

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ZQMB
Facility ID: 100212

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 185095		3. NAME AND ADDRESS OF FACILITY (L3) GOLDEN LIVINGCENTER - HILLCREEK (L4) 3116 BRECKINRIDGE LANE (L5) LOUISVILLE, KY (L6) 40220			4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CIOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other	
2. STATE VENDOR OR MEDICAID NO. (L2) 12505111		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) 01 Hospital 05 IIIA 09 ESRD 13 PTIP 22 CLIA 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 04 SNF 08 OPT/SP 12 RIIC 16 HOSPICE			8. Full Survey After Complaint	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 04/01/2006		10. THE FACILITY IS CERTIFIED AS X A. In Compliance With Program Requirements Compliance Based On: <u>X</u> .1. Acceptable POC B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A1* (L12)			FISCAL YEAR ENDING DATE: (L35) 12/31	
6. DATE OF SURVEY 08/29/2015 (L34)		11. LTC PERIOD OF CERTIFICATION From (a): To (b):			And/Or Approved Waivers Of The Following Requirements: <u>2</u> Technical Personnel <u>3</u> 24 Hour RN <u>4</u> 7-Day RN (Rural SNF) <u>5</u> Life Safety Code <u>6</u> Scope of Services Limit <u>7</u> Medical Director <u>8</u> Patient Room Size <u>9</u> Beds/Room	
8. ACCREDITATION STATUS: (L10) 0 Unaccredited 2 AOA 1 TJC 3 Other		12. Total Facility Beds 172 (L18)			13. Total Certified Beds 172 (L17)	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF (L37) 18/19 SNF (L38) 172		19 SNF (L39) ICF (L42) IID (L43)			15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): YES (L15)	
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): See Attached Remarks						
17. SURVEYOR SIGNATURE <i>Michelle K Zumstein</i> Date: 11/16/15 (L19)				18. STATE SURVEY AGENCY APPROVAL Date: 10/12/2015 (L20)		

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Participate ___ 2. Facility is not Eligible (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above: ___	
22. ORIGINAL DATE OF PARTICIPATION 06/15/1970 (L24)		23. LTC AGREEMENT BEGINNING DATE (L41)		24. LTC AGREEMENT ENDING DATE (L25)	
25. LTC EXTENSION DATE: (L27)		27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)		26. TERMINATION ACTION: (L30) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active	
28. TERMINATION DATE: (L28)		29. INTERMEDIARY/CARRIER NO. 00454 (L31)		30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE 10/12/2015 (L33)		DETERMINATION APPROVAL	

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ZQMB

Facility ID: 100212

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

A standard health and abbreviated (KY00023660) surveys were concluded on 08/14/15. The facility was found not meeting the minimum requirements for recertification with deficiencies cited at the highest scope and severity of a "F". The complaint KY00023660 was unsubstantiated with no related deficiencies cited. A Life Safety Code survey was conducted on 08/13/15 and was found not in compliance. Deficiencies were cited with the highest scope and severity of a "F".

After Supervisory review the survey was reopened on 08/21/15 with Immediate Jeopardy identified on 08/21/15 and determined to exist on 07/17/15 at 42 CFR 483.20 Resident Assessment (F281); 42 CFR 483.25 Quality of Care (F323); and, 42 CFR 483.75 Administration (F514) at a scope and severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 08/21/15. An extended survey was conducted on 08/27/15-08/29/15.

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 483.20 Resident Assessment (F281), 42 CFR 483.25 Quality of Care (F323) and 42 CFR 483.75 Administration (F514) 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.

Recommended Remedies:

- * CMP of \$3550.00 per day effective 07/17/15 through 08/26/15.
- * CMP of \$100.00 per day effective 08/27/15, to continue until substantial compliance is achieved or provider agreement is terminated;
- * DPNA effective as soon as notification requirements can be met; and
- * Provider agreement must be terminated if substantial compliance is not achieved within six (6) months from the last day of the survey identifying noncompliance.

A Statement of Deficiencies was issued to the facility on 09/15/15.

An amended SoD was issued to the facility on 09/16/15.

On 09/25/15 the facility requested an Informal Dispute Resolution (IDR).

A Plan of Correction was received on 09/28/15, however, it was determined to be unacceptable and re-issued to the facility on 09/29/15.

Refer to: 5095.IJ.ab.09.28.15

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

- * Mandatory Termination of provider agreement will become effective on 02/29/16, if facility remains out of compliance on the latter date.
- * CMP of \$5,500.00 per day from 07/17/15 through 08/26/15;
- * CMP of \$100.00 per day effective 08/27/15, which will continue to accrue until either substantial compliance is achieved or facility's Medicare participation is terminated
- * DPNA is effective 10/13/15, that continues until substantial compliance is achieved or provider agreement is terminated.

An acceptable PoC was received on 10/01/15 with a compliance date 09/30/15 for the standard health survey and 10/02/15 compliance date for the LSC survey.

The IDR was conducted by desk review on 11/04/15 and the following determination was made: F281 S/S J - No change, F323 S/S J - No change, and F514 S/S J - No change.

An onsite re-visit was concluded on 11/13/15 and found the facility in compliance on 10/02/15 as alleged in their PoC.

Recommended Remedies:

Refer to: 5095.IJ.ab.09.28.15

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

- * Mandatory Termination is rescinded.
- * CMP of \$5,500.00 per day from 07/17/15 through 08/26/15;
- * CMP of \$100.00 per day effective 08/27/15 through 10/01/15; and
- * DPNA is rescinded.

Recertification is recommended.

10 of 3

LTC Facility Bed List

Date of Survey 08/11/15

08/29/15

	Room #	Licensure Type and # of Beds	Certification
Example1:	100	NF - 2 beds	Title 18/19
Example2:	100A	NF - 1 bed	Title 18/19
	100B	NF - 1 bed	Title 18/19
	100-1	NF - 1 bed	Title 18/19
	100-2	NF - 1 bed	Title 18/19
	101-1	NF - 1 bed	Title 18/19
	101-2	NF - 1 bed	Title 18/19
	102-1	NF - 1 bed	Title 18/19
	102-2	NF - 1 bed	Title 18/19
	103-1	NF - 1 bed	Title 18/19
	103-2	NF - 1 bed	Title 18/19
	104-1	NF - 1 bed	Title 18/19
	104-2	NF - 1 bed	Title 18/19
	105-1	NF - 1 bed	Title 18/19
	105-2	NF - 1 bed	Title 18/19
	106-1	NF - 1 bed	Title 18/19
	106-2	NF - 1 bed	Title 18/19
	107-1	NF - 1 bed	Title 18/19
	107-2	NF - 1 bed	Title 18/19
	108-1	NF - 1 bed	Title 18/19
	108-2	NF - 1 bed	Title 18/19
	109-1	NF - 1 bed	Title 18/19
	109-2	NF - 1 bed	Title 18/19
	110-1	NF - 1 bed	Title 18/19
	110-2	NF - 1 bed	Title 18/19
	111-1	NF - 1 bed	Title 18/19
	111-2	NF - 1 bed	Title 18/19
	112-1	NF - 1 bed	Title 18/19
	112-2	NF - 1 bed	Title 18/19
	114-1	NF - 1 bed	Title 18/19
	114-2	NF - 1 bed	Title 18/19
	115-1	NF - 1 bed	Title 18/19
	116-1	NF - 1 bed	Title 18/19
	117-1	NF - 1 bed	Title 18/19
	127-1	NF - 1 bed	Title 18/19
	127-2	NF - 1 bed	Title 18/19
	129-1	NF - 1 bed	Title 18/19
	129-2	NF - 1 bed	Title 18/19

