Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.  Reference: NFPA 101 (2000 edition), 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.	K 027		
K 038 SS=F	Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.  NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		



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K 038	Continued From page 7  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors equipped with delayed egress had a readily visible sign in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect eleven (11) of eleven (11) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred seventy-two (172) beds and at the time of the survey, the census was one-hundred fifty (150).  The findings include:  1. Observation, on 08/13/15 at 9:58 AM, with the Maintenance Director revealed the exit door by Central Supply was obstructed from opening by five (5) sand bags piled against the outside of the door. Three (3) more sand bags were against the inside of the door.  Interview, on 08/13/15 at 9:59 AM, with the Maintenance Director revealed the sand bags were there in case it rained they would keep the water out of the building.  2. Observation, on 08/13/15 at 10:09 AM, with the Maintenance Director revealed the delayed egress signage located on 400 Hall exit door had half (1/2) inch letters and stated the door would open in thirty (30) seconds. The facility did not have documentation from an Authority Having Jurisdiction (AHJ) to increase the delay to thirty (30) seconds; however, the door opened in ten (10) seconds.	K 038	K038  1.  All the sandbags were removed immediately by the maintenance director on 08/13/15 that was obstructing the egress path by central supply. The delayed egress signage located on the 400 hall exit door, therapy exit door, exit door by 340, exit door by room 201, the 200 hall corridor exit door, restorative dining room exit door, 100 hall exit door by room 101, 100 hall exit door by room 140, and the solarium exit door all now have 1 inch letters and states 15 seconds delay as of 09/07/15, this was replaced by the maintenance director. The gate outside the solarium exit now swings in the path of egress; this was fixed by the maintenance director, as of 08/27/15. The exit to the stairwell by room #300 now has a bigger code posted on top of the key pad this was done by the maintenance director. The staff member was immediately trained on 08/13/15 by the maintenance director to look for the code on top of the key pad.  2. A facility tour was completed on 08/13/15 and no other areas were affected.  3. Maintenance Director or maintenance assistant will complete monthly checks X 4 months throughout the building to check that all areas of egress are clear, that all signage is intact and that the code to the exit by the stair well is maintained intact. The sandbags that were used to help in the prevention of water draining down into the door way are no longer in use. This has been fixed by putting weather stripping on the bottom of the door; the maintenance director did this on 09/01/15. The maintenance director was in serviced on the NFPA requirements for egress requirements, by the ED on 09/29/15.	09/30/15



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K 038	Continued From page 8 Interview, on 08/13/15 at 10:10 AM, with the Maintenance Director revealed he was not aware of the requirements for delayed egress signage.  3. Observation, on 08/13/15 at 10:14 AM, with the Maintenance Director revealed the delayed egress signage located at the Therapy exit door had half (1/2) inch letters and stated the door would open in thirty (30) seconds. The facility did not have documentation from an Authority Having Jurisdiction (AHJ) to increase the delay to thirty (30) seconds; however, the door opened in ten (10) seconds.  Interview, on 08/13/15 at 10:15 AM, with the Maintenance Director revealed he was not aware of the requirements for delayed egress signage.  4. Observation, on 08/13/15 at 10:24 AM, with the Maintenance Director revealed the exit to the stairwell by Room #300 was only equipped with a keypad to open the door. The code was posted on top of the keypad; however, a staff member picked at random was not trained to look for the code and was not able to open the door.  Interview, on 08/13/15 at 10:25 AM, with the Maintenance Director revealed he did train staff; however, he did not have documentation for training.  5. Observation, on 08/13/15 at 10:28 AM, with the Maintenance Director revealed the delayed egress signage located on the exit door by Room #340 had half (1/2) inch letters and stated the door would open in thirty (30) seconds. The facility did not have documentation from an Authority Having Jurisdiction (AHJ) to increase the delay to thirty (30) seconds; however, the	K 038	4. Maintenance Director will report the findings of the checks and to the QAPI team. The QAPI team meets monthly. Each month, the team will review the results of these checks to ensure that the areas of egress are clear, doors have proper signage and code to exit by the stair well is intact. This will be completed for 5 months to ensure compliance and resident safety.	



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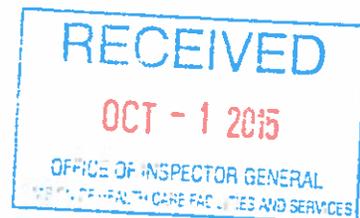
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K 038	Continued From page 9 door opened in ten (10) seconds.  Interview, on 08/13/15 at 10:29 AM, with the Maintenance Director revealed he was not aware of the requirements for delayed egress signage.  6. Observation, on 08/13/15 at 10:34 AM, with the Maintenance Director revealed the delayed egress signage located on the exit door by Room #201 had half (1/2) inch letters and stated the door would open in thirty (30) seconds. The facility did not have documentation from an Authority Having Jurisdiction (AHJ) to increase the delay to thirty (30) seconds; however the door opened in ten (10) seconds.  Interview, on 08/13/15 at 10:35 AM, with the Maintenance Director revealed he was not aware of the requirements for delayed egress signage.  7. Observation, on 08/13/15 at 10:45 AM, with the Maintenance Director revealed the delayed egress signage located on the 200 Hall Corridor Exit had half (1/2) inch letters and stated the door would open in thirty (30) seconds. The facility did not have documentation from an Authority Having Jurisdiction (AHJ) to increase the delay to thirty (30) seconds; however, the door opened in ten (10) seconds.	K 038			
	Interview, on 08/13/15 at 10:46 AM, with the Maintenance Director revealed he was not aware of the requirements for delayed egress signage.  8. Observation, on 08/13/15 at 10:47 AM, with the Maintenance Director revealed no delayed egress signage located on the exit door in the Restorative Dining Room.				



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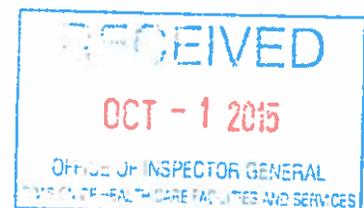
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	<p>Continued From page 10</p> <p>Interview, on 08/13/15 at 10:48 AM, with the Maintenance Director revealed he was not aware of the requirements for delayed egress signage.</p> <p>9. Observation, on 08/13/15 at 10:54 AM, with the Maintenance Director revealed the delayed egress signage located on the 100 Hall Exit by Room #101 had half (1/2) inch letters and stated the door would open in thirty (30) seconds. The facility did not have documentation from an Authority Having Jurisdiction (AHJ) to increase the delay to thirty (30) seconds; however, the door opened in ten (10) seconds.</p> <p>Interview, on 08/13/15 at 10:55 AM, with the Maintenance Director revealed he was not aware of the requirements for delayed egress signage.</p> <p>10. Observation, on 08/13/15 at 10:56 AM, with the Maintenance Director revealed the delayed egress signage located on the 100 Hall exit by Room #140 had half (1/2) inch letters and stated the door would open in thirty (30) seconds. The facility did not have documentation from an Authority Having Jurisdiction (AHJ) to increase the delay to thirty (30) seconds; however the door opened in ten (10) seconds.</p> <p>Interview, on 08/13/15 at 10:57 AM, with the Maintenance Director revealed he was not aware of the requirements for delayed egress signage.</p> <p>11. Observation, on 08/13/15 at 10:58 AM, with the Maintenance Director revealed the delayed egress signage located on Solarium exit door had less than half (1/2) inch letters and stated the door would open in thirty (30) seconds. The facility did not have documentation from an Authority Having Jurisdiction (AHJ) to increase</p>	K 038		



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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3119 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	
K 038	Continued From page 11 the delay to thirty (30) seconds; however the door opened in ten (10) seconds. Further observation revealed a gate outside the Solarium exit that did not swing in the path of egress.  Interview, on 08/13/15 at 10:59 AM, with the Maintenance Director revealed he was not aware of the requirements for delayed egress signage.  The census of one-hundred fifty (150) was verified by the Administrator on 08/13/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/13/15.  Actual NFPA Standard:  Reference: NFPA 101 (2000 edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.	K 038			



