STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185095	A. BUILDING _____ B. WING _____	R-C 12/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 12/24/14 as alleged.	{F 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.

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

PRINTED: 11/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS An Abbreviated Survey was initiated on 11/06/14 and concluded on 11/10/14 to investigate complaints KY22439 and KY22440. The Division of Health Care substantiated the allegation for KY22439 with deficiencies cited. KY22440 was unsubstantiated with no deficiencies cited.	F 000	**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.**	
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, it was determined, the facility failed to ensure a clean, comfortable homelike environment for one (1) of four (4) nursing units, (Unit 100). The findings include: The facility did not provide a policy on maintenance of the facility. Observation during tour, on 11/06/14 at 1:20 PM, revealed in Room 140, behind bed A and bed B the walls had holes in them with the gypsum exposed. In Room 137-2, behind the bed, the drywall was torn with the gypsum exposed and the outlet cover was broken. The bathroom in Room 136 had a strong odor of urine. The drywall behind the beds were torn with gypsum exposed. The bathroom in Room 135 had a hole in the	F 252	F 252 1.Room 140(1&2),137-2, 136(1&2), 102-2, and 100 (1&2) wall behind the bed has started to be patched and repaired and will be completely repaired by 12-05-14. 137-2 outlet cover was fixed. The bathroom, in room 135, hole in the wall has started to be patched and repaired and will be completely repaired by 12-05-14. Room 132-1 tube feeding pole was cleaned on 11-07-14. Room 127-1 toilet seat was thrown away on 11-10-14 and a new one was put in place. Room 111 fall mats were cleaned and replaced on 11-10-14. Room 103 sink faucet handle fixed on 11-10-14. Room 102-2 cover on the heating vent was repaired on 11-20-14. The hole in the bathroom door to room 110, has started to be patched and repaired and will be completely repaired by 12-05-14. The bathrooms in rooms 136, 127 and 104 were cleaned on 11-10-14 and were without a urine odor after cleaning. The wallpaper and the door frame in the restorative dining room, next to the 100 hall has started to be repaired and will be completed by 12-23-14.	12-24-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X [signature] WED
TITLE: X Exec. Dir.
(X6) DATE: X 11-26-14

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.

Revised 12-6-14

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F 252	Continued From page 1 wall. Room 132-1 had a tube feeding pole with dried splatters of a tannish substance on the base of the pole. The bathroom in Room 127 had a strong urine odor. The elevated toilet seat was in disrepair with jagged edges at the bottom. In Room 111 the fall mats had several black spots. The bathroom for Room 104 had a strong odor of urine. In Room 103, the sink faucet handle would not turn off. The drywall behind the bed in Room 102-2 was torn with the gypsum exposed and the cover on the heating vent was broken. The bathroom door to room 100 had a hole at the bottom and the drywall behind the bed was torn with gypsum exposed. Continued observation, on 11/06/14 at 3:15 PM, revealed the dining room next to the 100 Unit had multiple tears in the wallpaper. The door frame had a gouge in the piece of wood with lose jagged edges. Interview, on 11/07/14 at 1:20 PM, with Housekeeper #1 revealed they cleaned the rooms everyday including mopping the floors and the bathroom. Interview, on 11/10/14 at 2:26 PM, with the Administrator, Director of Nursing, and the Assistant Director of Nursing, revealed they were not sure why the 100 Unit was in such disrepair. The Administrator stated the 100 Unit was just painted in January 2014. She stated they were without Maintenance staff for a while. Interview with the Maintenance Director, on 11/10/14 at 4:00 PM, revealed he had been at the facility for three (3) months, but prior to that the facility did not have a maintenance person for awhile. He stated they had been playing catch	F 252	2. All resident rooms and all the facility areas have the potential to be affected for odors and a non home like environment. All rooms and areas of the facility were checked for odors on 11-11-14 and no other odors were found. All other areas were checked on 11-24 and 11-25-14 for holes in the walls and doors, broken outlet covers, dirty feeding poles, toilet seats in disrepair, dirty floor mats, sink faucet handles and heating vent covers. Other holes in the walls behind beds were found and were started to be repaired and patched and will be completed by 12-24-14. No other issues were found. 3. The staff will be in serviced on 11-25 and 11-26-14 on keeping the facility free of odors and providing a home like environment. Any problems found will be reported to a supervisor and the concern will be corrected. If the concern is an odor in the bathroom, the Director of Housekeeping (DOH) or shift supervisor will be notified and the bathroom will be cleaned immediately. If a maintenance concern is found the concern will be entered in the building engines system for repair. Maintenance will then fix the items entered timely. To identify areas of needed repairs that may not be getting put into building engine system, the ED will do monthly rounds to identify any needed repairs. The Maintenance Director will do monthly rounds to identify any needed repairs, The unit managers will do monthly rounds to identify any needed repairs This will be ongoing, with no stop date to ensure compliance greater than 4 months Any found needed repairs will be given to the Maintenance Director to correct. 4. The Executive Director (ED) will monitor the building engines system weekly for 4 weeks then monthly to ensure that any needed entered repairs are fixed timely. DOH or ED will randomly select 5 bathrooms on 100 hall per week for four weeks, checking for odors in	