Room #	Licensure Type and # of Beds	Certification
130-1	NF - 1 bed	Title 18/19
130-2	NF - 1 bed	Title 18/19
131-1	NF - 1 bed	Title 18/19
131-2	NF - 1 bed	Title 18/19
132-1	NF - 1 bed	Title 18/19
132-2	NF - 1 bed	Title 18/19
133-1	NF - 1 bed	Title 18/19
133-2	NF - 1 bed	Title 18/19
134-1	NF - 1 bed	Title 18/19
134-2	NF - 1 bed	Title 18/19
135-1	NF - 1 bed	Title 18/19
135-2	NF - 1 bed	Title 18/19
136-1	NF - 1 bed	Title 18/19
136-2	NF - 1 bed	Title 18/19
137-1	NF - 1 bed	Title 18/19
137-2	NF - 1 bed	Title 18/19
138-1	NF - 1 bed	Title 18/19
138-2	NF - 1 bed	Title 18/19
139-1	NF - 1 bed	Title 18/19
139-2	NF - 1 bed	Title 18/19
140-1	NF - 1 bed	Title 18/19
140-2	NF - 1 bed	Title 18/19
141-1	NF - 1 bed	Title 18/19
141-2	NF - 1 bed	Title 18/19
200-1	NF - 1 bed	Title 18/19
200-2	NF - 1 bed	Title 18/19
201-1	NF - 1 bed	Title 18/19
201-2	NF - 1 bed	Title 18/19
202-1	NF - 1 bed	Title 18/19
202-2	NF - 1 bed	Title 18/19
203-1	NF - 1 bed	Title 18/19
203-2	NF - 1 bed	Title 18/19
204-1	NF - 1 bed	Title 18/19
204-2	NF - 1 bed	Title 18/19
205-1	NF - 1 bed	Title 18/19
205-2	NF - 1 bed	Title 18/19
206-1	NF - 1 bed	Title 18/19
206-2	NF - 1 bed	Title 18/19
207-1	NF - 1 bed	Title 18/19
207-2	NF - 1 bed	Title 18/19

LTC Bed Breakdown:
(How many of each type at the facility)

18 SNF	18/19 SNF	19 SNF	ICF	IMR	PC	Licensed Only
	172					

LTC Facility Bed List

Date of Survey: 08 / 11 / 15

08/29/15

	Room #	Licensure Type and # of Beds	Certification
Example1:	100	NF - 2 beds	Title 18/19
Example2:	100A	NF - 1 bed	Title 18/19
	100B	NF - 1 bed	Title 18/19
	208-1	NF - 1 bed	Title 18/19
	208-2	NF - 1 bed	Title 18/19
	209-1	NF - 1 bed	Title 18/19
	209-2	NF - 1 bed	Title 18/19
	210-1	NF - 1 bed	Title 18/19
	210-2	NF - 1 bed	Title 18/19
	211-1	NF - 1 bed	Title 18/19
	211-2	NF - 1 bed	Title 18/19
	213-1	NF - 1 bed	Title 18/19
	213-2	NF - 1 bed	Title 18/19
	214-1	NF - 1 bed	Title 18/19
	215-1	NF - 1 bed	Title 18/19
	215-2	NF - 1 bed	Title 18/19
	216-1	NF - 1 bed	Title 18/19
	217-1	NF - 1 bed	Title 18/19
	219-1	NF - 1 bed	Title 18/19
	228-1	NF - 1 bed	Title 18/19
	228-2	NF - 1 bed	Title 18/19
	229-1	NF - 1 bed	Title 18/19
	229-2	NF - 1 bed	Title 18/19
	230-1	NF - 1 bed	Title 18/19
	230-2	NF - 1 bed	Title 18/19
	231-1	NF - 1 bed	Title 18/19
	231-2	NF - 1 bed	Title 18/19
	232-1	NF - 1 bed	Title 18/19
	232-2	NF - 1 bed	Title 18/19
	233-1	NF - 1 bed	Title 18/19
	233-2	NF - 1 bed	Title 18/19
	234-1	NF - 1 bed	Title 18/19
	234-2	NF - 1 bed	Title 18/19
	235-1	NF - 1 bed	Title 18/19
	235-2	NF - 1 bed	Title 18/19
	236-1	NF - 1 bed	Title 18/19
	236-2	NF - 1 bed	Title 18/19
	237-1	NF - 1 bed	Title 18/19

Room #	Licensure Type and # of Beds	Certification
237-2	NF - 1 bed	Title 18/19
238-1	NF - 1 bed	Title 18/19
238-2	NF - 1 bed	Title 18/19
239-1	NF - 1 bed	Title 18/19
239-2	NF - 1 bed	Title 18/19
300-1	NF - 1 bed	Title 18/19
301-1	NF - 1 bed	Title 18/19
302-1	NF - 1 bed	Title 18/19
303-1	NF - 1 bed	Title 18/19
304-1	NF - 1 bed	Title 18/19
305-1	NF - 1 bed	Title 18/19
306-1	NF - 1 bed	Title 18/19
307-1	NF - 1 bed	Title 18/19
308-1	NF - 1 bed	Title 18/19
309-1	NF - 1 bed	Title 18/19
310-1	NF - 1 bed	Title 18/19
311-1	NF - 1 bed	Title 18/19
312-1	NF - 1 bed	Title 18/19
313-1	NF - 1 bed	Title 18/19
314-1	NF - 1 bed	Title 18/19
315-1	NF - 1 bed	Title 18/19
324-1	NF - 1 bed	Title 18/19
325-1	NF - 1 bed	Title 18/19
326-1	NF - 1 bed	Title 18/19
327-1	NF - 1 bed	Title 18/19
328-1	NF - 1 bed	Title 18/19
329-1	NF - 1 bed	Title 18/19
330-1	NF - 1 bed	Title 18/19
331-1	NF - 1 bed	Title 18/19
332-1	NF - 1 bed	Title 18/19
333-1	NF - 1 bed	Title 18/19
334-1	NF - 1 bed	Title 18/19
335-1	NF - 1 bed	Title 18/19
336-1	NF - 1 bed	Title 18/19
337-1	NF - 1 bed	Title 18/19
338-1	NF - 1 bed	Title 18/19
339-1	NF - 1 bed	Title 18/19
340-1	NF - 1 bed	Title 18/19
341-1	NF - 1 bed	Title 18/19
400-1	NF - 1 bed	Title 18/19

LTC Bed Breakdown:

(How many of each type at the facility)