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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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K 038	Continued From page 12  (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.	K 038		
	(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.  (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the			
	releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.  (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than			



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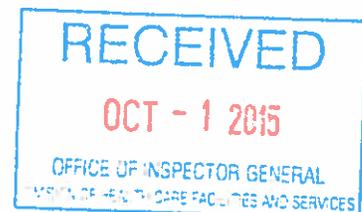
NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GOLDEN LIVINGCENTER - HILLCREEK

3115 BRECKINRIDGE LANE  
LOUISVILLE, KY 40220

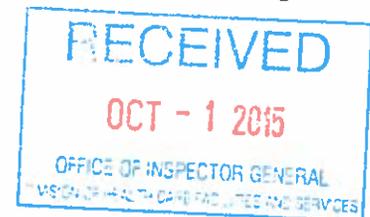
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K 038	Continued From page 13 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS  7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED (c) The locking device is of a type that is readily distinguishable as locked.	K 038		
	(d) A key is immediately available to any occupant inside the building when it is locked. Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause. Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made.			



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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3118 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	
K 038	Continued From page 14 Reference: NFPA 101 (2000 Edition) 7.2.1.4.4* During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 in. (17.8 cm) into the required width of an aisle, corridor, passageway, or landing, when fully open. Doors shall not open directly onto a stair without a landing. The landing shall have a width not less than the width of the door. (See 7.2.1.3.)	K 038			
K 046 SS=F	Exception: In existing buildings, a door providing access to a stair shall not be required to maintain any minimum unobstructed width during its swing, provided that it meets the requirement that limits projection to not more than 7 in. (17.8 cm) into the required width of a stair or landing when the door is fully open. NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to maintain emergency lighting in accordance with the	K 046			
	National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect eleven (11) of eleven (11) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred seventy-two (172) beds and the census was one-hundred fifty (150) on the day of the survey.  The findings include:				



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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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K 046	<p>Continued From page 15</p> <p>Record Review, on 08/13/15 at 11:33 AM, with the Maintenance Director revealed the facility failed to document the monthly thirty (30) second test and the annual ninety (90) minute test for battery powered emergency lighting.</p> <p>Interview, on 08/13/15 at 11:34 AM, with the Maintenance Director revealed he was not aware that documentation was to be provided for the thirty (30) second monthly and ninety (90) minute test for battery powered emergency lighting.</p> <p>The census of one-hundred fifty (150) was verified by the Administrator on 08/13/15. The survey findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/13/15.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting</p>	K 046	<p>K 046</p> <p>1. Maintenance Director removed the two battery powered emergency lighting from central supply area on 08/25/15. There are five foot candles in that area if the generator fails to come on. Generator powers the entire building. Generator tested weekly, monthly for 30 minutes and annually for 90 minutes.</p> <p>2. No other areas were affected because no other areas had battery powered emergency lighting.</p> <p>3. Maintenance director or maintenance assistant will continue to complete the weekly and monthly generator tests. Outside contractor, will continue to complete the annual test. The maintenance director was in serviced on the documentation requirements and for testing of battery powered lighting by the ED on 09/29/15.</p> <p>4. Since the battery powered lighting doesn't exist any longer, no further education is needed or needed to be monitored. The Maintenance Director will report the findings of the weekly and monthly tests and the annual tests of the generator to the safety team. The safety team meets monthly. Each month, the team will review the results of these checks. This will be completed for 5 months to ensure compliance and resident safety.</p>	09/30/15

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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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K 046	Continued From page 16 Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 046		
K 052 SS=F	Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals. NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		



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K 052	Continued From page 17  This STANDARD is not met as evidenced by: Based on fire alarm inspections and interview, it was determined the facility failed to ensure the fire alarm system was inspected and tested in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has the potential to affect eleven (11) of eleven (11) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred seventy-two (172) beds and at the time of the survey, the census was one-hundred fifty (150).  The findings include:  1. Review of the Fire alarm inspections, on 08/13/15 at 1:13 AM, with the Maintenance Director revealed the charger test was not documented on the fire alarm inspection paperwork.  Interview, on 08/13/15 at 1:14 PM, with the Maintenance Director revealed he was unaware the inspection company was to perform a charger test for the fire alarm batteries on an annual basis.	K 052	K 052  1. The charger test for the fire alarm batteries was completed on 08/13/15 and documented. The discharge test for the fire alarm batteries was completed on 08/13/15 and documented. The load voltage test was completed on 08/13/15. All of these tests were completed by an outside vendor.  2. No other areas were affected.  3. Maintenance Director or maintenance assistant will have a charger test, a discharge test and a load voltage test (semi-annual testing for this one only) for the fire alarm batteries done annually. This will be documented on the fire alarm inspection paperwork. The maintenance director was in serviced on the NFPA requirements for charger test, discharge test and load voltage testing of the fire alarm batteries by the ED on 09/29/15.  4. Maintenance Director will report the findings of the annual checks to the QAPI team annually (1X yearly) for the charger and	09/30/15
	2. Review of the Fire alarm inspections, on 08/13/15 at 1:13 PM, with the Maintenance Director revealed the discharge test was not documented on the fire alarm inspection paperwork.  Interview, on 08/13/15 at 1:14 PM, with the Maintenance Director revealed he was unaware the inspection company was to perform a discharge test for the fire alarm batteries on an		discharge testing. Maintenance Director will report the findings of the semi annual checks of the load voltage tests semi annually (2 X yearly) for this test. This will be completed for one year to ensure compliance and resident safety.	



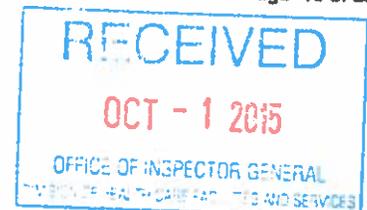
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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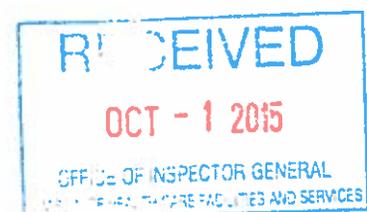
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K 052	<p>Continued From page 18 annual basis.</p> <p>3. Review of the Fire alarm inspections, on 08/13/15 at 1:13 PM, with the Maintenance Director revealed the load voltage test was not documented on the fire alarm inspection paperwork.</p> <p>Interview, on 08/13/15 at 1:14 PM, with the Maintenance Director revealed he was unaware the inspection company was to perform a load voltage test for the fire alarm batteries on a semi-annual basis.</p>	K 052		
K 072	<p>The census of one-hundred fifty (150) was verified by the Administrator on 08/13/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/13/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 ed.), 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.</p>	K 072		
SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p>			



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K 072	Continued From page 19  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficient practice has the potential to affect three (3) of eleven (11) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred seventy-two (172) beds and at the time of the survey, the census was one-hundred fifty (150).  The findings include:  1. Observation, on 08/13/15 at 9:58 AM, with the Maintenance Director revealed ten (10) wheelchairs, bathroom chair, shower chair, blood pressure machine, service cart, and a bed were being stored in the egress path by Central Supply.  Interview, on 08/13/15 at 9:59 AM, with the Maintenance Director revealed the items were routinely stored in this location.  2. Observation, on 08/13/15 at 10:05 AM, with the Maintenance Director revealed a wheelchair scale was being stored in the egress path of the 400 Hall.  Interview, on 08/13/15 at 10:06 AM, with the Maintenance Director revealed the scale was routinely stored in this location.  3. Observation, on 08/13/15 at 10:29 AM, with the Maintenance Director revealed four (4) medicine carts were being stored in the egress path of the 300 Hall.	K 072	K 072  1. All chairs and equipment that was in the egress path by central supply was removed immediately and placed in their permanent location of storage, central supply by the maintenance assistant on 08/13/15. The W/C scale that was in the egress path of the 400 hall, was removed immediately by the maintenance assistant and placed in the permanent storage location of the 400 shower room on 08/13/15. The four medicine carts that were in the path of the 300 hall were removed immediately by the 300 hall nurses and placed in a new locked med room on 08/13/15. This med room is the permanent location for these carts.  2. All other areas of the facility checked on 08/13/15 and no other areas of egress were being blocked.  3. Maintenance Director or maintenance assistant will complete weekly checks X 4 weeks, monthly checks X 4 months throughout the building to check that all areas of egress are clear.  4. Maintenance Director will report the findings of the checks and to the QAPI team. The QAPI team meets monthly. Each month, the team will review the results of these checks to ensure that the areas of egress are clear. This will be completed for 5 months to ensure compliance and resident safety.	10/01/15