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F 252	Continued From page 2 up.	F 252	the bathrooms. Then monthly for 3 months. The ED will report any negative findings in the QAPI meeting monthly for 4 months. Any negative findings from the monthly rounds by the ED, Maintenance Director or unit Managers will be reported in the QAPI meetings ongoing without a stop date, to ensure continued compliance greater than 4 months.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to follow the Care Plan for one (1) of six (6) sampled residents, (Resident #6) related to bathing and grooming. The findings include: The facility did not provide a policy for following Care Plans. Observation, on 11/06/14 at 3:21 PM, revealed Resident #6 was laying in bed. The resident had a thick growth of facial hair with the mustache much thicker and untrimmed. Observation, on 11/07/14 at 8:45 AM and 10:15 AM, revealed Resident #6 was laying in bed and alert. The resident still had a thick growth of facial hair with the mustache untrimmed. Review of the clinical record for Resident #6 revealed the facility admitted the resident on 08/03/12 with diagnoses of Cerebrovascular Disease, Atrial Fibulation, Hypertension, Congestive Heart Failure and Depression.	F 282	I-282 1. Resident # 6 was shaved on the afternoon of 11-7-14. The resident had already received his scheduled shower on 11-6-14. 2. All residents have the potential to be effected by this deficient practice. A audit was conducted of all residents on 11-24-14 and 11-25-14 by the unit managers to ensure that all the residents had been shaved. No others were found that needed to be shaved. 3. The nursing staff was in serviced on 11-22-14 - 11-25-14 by the Interdisciplinary Team (IDT) on shaving the residents everyday. 4. The Unit Managers will check every resident on their unit for 4 weeks, then monthly for 3 months, to check that each resident has been shaved. The Director of Nursing (DON) or Assistant Director of Nursing (ADON) will report any negative findings in QAPI committee monthly for 4 months. The DNS will continue to do random checks monthly and report any negative findings, to ensure compliance greater than 4 months.	12-23-14

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F 282	Continued From page 3 Review of the Quarterly Minimum Data Set Assessment for Resident #6, dated 09/17/14, revealed the facility assessed the resident to require extensive assistance of one (1) person with personal hygiene. Under the section Range of Motion, revealed the facility assessed the resident to have impairment on both sides of the upper and lower extremities that interfered with daily function. Review of the Comprehensive Care Plan for Resident #6 revealed the facility developed a care plan on 08/08/14 related to a physical function deficit due to an old hip fracture with impaired range of motion, a left knee contracture related to Cerebral Vascular Accident. The goal implemented was staff were to anticipate and assist with needs daily. Review of the Certified Nursing Assistant (CNA) Care Plan for Resident #6 revealed the resident's shower schedule was Monday and Thursday on first shift and required total care. Under the note section it stated to shave daily. Review of the facility Shower Schedule revealed Resident #6 was scheduled for a shower on Monday's and Thursday's on first shift. A notation at the bottom of the shower schedule stated everyone must be shaved daily and as needed. Interview, on 11/07/14 at 10:56 AM, with Licensed Practical Nurse #2 revealed she was assigned to Resident #6 today and the day before. She stated she was not sure if the resident had received a shower the day before, on his/her scheduled shower day. She then stated the resident received a bed bath as there was a	F 282		