18 SNF	18/19 SNF	19 SNF	ICF	IMR	PC	Licensed Only
	172					

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey

From: F1 03 11 15 To: F2 04 04 15
MM DD YY MM DD YY

Extended Survey

From: F3 06 28 15 To: F4 08 29 15
MM DD YY MM DD YY

Name of Facility: <u>G-GNSC Louisville Hillcreek LLC</u>		Provider Number: <u>18-5095</u>	Fiscal Year Ending: F5 <u>12</u> <u>31</u> <u>15</u> MM DD YY		
Street Address: <u>3116 Breckenridge Lane</u>		City: <u>Louisville</u>	County: <u>Jefferson</u>	State: <u>KY</u>	Zip Code: <u>40220</u>
Telephone Number: F6 <u>502-459-9120</u>		State/County Code: F7 <u>KY/18/550</u>		State/Region Code: F8 <u>KY/2C2</u>	

A. F9 03

- 01 Skilled Nursing Facility (SNF) - Medicare Participation
- 02 Nursing Facility (NF) - Medicaid Participation
- 03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes No

If yes, indicate Hospital Provider Number: F11

Ownership: F12 03

For Profit

- 01 Individual
- 02 Partnership
- 03 Corporation LLC

NonProfit

- 04 Church Related
- 05 Nonprofit Corporation
- 06 Other Nonprofit

Government

- 07 State
- 08 County
- 09 City
- 10 City/County
- 11 Hospital District
- 12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes No

Name of Multi-Facility Organization: F14

Golden Living

Dedicated Special Care Units (show number of beds for all that apply)

- | | |
|---|---|
| F15 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> AIDS | F16 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Alzheimer's Disease |
| F17 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dialysis | F18 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Disabled Children/Young Adults |
| F19 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Head Trauma | F20 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hospice |
| F21 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Huntington's Disease | F22 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ventilator/Respiratory Care |
| F23 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other Specialized Rehabilitation | |

- | | | | |
|---|-----|---|--|
| Does the facility currently have an organized residents group? | F24 | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> |
| Does the facility currently have an organized group of family members of residents? | F25 | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> |
| Does the facility conduct experimental research? | F26 | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Is the facility part of a continuing care retirement community (CCRC)? | F27 | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 Hours waived per week: F29 _____
 Waiver of 24 hr licensed nursing requirement. Date: F30 Hours waived per week: F31 _____
 MM DD YY

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes No

FACILITY STAFFING

	Tag Number	A			B			C			D		
		Services Provided			Full-Time Staff (hours)			Part-Time Staff (hours)			Contract (hours)		
		1	2	3									
Administration	F33				5	4	5		4	5			
Physician Services	F34	Y	N	N									
Medical Director	F35												26
Other Physician	F36												
Physician Extender	F37	Y	N	N									75
Nursing Services	F38	Y	N	N									
RN Director of Nurses	F39						80						
Nurses with Admin. Duties	F40				3	3	0						
Registered Nurses	F41				4	9	3		2	4	0		
Licensed Practical/ Licensed Vocational Nurses	F42												
Certified Nurse Aides	F43				2	3	50		1	4	1		
Nurse Aides in Training	F44				2	6	93		4	9	0		127
Medication Aides/Technicians	F45												
Pharmacists	F46	Y	N	N									0
Dietary Services	F47	Y	N	N									
Dietitian	F48						89						
Food Service Workers	F49				8	2	2		1	0	3		
Therapeutic Services	F50												
Occupational Therapists	F51	Y	N	N									165
Occupational Therapy Assistants	F52												332
Occupational Therapy Aides	F53												
Physical Therapists	F54	Y	N	N									205
Physical Therapists Assistants	F55												270
Physical Therapy Aides	F56												13
Speech/Language Pathologist	F57	Y											97
Therapeutic Recreation Specialist	F58	Y	N	N									
Qualified Activities Professional	F59	Y	N	N			80						
Other Activities Staff	F60	Y	N	N			111						
Qualified Social Workers	F61	Y	N	N			56						
Other Social Services	F62	Y	N	N			149						
Dentists	F63	Y	N	N									0
Podiatrists	F64	Y	N	N									0
Mental Health Services	F65	Y	N	N									0
Vocational Services	F66	Y	N	N									
Clinical Laboratory Services	F67	Y	N	N									
Diagnostic X-ray Services	F68	Y	N	N									
Administration & Storage of Blood	F69	Y	N	N									
Housekeeping Services	F70	Y	N	N			976						
Other Maintenance	F71	Y	N	N			160						

Name of Person Completing Form	Brenda Adkins, RN, ED	Time	12 pm
Signature	Mary Adkins, RN, ED	Date	8-10-15

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents		
185095	12	106	32	150		
	F75	F76	F77	F78		
ADL	Independent		Assist of One or Two Staff	Dependent		
Bathing	F79	26	F80	99	F81	25
Dressing	F82	16	F83	120	F84	14
Transferring	F85	20	F86	111	F87	19
Toilet Use	F88	15	F89	107	F90	28
Eating	F91	88	F92	55	F93	7

A. Bowel/Bladder Status

F94 15 With indwelling or external catheter

F95 Of the total number of residents with catheters, how many were present on admission 10

F96 107 Occasionally or frequently incontinent of bladder

F97 19 Occasionally or frequently incontinent of bowel

F98 5 On urinary toileting program

F99 5 On bowel toileting program

B. Mobility

F100 22 Bedfast all or most of time

F101 89 In a chair all or most of time

F102 7 Independently ambulatory

F103 32 Ambulation with assistance or assistive device

F104 0 Physically restrained

F105 Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints 0

F106 41 With contractures

F107 Of the total number of residents with contractures, how many had a contracture(s) on admission 23

C. Mental Status

F108-114 - indicate the number of residents with:

F108 2 Intellectual and/or developmental disability

F109 87 Documented signs and symptoms of depression

F110 53 Documented psychiatric diagnosis (exclude dementias and depression)

F111 48 Dementia: (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases), or Alzheimer's Disease

F112 17 Behavioral healthcare needs

F113 Of the total number of residents with behavioral healthcare needs, how many have an individualized care plan to support them 17

F114 0 Receiving health rehabilitative services for MI and/or ID/DD

D. Skin Integrity

F115-118 - indicate the number of residents with:

F115 14 Pressure ulcers (exclude Stage 1)

F116 Of the total number of residents with pressure ulcers excluding Stage 1, how many residents had pressure ulcers on admission 6

F117 34 Receiving preventive skin care

F118 0 Rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F 1 19-132 - indicate the number of residents receiving:

- ✓ F1 19 3 Hospice care
- F1 20 0 Radiation therapy
- F1 21 0 Chemotherapy
- F1 22 5 Dialysis ✓
- F1 23 1 Intravenous therapy, IV nutrition, and/or blood transfusion
- F1 24 26 Respiratory treatment
- F1 25 1 Tracheostomy care
- F1 26 5 Ostomy care

F127 0 Suctioning

F128 36 Injections (exclude vitamin B12 injections)

F129 10 Tube feedings

F130 44 Mechanically altered diets including pureed and all chopped food (not only meat)

✓ F131 53 Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.)
Exclude health rehabilitation for MI and/or ID/DD

F132 17 Assistive devices with eating

F. Medications

F133-139 - indicate the number of residents receiving:

- F133 94 Any psychoactive medication
- F134 35 Antipsychotic medications
- ✓ F135 19 Antianxiety medications
- F136 80 Antidepressant medications
- ✓ F137 5 Hypnotic medications
- F138 16 Antibiotics
- F139 91 On pain management program

G. Other

F140 12 With unplanned significant weight loss/gain

F141 1 Who do not communicate in the dominant language of the facility (include those who use American sign language)

F142 1 Who use non-oral communication devices

F143 86 With advance directives

F144 55 Received influenza immunization

F145 47 Received pneumococcal vaccine

I certify that this information is accurate to the best of my knowledge.