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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)	(X5) COMPLETION DATE	
K 072	Continued From page 20  Interview, on 08/13/15 at 10:07 AM, with the Maintenance Director revealed the storage room for the medicine carts was recently converted to an office leaving no dedicated storage location for the medicine carts.  The census of one-hundred fifty (150) was verified by the Administrator on 08/13/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/13/15.  Actual NFPA Standard:  Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.  Reference: NFPA 101 (200 Edition) 7.3.2* Measurement of Means of Egress. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration. Exception: Projections not more than 3 1/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below.	K 072			
K 076 SS=D	Reference: S&C-12-21-LSC NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.	K 076			

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

PRINTED: 09/15/2015  
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 01 - GOLDEN LIVING CENTER HILLCREEK B. WING _____	(X3) DATE SURVEY COMPLETED  08/13/2015
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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K 076	Continued From page 21 (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076	K076  1. All combustible boxes were moved by the central supply person and placed five feet away from the oxygen tanks on 08/14/15. A Sign was placed above oxygen tanks on 09/29/15 by maintenance director informing staff how far items (boxes) can be stored from tanks to ensure staff knows the requirements.  2. No other areas were affected because there are no other oxygen rooms or oxygen storage areas.  3. Tape was placed on the floor five feet around the oxygen tanks by the maintenance director on 09/29/15 to help to ensure that compliance is maintained for not putting combustible boxes within 5 feet of the oxygen tanks. The Maintenance Director or maintenance assistant will complete weekly checks X 4 weeks, monthly checks X 4 months to check that all combustible boxes are stored beyond five feet of the oxygen tanks. The maintenance director was in serviced on the	09/30/15
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eleven (11) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred seventy-two (172) beds and at the time of the survey, the census was one-hundred fifty (150).  The findings include:  Observation, on 08/13/15 at 1:15 PM, with the Maintenance Director revealed large amounts of combustible boxes were being stored within five (5) feet of oxygen tanks located in the Central Supply Storage Room. There were sixty-four (64) tanks in storage at the time of the survey.  Interview, on 08/13/15 at 1:16 PM, with the Maintenance Director revealed he was not aware of the requirements for oxygen storage.		requirements for oxygen storage by the ED on 09/29/15.  4. Maintenance Director will report the findings of the checks and to the QAPI team. The QAPI team meets monthly. Each month, the team will review the results of these checks to ensure that all combustible boxes are stored beyond five feet of the oxygen tanks. This will be completed for 5 months to ensure compliance and safety.	



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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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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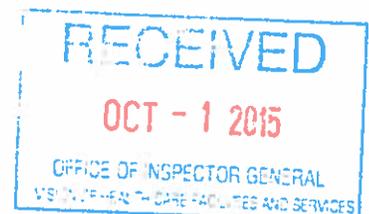
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 076	Continued From page 22 The census of one-hundred fifty (150) was verified by the Administrator, on 08/13/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/13/15.  Actual NFPA Standard:  Reference: NFPA 99 (1999 Edition). 8-3.1.11.2 8-3.1.11.2 <del>Storage for nonflammable gases less than 85 m3 (3000 ft3)</del>	K 076		
	(a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems			
	(3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations.			



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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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K 076	Continued From page 23 (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations.	K 076			
K 144 SS=F	(j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.  8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: <b>CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING</b> NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144			
	This STANDARD is not met as evidenced by: Based on interview and record review, it was				



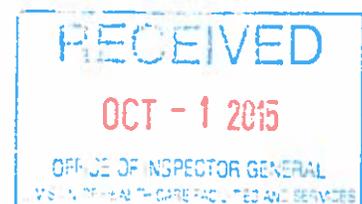
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K 144	Continued From page 24 determined the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect eleven (11) of eleven (11) smoke compartments, all residents, staff and visitors. The facility has the capacity for one-hundred seventy-two (172) beds with a census of one-hundred fifty (150) on the day of the survey.	K 144	K144  1.  Maintenance free batteries for the generator to be installed on 10/01/15. This will allow facility not to have to perform battery electrolyte level checks weekly.  2. No other areas were affected.	10/02/15
	The findings include:  Review of the Generator documentation, on 08/13/15 at 1:10 PM, with the Maintenance Director revealed the facility did not have documentation that the battery electrolyte levels were checked weekly.  Interview, on 08/13/15 at 1:11 PM, with the Maintenance Director revealed he was not aware of the requirement.  The census of one-hundred fifty (150) was verified by the Administrator on 08/13/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/13/15.  Actual NFPA Standard:		3. Maintenance Director or maintenance assistant will ensure that we always have these maintenance free batteries in place by purchasing 2 extra batteries on 10/01/15. This way there will never be a need for a process of obtaining a battery. There will always be a replacement on hand at the facility and if one is used it will be immediately reordered. The maintenance director was in serviced on the NFPA requirements for documentation of battery electrolyte level testing weekly by the ED on 09/29/15.  4. Maintenance Director will report monthly X 5 months to the QAPI team that we are current with the use of maintenance free batteries. The QAPI team meets monthly. This will be completed for 5 months to ensure compliance.	
	Reference: NFPA 110 (1999 Edition).  6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction			





**CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF INSPECTOR GENERAL**

**Steven L. Beshear**  
Governor

**Millie K. Zumstein, Regional Program Manager**  
908 West Broadway, 10 West  
Louisville, Kentucky 40203  
(502) 595-4958  
Fax: (502) 595-4540  
<http://chfs.ky.gov/os/oig>

**Audrey Tayse Haynes**  
Secretary

**Maryellen B. Mynear**  
Inspector General

November 18, 2015

Kentucky Board of Licensure for  
Long-Term Care Administrators  
PO Box 1360  
Frankfort, Kentucky 40602

Sections 1819 (g)(5)(C) and 1919 (g)(5)(C) of the Social Security Act require the State Survey Agency to notify the Nursing Home Administrators Board of Licensure if a skilled nursing facility or nursing facility is found to be providing substandard quality of care.

The Centers for Medicare and Medicaid Services has issued guidelines that define Substandard Quality of Care to exist whenever there is one or more deficiencies related to participation requirements under 42 CFR 483.13 Resident Behavior and Facility Practices, 42 CFR 483.15 Quality of Life, or 42 CFR 483.25 Quality of Care, which constitute either immediate jeopardy to resident health and/or safety, pattern or widespread deficiencies at severity level 3, or widespread deficiencies at severity level 2.

Accordingly, this is to notify you that on August 29, 2015, representatives of the Division of Health Care completed a visit at Golden Livingcenter - Hillcreek, 3116 Breckinridge Lane, Louisville, KY 40220, and deficiencies were cited under the following section(s) of regulation:

42 CFR 483.25

The administrator at the time of the visit was Renay Adkins.

We would suggest that any further inquiries be directed to the facility in question.

Sincerely,

Handwritten signature of Millie K. Zumstein in cursive.