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F 282	Continued From page 4 problem with the water the day before. She stated the resident should have been shaved even if he/she only received a bed bath. She stated the CNA's complete a bath and skin report when a resident was scheduled for a shower or bath and the nurse had to sign them off daily. She stated she signed so many she must have missed Residents #6's. She stated the care plan was not followed if the resident did not get bathed and groomed as scheduled. Interview, on 11/07/14 at 2:26 PM, with the Administrator, Director of Nursing and the Assistant Director of Nursing revealed they had been focusing on bathing and grooming of residents since their last survey and completed multiple inservices to try to ensure residents received bathing and grooming needs. The Administrator stated it was the responsibility of the Unit Managers to ensure residents on their units get showers and were groomed. Neither the Administrator, DON or the ADON could state who monitored the Unit Managers to ensure care plans were followed by staff to meet the needs of the residents.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 312		

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F 312	Continued From page 5 and review of the shower schedule, it was determined, the facility failed to provide assistance with showers and shaving of dependent residents for one (1) of six (6) sampled residents, (Resident #6). The findings include: The facility did not provide a policy on bathing and grooming of dependent residents. Observation of Resident #6, on 11/06/14 at 3:21 PM, revealed the resident had a thick growth of facial hair and the mustache was much thicker and untrimmed. Observation of Resident #6, on 11/07/14 at 8:45 AM and 10:15 AM, revealed the resident still had a thick growth of facial hair and the mustache had not been trimmed. Review of Resident #6's clinical record revealed the facility admitted the resident on 08/03/12 with diagnoses of Cerebrovascular Disease, Atrial Fibulation, Hypertension, Congestive Heart Failure and Depression. Review of Resident #6's Quarterly Minimum Data Set Assessment (MDS), dated 09/17/14, revealed the facility assessed the resident as requiring extensive assistance with two (2) person physical assist with dressing, bed mobility and transfer. The facility assessed the resident to require extensive assistance with one (1) person assist with eating and personal hygiene. Under the section Range of Motion, the facility assessed the resident to have impairment on both sides of the upper and lower extremities that interfered with daily function.	F 312	F312 1 Resident # 6 was shaved on the afternoon of 11-7-14. The resident had already received his scheduled shower on 11-6-14. 2. All residents have the potential to be effected by this deficient practice. A audit was conducted of all residents on 11-24-14 and 11-25-14 by the unit managers to ensure that all the residents had been shaved. No others were found that needed to be shaved. 3 The nursing staff was in serviced on 11-22-14 - 11-25-14 by the Interdisciplinary Team (IDT) on shaving the residents everyday 4 The Unit Managers will check every resident on their unit for 4 weeks, then monthly for 3 months, to check that each resident has been shaved. The Director of Nursing (DON) or Assistant Director of Nursing (ADON) will report any negative findings in QAPI committee monthly for 4 months. The DNS will continue to do random checks monthly and report any negative findings, to ensure compliance greater than 4 months.	12-23-14

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F 312	Continued From page 6 Review of Resident #6's Comprehensive Care Plan revealed the facility developed a care plan on 08/08/14 related to a physical function deficit due to an old hip fracture with impaired range of motion, and a left knee contracture related to the Cerebral Vascular Accident. An intervention implemented was for staff to anticipate and assist with resident's needs daily. Review of Resident #6's Certified Nursing Assistant (CNA) Care Plan revealed the resident's shower schedule was Monday and Thursday and required total care. Under the note section it stated to shave daily. Review of the facility's Shower Schedule revealed Resident #6 was to recieve a shower on Monday's and Thursday's on the first shift. A notation at the bottom of the shower schedule instructed staff that everyone must be shaved daily and as needed. Interview with Licensed Practical Nurse (LPN) #2, on 11/07/14 at 10:56 AM, revealed she was assigned to Resident #6 for today and the day before (11/06/14). She stated she was not sure if the resident had received a shower the day before, on his/her scheduled shower day. She then stated the resident received a bed bath as there was a problem with the water the day before. She stated the resident should have been shaved even if he/she only received a bed bath. She stated the CNA's complete a bath and skin report when a resident received a shower or bath and the nurse had to sign them off daily. She stated she signed so many she must have missed Residents #6's.	F 312		