Signature of Person Completing the Form

Title

Date

M. M. Delinger

RN / ADNS

8/11/15

TO BE COMPLETED BY SURVEY TEAM

- F146 Was ombudsman office notified prior to survey? Yes No
- F147 Was ombudsman present during any portion of the survey? Yes No
- F148 Medication error rate 0 %

Shawna Moore RN NCII

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents
185095	10	101	32	143
	F75	F76	F77	F78
ADL	Independent	Assist of One or Two Staff	Dependent	
Bathing	F79 17	F80 94	F81 32	
Dressing	F82 14	F83 100	F84 29	
Transferring	F85 17	F86 102	F87 24	
Toilet Use	F88 19	F89 93	F90 31	
Eating	F91 75	F92 60	F93 8	

A. Bowel/Bladder Status

- F94 17 With indwelling or external catheter
- F95 Of the total number of residents with catheters, how many were present on admission 12?
- F96 98 Occasionally or frequently incontinent of bladder
- F97 66 Occasionally or frequently incontinent of bowel
- F98 5 On urinary toileting program
- F99 5 On bowel toileting program

B. Mobility

- F100 21 Bedfast all or most of time
- F101 89 In a chair all or most of time
- F102 9 Independently ambulatory
- F103 24 Ambulation with assistance or assistive device
- F104 0 Physically restrained
- F105 Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints 0?
- F106 47 With contractures
- F107 Of the total number of residents with contractures, how many had a contracture(s) on admission 25?

C. Mental Status

- F108-114 - indicate the number of residents with:
- F108 2 Intellectual and/or developmental disability
- F109 83 Documented signs and symptoms of depression
- F110 77 Documented psychiatric diagnosis (exclude dementias and depression)
- F111 48 Dementia: (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases), or Alzheimer's Disease
- F112 19 Behavioral healthcare needs
- F113 Of the total number of residents with behavioral healthcare needs, how many have an individualized care plan to support them 19?
- F114 0 Receiving health rehabilitative services for MI and/or ID/DD

D. Skin Integrity

- F115-118 - indicate the number of residents with:
- F115 13 Pressure ulcers (exclude Stage 1)
- F116 Of the total number of residents with pressure ulcers excluding Stage 1, how many residents had pressure ulcers on admission 4?
- F117 135 Receiving preventive skin care
- F118 0 Rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F119-132 – indicate the number of residents receiving:

F119 3 Hospice care

F120 0 Radiation therapy

F121 0 Chemotherapy

F122 5 Dialysis

F123 2 Intravenous therapy, IV nutrition, and/or blood transfusion

F124 28 Respiratory treatment

F125 1 Tracheostomy care

F126 4 Ostomy care

F127 1 Suctioning

F128 39 Injections (exclude vitamin B12 injections)

F129 7 Tube feedings

F130 46 Mechanically altered diets including pureed and all chopped food (not only meat)

F131 52 Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.)
Exclude health rehabilitation for MI and/or ID/DD

F132 19 Assistive devices with eating

F. Medications

F133-139 – indicate the number of residents receiving:

F133 96 Any psychoactive medication

F134 35 Antipsychotic medications

F135 18 Antianxiety medications

F136 85 Antidepressant medications

F137 3 Hypnotic medications

F138 15 Antibiotics

F139 85 On pain management program

G. Other

F140 14 With unplanned significant weight loss/gain

F141 3 Who do not communicate in the dominant language of the facility (include those who use American sign language)

F142 1 Who use non-oral communication devices

F143 92 With advance directives

F144 53 Received influenza immunization

F145 50 Received pneumococcal vaccine

I certify that this information is accurate to the best of my knowledge.

Signature of Person Completing the Form

Title

Date

Michelle Meriwether

RD/ADNS

8/26/15

TO BE COMPLETED BY SURVEY TEAM

F146 Was ombudsman office notified prior to survey?

Yes

No

F147 Was ombudsman present during any portion of the survey?

Yes

No

F148 Medication error rate 4 %

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No. <u>1250511</u> <u>185095</u>	Medicare <u>4</u>	Medicaid <u>104</u>	Other <u>20</u>	Total Residents <u>128</u>
	F75	F76	F77	F78
ADL	Independent	Assist of One or Two Staff		Dependent
Bathing	F79 <u>5</u>	F80 <u>71</u>	F81 <u>52</u>	
Dressing	F82 <u>8</u>	F83 <u>11a</u>	F84 <u>8</u>	
Transferring	F85 <u>11</u>	F86 <u>103</u>	F87 <u>14</u>	
Toilet Use	F88 <u>13</u>	F89 <u>95</u>	F90 <u>20</u>	
Eating	F91 <u>59</u>	F92 <u>61</u>	F93 <u>8</u>	

A. Bowel/Bladder Status

- F94 14 With indwelling or external catheter
- F95 Of the total number of residents with catheters, how many were present on admission 2
- F96 86 Occasionally or frequently incontinent of bladder
- F97 53 Occasionally or frequently incontinent of bowel
- F98 5 On urinary toileting program
- F99 5 On bowel toileting program

B. Mobility

- F100 19 Bedfast all or most of time
- F101 61 In a chair all or most of time
- F102 7 Independently ambulatory
- F103 42 Ambulation with assistance or assistive device
- F104 0 Physically restrained
- F105 Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints 0
- F106 57 With contractures
- F107 Of the total number of residents with contractures, how many had a contracture(s) on admission 38

C. Mental Status

- F108-114 - indicate the number of residents with:
- F108 1 Intellectual and/or developmental disability
- F109 79 Documented signs and symptoms of depression
- F110 79 Documented psychiatric diagnosis (exclude dementias and depression)
- F111 42 Dementia: (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases), or Alzheimer's Disease
- F112 15 Behavioral healthcare needs
- F113 Of the total number of residents with behavioral healthcare needs, how many have an individualized care plan to support them 15
- F114 0 Receiving health rehabilitative services for MI and/or ID/DD

D. Skin Integrity

- F115-118 - indicate the number of residents with:
- F115 9 Pressure ulcers (exclude Stage 1)
- F116 Of the total number of residents with pressure ulcers excluding Stage 1, how many residents had pressure ulcers on admission 9
- F117 20 Receiving preventive skin care
- F118 0 Rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F119-132 - indicate the number of residents receiving:

F119 3 Hospice care

F120 0 Radiation therapy

F121 0 Chemotherapy

F122 0 Dialysis

F123 1 Intravenous therapy, IV nutrition, and/or blood transfusion

F124 29 Respiratory treatment

F125 0 Tracheostomy care

F126 3 Ostomy care

F127 0 Suctioning

F128 30 Injections (exclude vitamin B12 injections)

F129 4 Tube feedings

F130 35 Mechanically altered diets including pureed and all chopped food (not only meat)

F131 58 Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.)
Exclude health rehabilitation for MI and/or ID/DD

F132 17 Assistive devices with eating

F. Medications

F133-139 - indicate the number of residents receiving:

F133 87 Any psychoactive medication

F134 28 Antipsychotic medications

F135 21 Antianxiety medications

F136 78 Antidepressant medications

F137 3 Hypnotic medications

F138 9 Antibiotics

F139 91 On pain management program

G. Other

F140 14 With unplanned significant weight loss/gain

F141 1 Who do not communicate in the dominant language of the facility (include those who use American sign language)

F142 1 Who use non-oral communication devices

F143 79 With advance directives

F144 67 Received influenza immunization

F145 47 Received pneumococcal vaccine

I certify that this information is accurate to the best of my knowledge.