Millie K. Zumstein, R.D., L.D.  
Regional Program Manager  
Division of Health Care

MKZ/kt

cc: Vickie Barber, Department for Medicaid Services



**CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF INSPECTOR GENERAL**

**Steven L. Beshear**  
Governor

**Millie K. Zumstein, Regional Program Manager**  
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**Audrey Tayse Haynes**  
Secretary

**Maryellen B. Mynear**  
Inspector General

November 18, 2015

Dr. Eric Hilgefurd  
201 Meridian Avenue  
Louisville, Kentucky 40207

Dear Dr. Hilgefurd:

Sections 1819 (g)(5)(C) and 1919 (g)(5)(C) of the Social Security Act require the State Survey Agency to notify the resident's attending physician if a skilled nursing facility or nursing facility is found to be providing substandard quality of care to any of his/her patients.

The Centers for Medicare and Medicaid Services has issued guidelines that define Substandard Quality of Care to exist whenever there is one or more deficiencies related to participation requirements under 42 CFR 483.13 Resident Behavior and Facility Practices, 42 CFR 483.15 Quality of Life, or 42 CFR 483.25 Quality of Care, which constitute either immediate jeopardy to resident health and/or safety, pattern or widespread deficiencies at severity level 3, or widespread deficiencies at severity level 2.

Accordingly, this is to notify you that on August 29, 2015, representatives of the Division of Health Care completed a visit at Golden LivingCenter - Hillcreek, 3116 Breckinridge Lane, Louisville, KY 40220, and deficiencies were cited under the following section(s) of regulation:

42 CFR 483.25

We would suggest that any further inquiries be directed to the facility in question.

Sincerely,

A handwritten signature in cursive script that reads "Millie K. Zumstein".

Millie K. Zumstein, R.D., L.D.  
Regional Program Manager  
Division of Health Care

MKZ/kt



**CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF INSPECTOR GENERAL**

**Steven L. Beshear**  
Governor

**Millie K. Zumstein, Regional Program Manager**  
908 West Broadway, 10 West  
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**Audrey Tayse Haynes**  
Secretary

**Maryellen B. Mynear**  
Inspector General

November 16, 2015

via EMAIL: Renay Adkins ([renay.adkins@goldenliving.com](mailto:renay.adkins@goldenliving.com))

Ms. Renay Adkins, Administrator  
Golden LivingCenter - Hillcreek  
3116 Breckinridge Lane  
Louisville, KY 40220

Dear Ms. Adkins:

Thank you for submitting your proposed plan of correction regarding the deficiencies noted during the surveys completed on August 29, 2015. Upon reviewing this plan, we found it to be acceptable.

Based on implementation of your plan of correction, and the revisit completed on November 13, 2015, it was determined your facility had achieved compliance as of October 2, 2015. Therefore, we will recommend that your nursing facility be relicensed and recertified for continued participation in the Title XVIII/XIX programs.

Your cooperation is appreciated. If you have any questions regarding this information, please contact our office.

Sincerely,

A handwritten signature in blue ink that reads "Millie K. Zumstein".

Millie K. Zumstein, R.D., L.D.  
Regional Program Manager  
Division of Health Care

MKZ/kt



**CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF INSPECTOR GENERAL**

**Steven L. Beshear**  
Governor

275 E. Main Street, 5 E-A  
Frankfort, Kentucky 40621-0001  
(502) 564-2888  
Fax: (502) 564-6546  
<http://chfs.ky.gov/os/oig>

**Audrey Tayse Haynes**  
Secretary

**Maryellen B. Mynear**  
Inspector General

November 4, 2015

Ms. Renay Adkins  
Golden Livingcenter - Hillcreek  
3116 Breckinridge Lane  
Louisville, KY 40220

Dear Ms. Adkins:

On September 25, 2015, this office received your request for Informal Dispute Resolution (IDR) in response to the deficiencies cited during the survey completed at your facility on August 29, 2015. The Informal Dispute Resolution was conducted by desk review on November 4, 2015.

In accordance with 906 KAR 1:120, additional information/documentation was afforded every consideration. After careful review, the following determination was made:

- F281 S/S J - No change
- F323 S/S J - No change
- F514 S/S J - No change

This decision was based on the facility's failure to provide sufficient evidence to support being nonculpable. The Northern Enforcement Branch will be informed of the results of this Informal Dispute Resolution; therefore, no additional action is necessary at this time.

If you have any questions regarding this information, please feel free to contact Michelle Mitchell, Acting IDR Coordinator at 502/564-7963, ext. 3304.

Sincerely,

Maryellen B. Mynear  
Inspector General

MBM/mrm

c: Northern Enforcement Branch



**CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF INSPECTOR GENERAL**

**Steven L. Beshear**  
Governor

275 E. Main Street, 5 E-A  
Frankfort, Kentucky 40621-0001  
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Fax: (502) 564-8546  
<http://chfs.ky.gov/os/oig>

**Audrey Tayse Haynes**  
Secretary

**Maryellen B. Mynear**  
Inspector General

September 29, 2015

Ms. Renay Adkins  
Golden Livingcenter - Hillcreek  
3116 Breckinridge Lane  
Louisville, KY 40220

Dear Ms. Adkins:

On September 25, 2015, this office received your request for Informal Dispute Resolution (IDR) in response to the deficiencies cited during the survey completed at your facility on August 29, 2015.

A written response of affirmation, reversal, or change of the disputed deficiencies will be sent to you. If a change is made to the deficiencies as the result of the IDR, you will receive an amended Statement of Deficiencies and must submit a new plan of correction within ten calendar days from your receipt of the amended / new Statement of Deficiencies.

If you should have questions regarding this information, please feel free to contact Jan Keeling, IDR Coordinator at 502/564-7963, ext. 3301.

Sincerely,

Maryellen B. Mynear  
Inspector General

MBM/jk



CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF INSPECTOR GENERAL

Steven L. Beshear  
Governor

Millie K. Zumstein, Regional Program Manager  
908 West Broadway, 10 West  
Louisville, Kentucky 40203  
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Fax: (502) 595-4540  
<http://chfs.ky.gov/os/oig>

Audrey Tayse Haynes  
Secretary

Maryellen B. Mynear  
Inspector General

September 29, 2015

via EMAIL: Renay Adkins ([renay.adkins@goldenliving.com](mailto:renay.adkins@goldenliving.com))

Ms. Renay Adkins, Administrator  
Golden LivingCenter - Hillcreek  
3116 Breckinridge Lane  
Louisville, KY 40220

Dear Ms. Adkins:

The Division of Health Care has received your facility's plan of correction regarding the deficiencies identified during the standard health\abbreviated\life safety code surveys completed on August 29, 2015. The plan of correction submitted was determined to be unacceptable.

As you were informed in the September 15, 2015 letter accompanying the CMS-2567/Statement of Deficiencies, your plan of correction must contain the following:

1. What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice;
2. How you will identify other residents/patients having the potential to be affected by the same deficient practice;
3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
4. How the facility plans to monitor its performance to ensure that solutions are sustained; and
5. **Include dates when corrective action will be completed. In the right column with the heading 'completion date', include only one date for each corresponding deficiency with the heading 'ID Prefix Tag' listed in the left column.**

Your plan of correction is being returned for amendment, as it did not meet the above criteria as follows:

Not Met #5. - Detail completion date, ensure it does not exceed any termination dates and is after the exit date of the survey.

This is an IJ deficiency-you cannot be in compliance before the exit date of the survey. The AOC only removed the jeopardy and lowered the scope and severity to a D. You still have remaining noncompliance. You are not allowing sufficient time for the QA Committee to monitor the POC for effectiveness or the need to revise to maintain compliance.

**K018**

Not Met #1. - Corrective action taken for residents identified by the deficient practice?  
Specify by title who adjusted the door.

Not Met #5. - Detail completion date, ensure it does not exceed any termination dates and is after the exit date of the survey.

You cannot allege compliance before or on the date of exit.

**K027**

Not Met #1. - Corrective action taken for residents identified by the deficient practice?  
Specify by title who adjusted the doors.