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F 312	Continued From page 7 Interview with Certified Nursing Assistant (CNA) #1, on 11/07/14 at 1:10 PM, revealed residents got showers two (2) times a week and shaved every day unless they refused. She stated if that happened she would report it to the nurse. She stated if residents were not bathed or groomed as needed it could make them feel terrible. Interview with the Administrator, Director of Nursing (DON) and the Assistant Director of Nursing (ADON), on 11/07/14 at 2:26 PM, revealed they had focused on bathing and grooming of the residents since their last survey and completed multiple inservices to try to ensure residents received bathing and grooming needs. The Administrator stated it was the Unit Managers responsibility to ensure residents on their units get their showers and are groomed.	F 312		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the daily census activity, it was determined the facility failed to ensure one (1) of six (6) sampled residents had a functioning call light (Resident #2). The findings include: The facility did not provide a policy for call lights.	F 463	F463 1 Resident #2 was given a call light on 11-7-14. The resident was alert and oriented and without any harm. 2 All residents have the potential to be affected by this deficient practice. A audit was conducted of all residents on 11-7-14, checking that every resident had a working call light and no other residents were found to be without a working call light.	12-02-14

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F 463	Continued From page 8 Observation, on 11/06/14 at 2:50 PM, revealed Resident #2 was laying on the bed. There was no call light present for the resident to use. There was a plug in the wall, but no call light was attached. Observation, on 11/07/14 at 8:30 AM and 10:40 AM, revealed Resident #2 did not have a call light to use to summon staff. The facility was not aware of the missing call light and was notified at this time. Review of the clinical record for Resident #2 revealed the facility admitted the resident on 07/31/14 and readmitted the resident on 10/10/14 with diagnoses of Depression, Bipolar, Anemia, Heart Failure, and Chronic Obstructive Pulmonary Disease. Review of Resident #2's Minimum Data Set (MDS) Admission Assessment, dated 10/23/14, revealed the facility assessed the resident's cognition at a fifteen (15), meaning cognitively intact, using the Basic Interview for Mental Status (BIMS). The facility assessed the residents mobility and transfer as requiring limited physical assistance of one (1) person. Interview, on 11/06/14 at 2:50 PM, with Resident #2 revealed there had not been a call light in the room since he/she had been in the room. Review of Daily Census Activity Report, dated 10/31/14, revealed Resident #2 was moved to room 207-1 on 10/31/14, for eight (8) days. Interview, on 11/07/14 at 10:45 AM, with Licensed Practical Nurse (LPN) #3 revealed a resident not	F 463	3 The nursing staff was in serviced on 11-22-14 - 11-25-14 by the interdisciplinary Team (IDT) on checking that the residents always have a working call light in place. The nursing staff is to ensure that every room has a working call light, The unit managers are to have oversight of their staff on their units to ensure this is done. The UM will do random check: weekly to ensure the staff are checking 4 The unit Managers will check every resident on their unit for 4 weeks, then monthly for 3 months, to check that each resident has a call light in place. The Director of Nursing (DON) or Assistant Director of Nursing (ADON) will report any negative findings in QAPI committee monthly for 4 months. The UM will continue to report any negative findings to the DON or ADON after 4 months and they will continue to report in QAPI ongoing.	

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GOLDEN LIVINGCENTER - HILLCREEK	3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 9 having a call light should never happen. She stated Resident #2 was able to walk and did not use a call light so no one noticed the call light was missing. Interview, on 11/10/14 at 2:26 PM, with the Administrator, the Director of Nursing, and the Assistant Director of Nursing revealed room 207-1 was empty for a long time before Resident #2 was transferred to that room. They stated they did not know why there was not a call light in the room as all rooms are checked upon admission to ensure there was a functioning call light.	F 463		

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