Signature of Person Completing the Form

Title

Date

Michelle Meriwether

PN / DNS

11/12/15

TO BE COMPLETED BY SURVEY TEAM

F146 Was ombudsman office notified prior to survey? Yes No

F147 Was ombudsman present during any portion of the survey? Yes No

F148 Medication error rate N/A %

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

PRINTED: 11/16/2015
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 R 11/13/2015
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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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(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
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{F 000}	<p>INITIAL COMMENTS</p> <p>An On-Site Revisit Survey was initiated on 11/12/15 and concluded on 11/13/15. The facility was found to be in compliance as of 09/30/15 as alleged in their Plan of Correction.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) 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	(Y3) Date of Revisit 11/13/2015
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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 <u>F0241</u> Reg. # <u>483.15(a)</u> LSC _____	Correction Completed <u>09/30/2015</u>	ID Prefix <u>F0253</u> Reg. # <u>483.15(h)(2)</u> LSC _____	Correction Completed <u>09/30/2015</u>	ID Prefix <u>F0276</u> Reg. # <u>483.20(c)</u> LSC _____	Correction Completed <u>09/30/2015</u>
ID Prefix <u>F0280</u> Reg. # <u>483.20(d)(3), 483.10(k)(2)</u> LSC _____	Correction Completed <u>09/30/2015</u>	ID Prefix <u>F0281</u> Reg. # <u>483.20(k)(3)(I)</u> LSC _____	Correction Completed <u>09/30/2015</u>	ID Prefix <u>F0282</u> Reg. # <u>483.20(k)(3)(II)</u> LSC _____	Correction Completed <u>09/30/2015</u>
ID Prefix <u>F0314</u> Reg. # <u>483.25(c)</u> LSC _____	Correction Completed <u>09/30/2015</u>	ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____	Correction Completed <u>09/30/2015</u>	ID Prefix <u>F0371</u> Reg. # <u>483.35(i)</u> LSC _____	Correction Completed <u>09/30/2015</u>
ID Prefix <u>F0431</u> Reg. # <u>483.60(b), (d), (e)</u> LSC _____	Correction Completed <u>09/30/2015</u>	ID Prefix <u>F0441</u> Reg. # <u>483.65</u> LSC _____	Correction Completed <u>09/30/2015</u>	ID Prefix <u>F0514</u> Reg. # <u>483.75(I)(1)</u> LSC _____	Correction Completed <u>09/30/2015</u>
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>MZ</u>	Reviewed By <u>VJ</u>	Date: <u>11/16/15</u>	Signature of Surveyor: <u>[Signature]</u>	Date: <u>11/16/15</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>8/29/2015</u>	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
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

OCT - 1 2015

OFFICE OF INSPECTOR GENERAL

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 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
F 000	<p>INITIAL COMMENTS</p> <p>Amended 09/16/15</p> <p>A Recertification Survey was initiated on 08/11/15 and concluded on 08/14/15. The facility was found not meeting the minimum requirements for recertification with deficiencies cited at the highest scope and severity of an "F".</p> <p>In addition, an Abbreviated Survey was initiated on 08/11/15 and concluded on 08/14/15 to investigate complaint KY23660. The Division of Health Care unsubstantiated the allegation with no deficiencies cited.</p> <p>Upon Supervisory review the survey was reopened on 08/21/15 with Immediate Jeopardy identified on 08/21/15 and determined to exist on 07/17/15 at 42 CFR 483.20 Resident Assessment (F281); 42 CFR 483.25 Quality of Care (F323); and, 42 CFR 483.75 Administration (F514) at a scope and severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 08/21/15. An Extended Survey was conducted on 08/27/15 and concluded on 08/29/15.</p> <p>On 07/17/15 the facility staff transported Resident #26 in a facility van from another nursing home. The staff failed to secure the resident via all available safety restraints. 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</p>	F 000		

revised

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
X Nancy Adams W EP

TITLE
X Exe. Dir. X 9-30-15

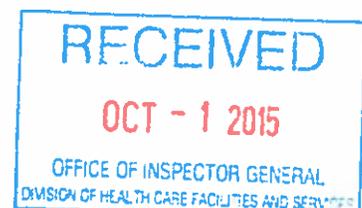
(X6) DATE

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: 09/18/2015
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
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 1 from complications. The facility failed to complete a Situation Background Assessment Recommendation (SBAR) form for Resident #26 until the resident was sent to the hospital. The facility also failed to document the fall on the twenty-four hour report; therefore, nursing staff was not all aware of the fall or the details related to the fall the resident sustained.	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 241 SS=D	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 483.20 Resident Assessment (F281), 42 CFR 483.25 Quality of Care (F323) and 42 CFR 483.75 Administration (F514) 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. Additional deficiencies were cited during the Recertification/Abbreviated Survey with the highest scope and severity of a "F". 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241			
	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review				



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/29/2015
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	
F 241	Continued From page 2 and facility policy review, it was determined the facility failed to ensure staff provided care in a manner that maintained dignity for two (2) of twenty-six (26) residents, and one (1) of seven (7) unsampled residents, (Resident #4 and #6 and Unsampled Resident A) Observation revealed the residents' bodies were exposed during the provision of care. The findings include: Review of the Resident Rights Policy, revised March 2010, revealed each resident should be treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment. 1. Resident #6 was admitted on 07/22/15 with a diagnosis of Cerebrovascular Disease, Hypothyroidism, Metabolic Encephalopathy and Chronic Heart Failure. Review of Resident #6's Admission Minimum Data Set (MDS) Assessment, dated 07/22/15, revealed Resident #6 had a BIMS score of ninety-nine (99) which meant the resident was not interviewable. Observation of Resident #6's Gastrostomy tube (G-tube) care, on 08/03/15 at 11:09 AM, revealed Resident #6's window blinds were open when Registered Nurse (RN) #4 exposed Resident #6's breasts to clean Resident #6's G-tube site. Interview with RN #4, on 08/13/15 at 11:25 AM, revealed she should have closed Resident #6's blinds. RN #4 stated some of the visitors park in the back parking lot and this could allow viewing into the room and cause embarrassment for the	F 241	F 241 1. Resident # 6 blinds are now being closed when care is provided by nursing staff. Un sampled resident A door is now being shut when care is provided by nursing staff. Resident #4 privacy curtain is now being pulled when care is provided by nursing staff. 2. All residents that have care provided have the potential to be affected. Random rounds were completed on 09/22/15 by the ADON and no other residents were found to be affected by this deficient practice. 3. An in service was held on 09/15/15 - 09/17/15 for all nursing staff on resident's dignity and providing privacy with all treatments/care. The IDT team including the Executive Director (ED), Unit Managers (UM), Staffing Coordinator, Assistant Director of Nursing (ADON) conducted this in-service. 4. The UM will make rounds weekly for 4 weeks to check that dignity and privacy is being provided during resident care, then monthly thereafter for 4 months. These audits will be documented on a check sheet. The check sheet will be reviewed by the ED and DON weekly and then monthly. The UM will report their 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.	09/30/15	