**K038**

Not Met #1. - Corrective action taken for residents identified by the deficient practice?  
You must identify by title who removed the sandbags, replaced the egress signage, modified the gate, and placed the code above the keypad. You must give dates and titles of the person who educated the employee.

Not Met #3. - Detail systemic changes to prevent recurrence of the deficient practice?  
Detail education of maintenance staff regarding egress requirements by NFPA, give dates and titles. The POC does not address the reason for the sandbags and what was done to prevent the use of sandbags in the future. How was this fixed?

**K046**

Not Met #1. - Corrective action taken for residents identified by the deficient practice?  
You must clarify where the battery powered emergency lighting was removed from and specify the foot candles in that area without the battery lighting and if the generator fails to come on.

Not Met #2. - Identified other residents that may be or were affected by the deficient practice and detail corrective action taken for those residents? You must specify how you determined no other areas were affected.

Not Met #3. - Detail systemic changes to prevent recurrence of the deficient practice?  
The SOD was not citing the fact the testing was not done, it cited the lack of documentation and the interview with maintenance that they were not aware the documentation was required. The POC must address both.

Not Met #4. - Detail how the facility will monitor to ensure continued compliance is achieved and/or maintained? The QA Committee needs to address the lack of knowledge by maintenance and the lack of documentation.

Not Met #5. - Detail completion date, ensure it does not exceed any termination dates and is after the exit date of the survey.

You cannot allege compliance before or on the date of exit of the health survey.

#### **K052**

Not Met #1. - Corrective action taken for residents identified by the deficient practice?

The POC does not address the load voltage test, see #3 in the SOD, Specify titles of who completed and documented the tests, it a vendor just specify vendor.

Not Met #3. - Detail systemic changes to prevent recurrence of the deficient practice?

The POC does not address the load voltage test. Detail education of maintenance to the NFPA requirements as interview revealed he was not aware of the requirement-give dates and titles.

Not Met #4. - Detail how the facility will monitor to ensure continued compliance is achieved and/or maintained?

The POC does not address the documentation of the three (3) tests on the fire alarm inspection paperwork. Detail how an annual review by QA ensures compliance with the load voltage testing that is semi-annual.

#### **K072**

Not Met #1. - Corrective action taken for residents identified by the deficient practice?

Specify the titles of the persons who removed the furniture, moved the scale and the med carts; you must specify where these items were moved to and specify the permanent location for storage.

#### **K076**

Not Met #1. - Corrective action taken for residents identified by the deficient practice?

Specify the title of the person who moved the boxed and the number of feet they were moved.

Specify how staff will know how far the items can safely be stored.

Not Met #2. - Identified other residents that may be or were affected by the deficient practice and detail corrective action taken for those residents?

Specify how you determined no other areas were affected.

Not Met #3. - Detail systemic changes to prevent recurrence of the deficient practice? Specify education of the staff give dates and titles, Specify education of Maintenance who was not aware of the requirements for oxygen storage.

**K144**

Not Met #3. - Detail systemic changes to prevent recurrence of the deficient practice?  
Detail how the maintenance will ensure that a supply of batteries are available and what is the process if there is not. Specify education of maintenance to the NFPA requirement, give date and title.

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902 KAR 20:008 Section 2.(5)(b) and/or 42 CFR 488.28, 42 CFR 456, and 42 CFR 489.453 requires that you submit a modified or amended plan of correction. **Failure to submit an acceptable plan of correction within five (5) days of receipt of this letter will result in a recommendation that action be taken against your state-issued license and/or your Medicare provider agreement be terminated.**

If you should have questions regarding this information, please contact our office.

Sincerely,



Millie K. Zumstein, R.D., L.D.  
Regional Program Manager  
Division of Health Care

MKZ/kt

Enclosures

**F281**

Not Met #2. - Identified other residents that may be or were affected by the deficient practice and detail corrective action taken for those residents?

Specify the date the 146 falls were reviewed, date the 4 residents were reviewed, the date all careplans were reviewed.

---

Not Met #3. - Detail systemic changes to prevent recurrence of the deficient practice? : Detail what evidence will be provided to the State Survey Agency to validate the managers are doing daily rounds and addressing issues identified, specify titles of who is auditing the IPOC.

Not Met #5. - Detail completion date, ensure it does not exceed any termination dates and is after the exit date of the survey.

This is an IJ tag with remaining scope and severity of a D. You cannot allege compliance before the exit date of the survey. The AOC only removed the Jeopardy not the remaining deficiency. You must allow sufficient time for the QA Committee to determine if the POC is effective or in need of revision.

**F282**

Not Met #4. - Detail how the facility will monitor to ensure continued compliance is achieved and/or maintained?

Reporting negative findings does not address the responsibility of the QA Committee to monitor the POC for effectiveness, Who is responsible for the oversight of the IDT morning meeting to ensure the orders are reviewed and changes made to the careplan.

**F314**

Not Met #1. - Corrective action taken for residents identified by the deficient practice?

Specify by title who put the boots on Resident #6.

Not Met #4. - Detail how the facility will monitor to ensure continued compliance is achieved and/or maintained?

Specify the number of UM, is that 4 residents per UM—please clarify. The POC does not address how and when the QA Committee will monitor the POC for effectiveness, reporting negative findings does not ensure the POC is achieving compliance.

**F323**

Not Met #4. - Detail how the facility will monitor to ensure continued compliance is achieved and/or maintained?

The POC does not address how and when the QA Committee will monitor the POC for effectiveness. Reporting negative findings by the nurse places the QA responsibility on the nurse. Specify how and when the committee will aggregate data, and develop plans of action to ensure the POC achieves compliance.

Not Met #5. - Detail completion date, ensure it does not exceed any termination dates and is after the exit date of the survey.

This is an IJ tag with remaining scope and severity of a D. You cannot allege compliance before the exit date of the survey. The AOC only removed the Jeopardy not the remaining deficiency. You must allow sufficient time for the QA Committee to determine if the POC is effective or in need of revision.

**F241**

Not Met #2. - Identified other residents that may be or were affected by the deficient practice and detail corrective action taken for those residents?

You must specify the title of the person who made the rounds of other residents.

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Not Met #4. - Detail how the facility will monitor to ensure continued compliance is achieved and/or maintained?

What evidence will be provided to the State Survey Agency to validate the weekly rounds by the UM were made and any issues were addressed. The POC does not address how or when the QA Committee will monitor the POC for effectiveness. Reporting negative findings to the QA Committee does not ensure the QA Committee is evaluating the issues, aggregating data and developing plans of action to ensure the POC is achieving and maintaining compliance.

**F253**

Not Met #2. - Identified other residents that may be or were affected by the deficient practice and detail corrective action taken for those residents?

Specify by title who completed the check of the facility for towel dispensers and door frames.

Not Met #4. - Detail how the facility will monitor to ensure continued compliance is achieved and/or maintained?

The POC does not address how or when the QA Committee will monitor the POC for effectiveness. Reporting negative findings to the QA Committee does not ensure the QA Committee is evaluating the issues, aggregating data and developing plans of action to ensure the POC is achieving and maintaining compliance.

**F276**

Not Met #1. - Corrective action taken for residents identified by the deficient practice?

Specify the next scheduled date for Resident #15.

Not Met #2. - Identified other residents that may be or were affected by the deficient practice and detail corrective action taken for those residents?

Specify by title who completed the MDS audit.

Not Met #3. - Detail systemic changes to prevent recurrence of the deficient practice?

The POC response in #3 does not address any changes to the MDS system to ensure compliance with F276 or N184. The response in #3 needs to be in #4. The POC does not address the break in the MDS system—address the education of the new MDS nurse to the system, give dates and titles, address the system to ensure MDS are completed timely, see interview with the MDS nurse.

**F280**

Not Met #4. - Detail how the facility will monitor to ensure continued compliance is achieved and/or maintained?

The POC does not address how and when the QA Committee will monitor the POC for effectiveness. Reporting negative findings by the nurse places the QA responsibility on the nurse. How and when is the committee aggregating data, and developing plans of actions to ensure the POC is achieving compliance.

**F371**

Not Met #1. - Corrective action taken for residents identified by the deficient practice?  
This is not the forum for IDR. Specify action taken for Resident #1 and #4 only.

Not Met #2. - Identified other residents that may be or were affected by the deficient practice and detail corrective action taken for those residents? You must identify how you determined no other residents were affected.

Not Met #3. - Detail systemic changes to prevent recurrence of the deficient practice?  
Specify if the education included the Cook who placed the food on the wet plates

Not Met #4. - Detail how the facility will monitor to ensure continued compliance is achieved and/or maintained? Detail how effective it is for the employee who was involved in the deficient practice to be monitoring themselves.

**F431**

Not Met #4. - Detail how the facility will monitor to ensure continued compliance is achieved and/or maintained?

The POC does not address how or when the QA committee will monitor the POC for effectiveness or the need for revisions to achieve and maintain compliance.

**F441**

Not Met #1. - Corrective action taken for residents identified by the deficient practice?  
Specify the titles of the persons who completed the tasks described in the POC.

Not Met #2. - Identified other residents that may be or were affected by the deficient practice and detail corrective action taken for those residents?

You must detail how you determined no other residents were affected.

Not Met #3. - Detail systemic changes to prevent recurrence of the deficient practice?  
Detail who has oversight to ensure this process is followed and how do they accomplish that oversight, when do they perform this oversight and what is done when issues are identified. This does not include the 5 month audit.

Not Met #4. - Detail how the facility will monitor to ensure continued compliance is achieved and/or maintained?

The POC does not address how or when the QA Committee will monitor the effectiveness of the POC or the need for any revision. How is the committee going to ensure the POC achieves compliance and maintains it?

**F514**

Not Met #2. - Identified other residents that may be or were affected by the deficient practice and detail corrective action taken for those residents?

You must specify how you determined no other residents were affected.

COT 9/30/15  
Department of Health & Human Services  
Centers for Medicare & Medicaid Services  
61 Forsyth Street, SW, Suite 4T20  
Atlanta, Georgia 30303-8909



Refer to: 5095.IJ.ab.09.28.15

**IMPORTANT NOTICE – PLEASE READ CAREFULLY**  
**SENT VIA FEDEX AND INTERNET E-MAIL**

**(Receipt of this notice is presumed to be September 28, 2015 – date notice e-mailed)**

September 28, 2015

Ms. Renay Adkins, Administrator  
Golden Livingcenter - Hillcreek  
3116 Breckenridge Lane  
Louisville, Kentucky 40220

**Re: Imposition Notice**  
**CMS Certification Number (CCN#): 18-5095**

Dear Ms. Adkins:

A facility must meet the pertinent provisions of Sections 1819 and 1919 of the Social Security Act and be in substantial compliance with each of the requirements for long term care facilities, established by the Secretary of Health and Human Services in 42 C.F.R. section 483.1 et seq., in order to qualify to participate as a skilled nursing facility in the Medicare program and as a nursing facility in the Medicaid program.

On August 29, 2015, a health recertification survey was completed to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. This survey found that your facility was not in substantial compliance with the participation requirements, and that **conditions in your facility constituted immediate jeopardy and substandard quality of care to residents' health and safety. The immediate jeopardy situation was identified to exist as of July 17, 2015 and was removed on August 27, 2015.** While corrective action taken by your facility removed the immediate jeopardy, conditions in your facility remained out of substantial compliance with Program requirements. A statement of the deficiencies (CMS-2567) was furnished to you by the Kentucky State Survey Agency (SAA) with a notice dated September 16, 2015. A life safety code recertification survey was completed on August 13, 2015 with noncompliance identified.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

## Remedies Imposed

We have reviewed the August 29, 2015 survey findings and the State Survey Agency's recommendations, and we are imposing the following mandatory and discretionary enforcement remedies on the dates indicated:

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### I. MANDATORY REMEDIES

- Mandatory Termination

In accordance with federal law at 42 C.F.R. 488.412(d), we must terminate the Medicare provider agreement of any facility that remains out of substantial compliance six (6) months after its initial survey identifying noncompliance. **Based on your facility's initial survey date of August 29, 2015, your facility's mandatory termination will become effective on February 29, 2016, if your facility remains out of compliance on the latter date.**

### II. DISCRETIONARY REMEDIES

- Civil Money Penalty (CMP)

A CMP of \$5,500.00 per day from July 17, 2015 through August 26, 2015 and a CMP of \$100.00 per day effective August 27, 2015, which will continue to accrue until either substantial compliance is achieved or your facility's Medicare participation is terminated. We considered factors identified at 42 C.F.R. 488.438(f) in setting the amount of the CMP being imposed for each day of your facility's noncompliance. The daily amount of your facility's CMP may be changed in the future, if we find that conditions worsen and noncompliance continues.

### NOTICE OF INTENT TO HOLD YOUR FACILITY'S CMP IN ESCROW

In accordance with federal law at 42 C.F.R. 488.431 and based on the scope/severity of noncompliance identified during your facility's survey, we have decided to collect your facility's CMP and place it in an escrow account. If you wish to dispute the findings of noncompliance upon which we have made this decision, you may request an Independent Informal Dispute Resolution (Independent IDR) proceeding in accordance with 42 C.F.R. sections 488.331 and 488.431. **If you would like to request an Independent IDR, you must do so in writing within ten (10) days of receiving this notice.** Your written request should identify the specific findings of noncompliance you are disputing, as well as an explanation of why you are disputing them (and/or why you are disputing the scope/severity of noncompliance constituting immediate jeopardy or substandard quality of care). Your request for an Independent IDR should be sent to the following address:

Jan Keeling  
275 E. Main Street 5E-A  
Frankfort, KY 40621

E-mail: Jan.keeling@ky.gov  
Telephone: (502)-564-7963 ext. 3301

**Please note that an incomplete Independent IDR process will not delay the effective date of any enforcement remedy imposed on your facility, and it will not delay our collection of your facility's CMP for more than ninety (90) days.** We are authorized by federal law at 42 C.F.R. 488.431(b) to collect your CMP in 90 days and place it in escrow, or to do so when a decision is issued from an Independent IDR proceeding, whichever is earlier.

**Please note, furthermore, that an incomplete IDR or Independent IDR process will not delay any deadline listed below under "Appeal Rights" for requesting a hearing, or for requesting a waiver of hearing rights.**

### **NOTICE OF RIGHT TO REQUEST HEARING OR WAIVE HEARING RIGHTS**

As explained more fully below under "Appeal Rights," you have the right to request a hearing before the Departmental Appeals Board (DAB) if you wish to dispute the basis and amount of your facility's CMP. You also may decide to waive your right to a hearing, in accordance with regulations at 42 C.F.R. 488.436. If you would like to waive your right to a hearing, you must do so in writing within sixty (60) days of receiving this notice. If you waive your right to a hearing, the amount of your CMP will be reduced by thirty-five percent (35%); on the other hand, if you request a hearing or miss the deadline for requesting a waiver, your CMP will not be reduced by 35 percent.

You must submit your waiver request directly to our Atlanta Regional Office by certified mail or via Internet e-mail to the CMP Waiver mail box. The Atlanta Regional Office does not accept CMP waivers via facsimile.

CMP waivers on company letterhead may be submitted via Internet e-mail to the CMP Waiver mail box. The Internet e-mail address is:

**CMPWaiversATL@cms.hhs.gov**

- **Discretionary Denial of Payment for New Admissions (DPNA)**

Denial of Payment for New Admissions is effective October 13, 2015, that continues until substantial compliance is achieved or your provider agreement is terminated.