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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

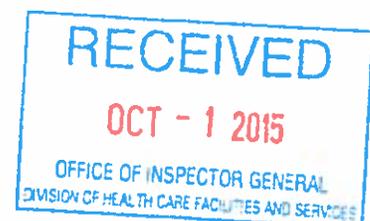
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/29/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	Continued From page 3 resident. Interview with the Assistant Director of Nursing (ADON), on 08/14/15 at 4:30 PM, revealed keeping a resident's window blinds open could be a dignity concern. The ADON stated it could make the resident feel embarrassed or ashamed.	F 241			
	2. Observation, on 08/12/13 at 8:35-AM, during the morning medication pass on the 200 Hallway, revealed Licensed Practical Nurse (LPN #14) entered Unsampld Resident A's room to administer the resident's dose of insulin. Unsampld Resident A was in Bed-1 closest to the door that opened into the hallway. The nurse did not close the resident's door and after verifying the correct resident and medication dosage, she asked Unsampld Resident A to lift his/her shirt, exposing his/her abdomen, and administered the sub cutaneous injection without first closing the resident's door to provide privacy. 3. Observation on 08/12/13 at 8:35 AM, during the medication observation, revealed Resident #4, was reclining in bed and was receiving morning care provided by Certified Nursing Assistant (CNA) #10. Resident #4's abdomen/chest was partially exposed and his/her legs were partially uncovered. The CNA did not pull Resident #4's privacy curtain when LPN #14 and the Surveyors entered the room to observe the insulin injection for Unsampld Resident A. Review of the facility's BIMS list, not dated, revealed the facility assessed the resident with a score of 15, meaning the resident was interviewable. Interview, on 08/13/15 at 8:16 AM with CNA #10,				



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

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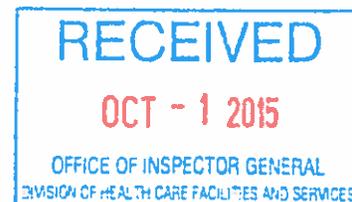
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/29/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 241	Continued From page 4 revealed she typically assisted Resident #4 with morning care which included bathing, oral care, shaving, catheter and colostomy care. CNA #10 stated when the surveyors and the licensed nurse entered the room, she was washing the resident's face, and was to apply his/her deodorant, cleanse his/her hands and provide perineal and colostomy care. CNA #10 stated she had pulled Resident #4's privacy curtain when she began providing the care, but she stated Resident #4's roommate, Un-Sampled Resident A, had pulled the curtain back as he/she was returning from the restroom. CNA #10 stated it was important to ensure that Resident #4's privacy and maintain his/her dignity. CNA #10 stated Resident #4 was a very private person, and did not like people to see his/her colostomy. Interview, on 08/14/15 at 4:25 PM with the ADON, revealed staff should ensure the privacy of residents when providing care and this should be done by pulling the privacy curtain between residents' beds in double rooms and closing entry doors from the hallway. The ADON stated exposing a resident's abdomen when providing an injection, and not closing the entry door from the hallway, could be a dignity issue for the resident.	F 241			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by:	F 253			



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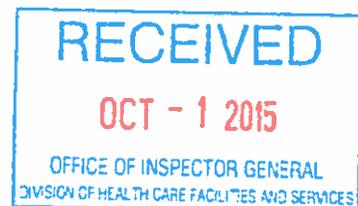
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F 253	Continued From page 5 Based on observation and interview, it was determined the facility failed to ensure the environment was maintained in good repair for three (3) of four (4) nursing units. The 100 Unit had multiple rooms with paint chipped off the door frames, and paper towel dispensers were found empty. The 200 Unit had splintered wood on the fire doors and paper towel dispensers were empty. The 300 Unit had two (2) soap dispensers that were empty. The findings include: Interview with the Resident Council, on 08/11/15 at 3:00 PM, revealed three (3) of fifteen (15) residents who attended the group meeting voiced the facility never had soap and would have to utilize their own. 1. Observation of the 100 Unit, on 08/12/15 at 9:18 AM, revealed in room 333, when the nurse attempted to wash their hands, the soap dispenser was empty. Licensed Practical Nurse (LPN) #7 had to leave the room and get a portable bottle of hand soap. Observation, of the on 08/13/15 at 8:56 AM, during the morning medication pass on the 100 Unit, revealed the paper towel dispenser in Resident Room 103 was empty and the licensed nurse had to cross the hall to Resident Room 102 to obtain a paper towel for drying her hands. Observation, on 08/13/15 at 9:10 AM, during the morning medication pass on the 100 Unit, revealed the paper towel dispenser in Resident Room 127 was empty, and the licensed nurse obtained facial tissues from the resident in Bed-2 for drying her hands after washing them at the	F 253	F253 1. Resident room #333 soap dispenser filled on 08/19/15 by housekeeping staff (hsk). Paper towel dispensers in resident rooms # 103, 127, 105, 106 and 209 all filled immediately on 08/14/15. All the resident door frames on 100 have been painted by an outside contract painter on 08/20/15. The 200 unit fire door was repaired on 08/13/15 by the maintenance director. 2. All residents' rooms and facility areas have the potential to be affected by this deficient practice. The whole facility was checked on 08/14/15 by the housekeeping manager for empty soap and towel dispensers and checked by the maintenance director for any chipped resident door frames and no other rooms were found to have been affected. 3. The Housekeeping daily schedule was reviewed by the Director of Housekeeping (DOH) and revised on 09/17/15. The DOH in-serviced the housekeeping staff on 09/23/15 on keeping the soap and paper towel dispensers full. The IDT team in serviced the nursing staff on 09/15/15 - 09/17/15 on putting any needed repairs or painting of doors in our computer maintenance work order system (building engines). Reporting any maintenance needs immediately by placing the concern/item to be fixed in the Building Engines System will ensure notification timely to the maintenance director or assistant. Then the maintenance director or assistant will then fix the items timely that are reported timely. 4. The ED will monitor the building engines system weekly for 4 weeks, then monthly times 4 months to ensure that the repairs are fixed timely. The findings will be reported in QAPI monthly by the ED for 5 months.	09/30/15	