Please note that filing of Medicare or Medicaid claims for new admissions after the denial of payment for new admissions (DPNA) is in effect could result in such claims being considered "false" claims under applicable federal statutes and thus potentially subjecting the filing entity to a referral to the appropriate authorities and possibly to the penalties prescribed under such statutes. An exception possibly applies where a timely appeal of the controlling certification/finding of noncompliance is filed (and remains pending) under 42 C.F.R. Part 498, and where your facility has made arrangements acceptable to your Medicare Administrative Contractor to submit the claim (or claims) with prominent flagging clearly indicating that the claim(s) is/are being filed not for current payment, but "under protest" and for the sole purpose of preserving a timely filing should the facility prevail on its

administrative appeal under 42 C.F.R. Part 498. Please note that the Denial of Payment for New Medicare Admissions includes Medicare beneficiaries enrolled in Medicare managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payments for new admissions.

### **Substandard Quality of Care (SQC)**

Your facility's noncompliance with 42 C.F.R. 483.25 at F323J has been determined to constitute substandard quality of care (SQC) as defined at 42 C.F.R. 488.301. Sections 1818(g)(5)(C) and 1919 (g)(5)(C) of the Social Security Act, as well as implementing regulations at 42 C.F.R. 488.325(h), require the State Survey Agency to send written notice of your facility's SQC to the attending physician of each resident, as well as the state board responsible for Insing the facility's administrator. In order to satisfy these notification requirements, you are required to provide the State Survey Agency with the name and address of the attending physician for each resident found to have received SQC. The State Survey Agency will advise you of the deadline for providing this information.

Please note that, in accordance federal law at 42 C.F.R. 488.325(g), your failure to provide this information in a timely fashion will result in the termination of your facility's Medicare provider agreement, or the imposition of alternative remedies.

### **Loss of Nurse Aide Training Program (NATCEP)**

Please note that federal law in the Social Security Act at sections 1819 (f)(2)(B) and 1919 (f)(2)(B), prohibits approval of Nurse Aide Training and Competency Evaluation Programs (NATCEP) offered by a facility which within the previous two years has operated under a section 1819 (b)(4)(c)(ii)(II) or section 1919 (b)(4)(ii) waiver; has been subject to an extended or partial extended survey; has been assessed a civil money penalty of \$5,000 or more; or, has been subject to denial of payment, the appointment of a temporary manager, termination or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities. As a result of your facility's noncompliance, these NATCEP provisions may be applicable to your facility. You will receive further notification from the State agency responsible for such matters.

### **Appeal Rights**

If you disagree with enforcement remedies imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services  
Departmental Appeals Board, MS 6132  
Director, Civil Remedies Division  
330 Independence Avenue, S.W.  
Cohen Building – Room G-644  
Washington, D.C. 20201

Alternatively, you may file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov>.

Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

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Region4\_DAB\_HearingRequest@cms.hhs.gov

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense.

If you have any questions regarding this letter, please contact Tina Holloway by phone at (404) 562- 7468 or by e-mail at [Leontyne.holloway@cms.hhs.gov](mailto:Leontyne.holloway@cms.hhs.gov).

Sincerely,

/s/

Sandra M. Pace  
Associate Regional Administrator  
Division of Survey and Certification

cc: State Survey Agency  
State Medicaid Agency  
Medicare Administrative Contractor  
LTCE Branch Manager  
HUD – Office of Healthcare Programs  
Medicare Advantage Branch

Enclosure

**How to Use the Departmental Appeals Board's Electronic Filing System (DAB E-File)**  
**<https://dab.efile.hhs.gov>**

To file a new appeal using DAB E-File, you first must register a new account by: (1) clicking **Register** on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking **Register Account** at the bottom of the form. ~~If you have more than one representative handling your appeal, each representative must register separately to use DAB E-File on your behalf.~~

How to log-in to DAB E-File. To access DAB E-File, the e-mail address and password provided during the registration process must be entered on the **Login** screen at [https://dab.efile.hhs.gov/user\\_sessions/new](https://dab.efile.hhs.gov/user_sessions/new). A registered user's access to DAB E-File is restricted to the appeals for which s/he is a party or authorized representative.

How to file an appeal (request for hearing) in DAB E-File. After you have registered and logged-in to DAB E-File, you may file an appeal by: (A) clicking the **File New Appeal** link on the **Manage Existing Appeals** page, then at the next page clicking the **Civil Remedies Division** button; then (B) entering and uploading the requested information and documents on the form labeled "File New Appeal – Civil Remedies Division."

Basic requirements for using DAB E-File. At a minimum, the DAB's Civil Remedies Division (CRD) requires a party filing an appeal to submit the following: (1) a signed hearing request; and (2) a copy of the underlying notice letter from CMS which sets forth CMS's adverse action and the party's appeal rights. All documents must be submitted in Portable Document Format (PDF). Any document, including a hearing request, will be deemed to have been filed on the date it is submitted via DAB E-File (through 11:59 p.m. EST on the date of submission). A party filing a hearing request via DAB E-File will be deemed to have consented to receiving and accepting electronic service of appeal-related documents which CMS subsequently submits via DAB E-File and/or which the CRD subsequently submits via DAB E-File on behalf of an Administrative Law Judge. CMS also will be deemed to have consented to electronic service.

Detailed information regarding DAB E-File. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For general questions regarding the DAB E-File System, you may call the Civil Remedies Division main telephone line at 202-565-9462. If you experience any technical issues with the DAB E-file System, please contact E-File System support. This support system may be reached at [OSDABImmediateOffice@hhs.gov](mailto:OSDABImmediateOffice@hhs.gov).



**CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF INSPECTOR GENERAL**

**Steven L. Beshear**  
Governor

**Millie K. Zumstein, Regional Program Manager**  
908 West Broadway, 10 West  
Louisville, Kentucky 40203  
(502) 595-4958  
Fax: (502) 595-4540  
<http://chfs.kv.gov/os/oig>

**Audrey Tayse Haynes**  
Secretary

**Maryellen B. Mynear**  
Inspector General

**Amended Letter**

September 16, 2015

via EMAIL: Renay Adkins ([renay.adkins@goldenliving.com](mailto:renay.adkins@goldenliving.com))

Ms. Renay Adkins, Administrator  
Golden LivingCenter - Hillcreek  
3116 Breckinridge Lane  
Louisville, KY 40220

Dear Ms. Adkins:

On August 29, 2015, a standard\abbreviated\life safety code\extended surveys were completed at your facility by the Division of Health Care to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This visit found that your facility was not in substantial compliance with the participation requirements. These surveys determined the conditions identified in your facility to constitute Immediate Jeopardy in the area(s) of

F0323 -- S/S: J -- 483.25(h) -- Free Of Accident Hazards/supervision/devices  
F0281 -- S/S: J -- 483.20(k)(3)(i) -- Services Provided Meet Professional Standards  
F0514 -- S/S: J -- 483.75(l)(1) -- Res Records-Complete/accurate/accessible and  
Substandard Quality of Care in the area(s) of  
F0323 -- S/S: J -- 483.25(h) -- Free Of Accident Hazards/supervision/devices.

Immediate Jeopardy was identified on August 21, 2015, was determined to exist on July 17, 2015, and was removed on August 27, 2015.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

## Plan of Correction (POC)

A POC for the deficiencies must be submitted no later than **ten (10) days from receipt of this letter**. ~~Failure to submit an acceptable POC may result in a recommendation that remedies be imposed immediately upon notification requirements being met.~~

Your POC must:

- Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and
- **Include dates when corrective action will be completed. In the right column with the heading 'completion date', include only one date for each corresponding deficiency with the heading 'ID Prefix Tag' listed in the left column.**

You are required to record your plan of correction in the appropriate column on the enclosed form(s) CMS-2567. **Sign, date, and indicate your title in the blocks provided at the bottom of page one.**

## Recommended Remedies

As a result of the Immediate Jeopardy and Substandard Quality of Care identified during the survey, we are recommending to the Centers for Medicare and Medicaid Services (CMS) Regional Office the following:

- A Civil Money Penalty of an amount and duration to be determined by CMS; and
- Denial of payment for new admissions effective as soon as notification requirements can be met.

A change in the seriousness of the noncompliance at the time of a revisit may result in a change in the remedy(ies). If this occurs, you will be notified.

Your provider agreement must be terminated if substantial compliance is not achieved **within six (6) months** from the last day of the survey identifying noncompliance.

**Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other sanction is warranted, it will provide you with a separate formal notification of that determination.**

Your facility's noncompliance with 42 CFR 483.25 has been determined to constitute Substandard Quality of Care as defined at 488.301. Sections 1819(g)(5)(c) and 1919(g)(5)(c) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the Nursing Home Administrator's Board of Licensure, be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

List of affected resident: #26

Please note that, in accordance with 488.325(g), your failure to provide this information timely will result in termination of participation or imposition of alternative remedies.

Also, as a result of the determination of Substandard Quality of Care pursuant to 42 CFR 488.325, your facility is prohibited from providing a Nurse Aide Training and Competency Evaluation Program effective August 29, 2015, and continuing for the next two (2) years.

#### Loss of Nurse Aide Training Program (NATCEP)

Please note that Federal law, as specified in the Social Security Act at sections 1819 (f)(2)(B) and 1919 (f)(2)(B), prohibit approval of nurse aide training and competency evaluation programs offered by or in your facility which within the previous two years has operated under a section 1819 (b)(4)(c)(ii)(II) or section 1919 (b)(4)(ii) waiver; has been subject to an extended or partial extended survey; or has been assessed a civil money penalty of not less than \$5,000; or, has been subject to denial of payment, the appointment of a temporary manager, termination or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities. As a result of the extended survey and the immediate jeopardy, this provision may be applicable to your facility and you may receive further notification from the State.

#### Informal Dispute Resolution

In accordance with 42 CFR 488.331 and 906 KAR 1:120, a provider shall have one informal opportunity to dispute a cited deficiency, or scope and severity assessment that constitutes Substandard Quality of Care or Immediate Jeopardy. You are required to send your request in writing to IDR Coordinator, Office of Inspector General, Division of Health Care, 275 East Main Street, 5E-A, Frankfort, Kentucky 40621. Your request shall specify the format for the informal dispute resolution, specify the deficiency in dispute, explain the dispute, and provide a detailed basis for the dispute. Documentation in support of the dispute shall be attached to the request.

The request and attachments shall be delivered **on or before the tenth calendar day after receipt of the Statement of Deficiencies**. A request for informal dispute resolution shall not delay an enforcement action.

---

If you should have questions regarding this information, please contact our office.

Sincerely,

A handwritten signature in blue ink that reads "Millie K. Zumstein". The signature is written in a cursive, flowing style.

Millie K. Zumstein, R.D., L.D.  
Regional Program Manager  
Division of Health Care

MKZ/kt



**CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF INSPECTOR GENERAL**

**Steven L. Beshear**  
Governor

**Millie K. Zumstein, Regional Program Manager**  
908 West Broadway, 10 West  
Louisville, Kentucky 40203  
(502) 595-4958  
Fax: (502) 595-4540  
<http://chfs.ky.gov/os/oig>

**Audrey Tayse Haynes**  
Secretary

**Maryellen B. Mynear**  
Inspector General

September 15, 2015

via EMAIL: Renay Adkins ([renay.adkins@goldenliving.com](mailto:renay.adkins@goldenliving.com))

Ms. Renay Adkins, Administrator  
Golden LivingCenter - Hillcreek  
3116 Breckinridge Lane  
Louisville, KY 40220

Dear Ms. Adkins:

On August 29, 2015, a standard\abbreviated\life safety code\extended surveys were completed at your facility by the Division of Health Care to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This visit found that your facility was not in substantial compliance with the participation requirements. These surveys determined the conditions identified in your facility to constitute Immediate Jeopardy in the area(s) of

F0323 -- S/S: J -- 483.25(h) -- Free Of Accident Hazards/supervision/devices  
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F0514 -- S/S: J -- 483.75(l)(1) -- Res Records-Complete/accurate/accessible and  
Substandard Quality of Care in the area(s) of  
F0323 -- S/S: J -- 483.25(h) -- Free Of Accident Hazards/supervision/devices.

Immediate Jeopardy was identified on August 21, 2015, was determined to exist on July 17, 2015, and was removed on August 27, 2015.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction (POC)

A POC for the deficiencies must be submitted no later than **ten (10) days from receipt of this letter.** Failure to submit an acceptable POC may result in a recommendation that remedies be imposed immediately upon notification requirements being met.

Your POC must:

- Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and
- **Include dates when corrective action will be completed. In the right column with the heading 'completion date', include only one date for each corresponding deficiency with the heading 'ID Prefix Tag' listed in the left column.**

You are required to record your plan of correction in the appropriate column on the enclosed form(s) CMS-2567. **Sign, date, and indicate your title in the blocks provided at the bottom of page one.**

#### Recommended Remedies

As a result of the Immediate Jeopardy and Substandard Quality of Care identified during the survey, we are recommending to the Centers for Medicare and Medicaid Services (CMS) Regional Office the following:

- A Civil Money Penalty of an amount and duration to be determined by CMS; and
- Denial of payment for new admissions effective as soon as notification requirements can be met.

A change in the seriousness of the noncompliance at the time of a revisit may result in a change in the remedy(ies). If this occurs, you will be notified.

Your provider agreement must be terminated if substantial compliance is not achieved **within six (6) months** from the last day of the survey identifying noncompliance.

**Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other sanction is warranted, it will provide you with a separate formal notification of that determination.**

Your facility's noncompliance with 42 CFR 483.25 has been determined to constitute Substandard Quality of Care as defined at 488.301. Sections 1819(g)(5)(c) and 1919(g)(5)(c) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the Nursing Home Administrator's Board of Licensure, be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

List of affected resident: #26

Please note that, in accordance with 488.325(g), your failure to provide this information timely will result in termination of participation or imposition of alternative remedies.

Also, as a result of the determination of Substandard Quality of Care pursuant to 42 CFR 488.325, your facility is prohibited from providing a Nurse Aide Training and Competency Evaluation Program effective August 29, 2015, and continuing for the next two (2) years.

#### Loss of Nurse Aide Training Program (NATCEP)

Please note that Federal law, as specified in the Social Security Act at sections 1819 (f)(2)(B) and 1919 (f)(2)(B), prohibit approval of nurse aide training and competency evaluation programs offered by or in your facility which within the previous two years has operated under a section 1819 (b)(4)(c)(ii)(II) or section 1919 (b)(4)(ii) waiver; has been subject to an extended or partial extended survey; or has been assessed a civil money penalty of not less than \$5,000; or, has been subject to denial of payment, the appointment of a temporary manager, termination or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities. As a result of the extended survey and the immediate jeopardy, this provision may be applicable to your facility and you may receive further notification from the State.

#### **Informal Dispute Resolution**

In accordance with 42 CFR 488.331 and 906 KAR 1:120, a provider shall have one informal opportunity to dispute a cited deficiency, or scope and severity assessment that constitutes Substandard Quality of Care or Immediate Jeopardy. You are required to send your request in writing to IDR Coordinator, Office of Inspector General, Division of Health Care, 275 East Main Street, 5E-A, Frankfort, Kentucky 40621. Your request shall specify the format for the informal dispute resolution, specify the deficiency in dispute, explain the dispute, and provide a detailed basis for the dispute. Documentation in support of the dispute shall be attached to the request. The request and attachments shall be delivered **on or before the tenth calendar day after receipt of the Statement of Deficiencies**. A request for informal dispute resolution shall not delay an enforcement action.

If you should have questions regarding this information, please contact our office.

Sincerely,



Millie K. Zumstein, R.D., L.D.  
Regional Program Manager  
Division of Health Care

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