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F 253	<p>Continued From page 6 room's sink.</p> <p>Observation, on 08/14/15 at 9:35 AM, on the 100 Unit, revealed the paper towel dispensers in Resident Rooms 105 and 106 were empty.</p> <p>2. Observation on the 200 Unit, on 08/14/15 at 10:00 AM, revealed the paper towel dispenser was empty in Resident Room 209, and Unit Manager for the 200 Unit had to obtain a package of paper towels to fill the dispenser prior to the licensed nurse (LPN #4) beginning the wound care/dressing change for Resident #4.</p> <p>Interview, on 08/14/15 at 9:40 AM, with Housekeeper #11 revealed he normally performed housekeeping duties on the 100 Halfway of the facility, and that it was his responsibility to ensure paper towels were available for use in each of the resident's rooms. Housekeeper #11 stated he normally began the daily cleaning of the resident's rooms about 9:30 AM after the breakfast trays had been picked up. Housekeeper #11 stated when he cleaned each resident room sink, he would make sure the paper towel dispensers were refilled, if needed. Housekeeper #11 stated he returned to the unit later in his shift (usually after lunch) to re-clean the bathrooms as needed, and refill the paper towel dispensers.</p> <p>3. Observation of the 100 Unit, on 08/13/15 at 8:25 AM, revealed twelve (12) rooms from 127-140 had door frames with paint chipped off. The door frames were painted brownish in color, but with the paint chips, the color underneath was white. Room 134 had the most paint chipped off. At least half of the door frame on each side was</p>	F 253	<p>DOH will randomly select 4 resident rooms, one on each unit, per week for 4 weeks checking for empty soap or paper towel dispensers, then monthly for 4 months. The ED and DOH will report their 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 253	Continued From page 7 chipped off. 4. Observation of the 200 Unit, on 08/13/15 at 8:45 AM, revealed the fire door had an area of wood chipped off causing jagged edges and splintering, just above the lower third hinge. Interview, on 08/13/15 at 2:32 PM, with the Housekeeping Supervisor, revealed he did audits weekly of privacy curtains, and dispensers, but had no documentation of those audits. He stated the soap dispensers on the 300 Unit lasted a lot longer than the others and the housekeepers must have just missed it. In regards to the empty paper towel dispensers, he stated the 100 Unit had the smaller dispensers so they run out faster. He stated he had on order for the new ones, but was waiting on the approval. Interview, on 08/13/15 at 2:32 PM, with the Maintenance Director revealed he had a contract person who came in about twenty (20) hours a month to do painting. He stated he went hallway by hallway and he just had not got back to the 100 unit yet. He stated it may seem like a lot of time to paint but is wasn't. The Administrator at this time stated she would get approval for ten (10) hours a week for painting.	F 253			
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced	F 276			



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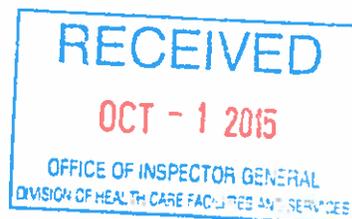
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F 276	Continued From page 8 by: Based on interview, record review, and review of the Resident Assessment Instrument Manual, it was determined the facility failed to complete a Quarterly Minimum Data Set (MDS) Assessment within ninety-two (92) days of the Assessment Reference Date (ARD) of the most recent clinical assessment for one (1) of twenty-six (26) sampled residents, (Resident #15).	F 276	F 276 1. Resident # 15 had a quarterly MDS completed on 05/20/15 which was late. His next quarterly assessment was completed timely on 07/16/15. His next assessment is already scheduled timely for 10/16/15. 2. All residents have the potential to be effected by this deficient practice. A audit was conducted of all residents MDS's on 08/20/15 and 08/21/15 by the MDS RN and no other residents were found to have had any MDS assessments missed. 3. The new MDS nurse was in serviced by the MDS RN Director of resident assessment on 09/29/15 on timely quarterly assessments. Now MDS RN's review each individual's ARD/MDS calendar once a month to ensure no MDS is missed. 4. The MDS RN's will complete a monthly audit of all residents X 5 months to ensure that all residents have their MDS completed on the correct schedule. The MDS RN will report these findings of the audits 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.	09/30/15	
	The findings include: Review of the Resident Assessment Instrument Users Manual Version 3.0, Chapter 2-30, revealed the quarterly assessment was an Omnibus Budget Reconciliation Act (OBRA) non-comprehensive assessment for a resident that must be completed at least every ninety-two (92) days following the previous OBRA assessment of any type. It's used to track a residents status between comprehensive assessments to ensure critical indicators of gradual change in a residents status is monitored. Review of the medical record for Resident #15, revealed the facility admitted the resident on 12/31/14 with diagnoses including, Flight Below the Knee Amputation, Diabetes Mellitis, Hypertension, and End Stage Renal Disease, Dialysis Dependent. The facility completed an admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date of 01/07/15. The facility did not complete the quarterly assessment until 05/20/15; however, it should have been completed no later than 04/03/15. Interview, on 08/14/15 at 12:35 PM, with Minimum Data Set (MDS) Registered Nurse, (RN) Coordinator #1, revealed she had been				



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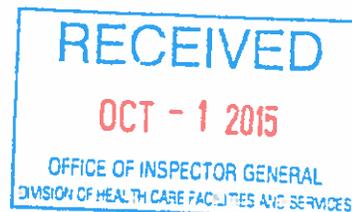
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F 276	Continued From page 9 doing MDS Assessments for the facility since 2013. She stated the previous coordinator who managed the 300 Unit had recently resigned and there was a new staff person being trained. She stated she could not give an explanation of why the Assessment was late for Resident #15. Interview, on 08/14/15 at 4:30 PM, with the Assistant Director of Nursing revealed she was not very familiar with the MDS process. She stated the purpose of the assessment was to ensure residents were assessed as required and a care plan was developed to identify care needs of the resident. She stated the Director of Nursing was responsible to oversee the assessments and care plan process to ensure work was completed in a timely manor.	F 276		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		



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F 280	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility policy, it was determined the facility failed to ensure residents were invited and attended their care plan meeting and/or care plans were reviewed and revised for four (4) of twenty-six (26) sampled residents. The facility failed to ensure Residents #5, #6, #7, and #15 were invited to their care plan meetings. In addition, the facility failed to revise the care plan and Certified Nursing Assistant (CNA) care card related to Prevalon boots for Resident #6. The findings include: The facility did not provide a policy and procedure for care plan revision or care plan meeting notifications. Review of the facility policy regarding Medical Record Documentation 02/26/15, revealed the resident/legal representative will be notified prior to each interdisciplinary care plan meeting, encouraged to attend, and solicit their input. Name of participants and their responses will be recorded. 1. Review of the medical record for Resident #15, revealed the facility admitted the resident on 12/31/14 with Diagnoses including Right Below the Knee Amputation, Diabetes Mellitus, Hypertension, and End Stage Renal Disease	F 280	F280 1. Residents #5, 7 and 15 will now be invited to their next care plan (CP) meeting by the MDS RN's. Resident # 6 has been discharged (D/C'd). Two of these meetings have already been conducted and the other has been scheduled. Resident #6 CP and cna care card was revised on 08/14/15 by the MDS RN and the UM to reflect the order for prevalon boots; now resident has been D/C'd. 2. All residents have the potential to be affected by this deficient practice. All residents were reviewed by the MDS coordinators on 08/13/15. All residents were found to have no documentation of being asked to their CP meeting. They now will be asked to attend and this will be documented. All CP's were reviewed by the MDS RN's on 08/14/15 and 09/15/15 for accurate interventions to be in place. No other errors were found. All cna care records were reviewed by the unit managers on 08/13/15 and no other errors were found. 3. All resident's responsible party's will have an invitation sent to them by the MDS RNs and a copy will be given to the resident. Copies of the letters, as well as a sign in sheet will be placed in a binder for easy review. All resident's daily new orders will be reviewed in the daily morning clinical meeting by the IDT team. The MDS coordinators will update the CP daily with any changes to reflect an accurate CP. The UM's will update the cna care records daily with any changes to reflect an accurate care record for the cna's use.	09/30/15	



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F 280	<p>Continued From page 11 (ESRD), Dialysis Dependent. Review of the Admission Minimum Data Set (MDS) Assessment, dated 01/07/15, revealed the facility assessed the residents cognition using the Basic Interview for Mental Status (BIMS) with a score fifteen (15) which meant the resident was cognitively intact and interviewable. Review of the most recent Quarterly MDS Assessment, dated 07/16/15, revealed the facility assessed the resident's cognition with a BIMS score of fifteen (15) meaning cognitively intact and interviewable.</p> <p>Review of the Comprehensive Care Plan for Resident #15, revealed the facility developed a care plan on 06/11/15 related to impaired communication secondary to short term memory impairment as indicated by the resident repeatedly asking the same questions despite answers given.</p> <p>Review of the Resident Care Conference Signature Sheet for Resident #15 revealed the facility documented one (1) care conference meeting dated Friday, 05/26/15. The facility indicated the resident and family were invited but did not attend.</p> <p>Interview, on 08/11/15 at 5:05 PM, with Resident #15 revealed the the facility admitted the resident in January 2015. The resident stated he/she was upset because he/she came to the facility for rehabilitation; however, the resident only received therapy in January and February. The resident stated at the beginning of March they just stopped coming. The resident stated nobody told him/her why, but they told him/her they would schedule a care plan meeting to discuss the situation, but that never happened. The resident stated he/she did not get anymore therapy until</p>	F 280	<p>4. The ADON will check monthly for 5 months that the residents have been invited to their care plan meetings. She will review the scheduled meetings compared to the copies of the invitations in the binder. The ADON will report the findings to QAPI committee monthly for 5 months. The UM will randomly select 4 residents per week for 4 weeks to audit the CP compared to the orders for accuracy and the cna care record for accuracy. Then monthly for 4 months. 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 280	<p>Continued From page 12</p> <p>June 2015, after the left leg was amputated. The resident stated they had not attended a care conference since admission and it was very frustrating because he/she did not know what was going on. He/She stated everyone was telling him/her a different story about why therapy was discontinued. The resident stated he/she went to Dialysis on Mondays, Wednesdays, and Fridays, and had even changed his/her pickup time for dialysis to attend therapy sessions.</p> <p>2. Review of the medical record for Resident #5, revealed the facility admitted the resident on 07/09/15 with Diagnoses including Urinary Tract Infection, Constipation, History of Cerebral Vascular Accident (CVA) with Hemiplegia, Deformed Right foot and Pressure Ulcer. Review of the Admission MDS Assessment dated 07/26/15, revealed the facility assessed the resident cognition with a BIMS score of fourteen (14), cognitively intact. There was no Care Conference Signature sheet for Resident #5.</p> <p>Interview, on 08/12/15 at 10:05 AM, with Resident #5 revealed he/she had not been invited to a care plan meeting and did not know if there had been a meeting regarding his/her care and medical treatment.</p> <p>Interview, on 08/13/15 at 11:10 AM, with MDS Nurse #2 revealed she was still in training and had been doing MDS since March 2015. She stated she was tentatively responsible for the 200 and 300 units assessments and care plans. She stated the previous MDS nurse, who resigned, had made the care plan meeting calendar until June 2015. She stated the process for care plan meetings were to schedule the meeting, and send an invitation letter to the resident's contact</p>	F 280			



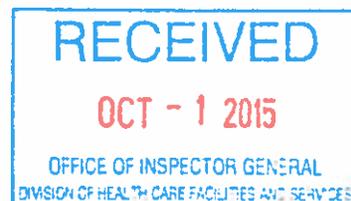
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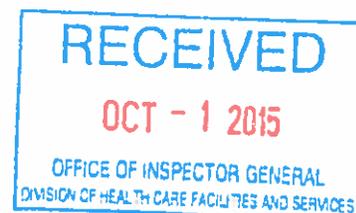
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F 280	<p>Continued From page 13</p> <p>person. She stated the meeting then took place in the office or conference room if family attended and afterwards some of the staff would visit the resident in their room. She stated the residents were not notified or invited prior to the meeting. In addition, she stated residents on the rehab units, (300 unit) had a seventy-two (72) hour meeting. This meeting was held within three (3) days of admission and was considered a care plan meeting. She stated the Discharge Planner, Dietician, Rehabilitation Manager, and Social Services staff attended the meeting. She stated MDS nurses did not attend the seventy-two hour meeting. She stated there was no sign in sheet for this meeting.</p> <p>Interview, on 08/14/15 at 12:35 PM, with MDS Nurse #1 revealed she was now the MDS Coordinator. She stated she had been trained by the former director about care conferences. She stated residents on the rehabilitation units (300, and 400), were "managed" differently than long term care residents. She stated Licensed Practical Nurse (LPN) #8, who was the discharge planner on the 300 unit, utilized a computer program that developed Care Management Strategies. She stated this was the information presented in the seventy-two (72) hour meeting. This program included an Initial Care Management Meeting note. She stated this information was not based on the Admission MDS Assessment, and the MDS nurses did not attend this meeting. She stated once the resident approached ninety (90) days, the Quarterly MDS was completed and care plan was revised. She stated they sent letters out a month in advance to family members but did not know the resident was to be notified in advance of the care plan meeting. She stated she had no idea about the</p>	F 280		



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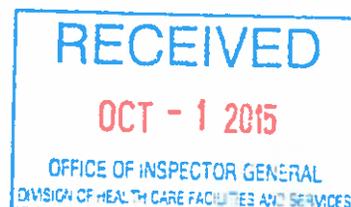
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 280	<p>Continued From page 14 situation with Resident #15.</p> <p>Interview, on 08/14/15 at 1:35 PM, with LPN # 8 revealed the seventy-two (72) hour meeting was a meeting set up with Therapy, Dietician, Social Services, Nurses and the Discharge Planner to discuss goals and future plan and how long the anticipated stay was for residents. She stated this had nothing to do with the regulatory requirements for MDS assessments and care plan.</p> <p>3. Review of the clinical record for Resident #7 revealed he/she was admitted to the facility 10/10/14 with diagnoses of General Muscle Weakness, Congestive Heart Failure, Anemia, Bi-Polar Disorder, Depression, Unspecified Essential Hypertension, Chronic Airway Obstruction, Esophageal Reflux Disease, Chronic Kidney Disease, and Insomnia.</p> <p>Review of Resident #7's most recent Quarterly MDS Assessment, dated 07/07/15, revealed the resident scored 15 (the highest possible rating) on the Basic Interview for Mental Status (BIMS). The facility initiated a care plan for the resident on 10/14/14 with revisions on 11/10/14, 12/16/14, 05/18/15, 05/29/15, 06/12/15, and 08/11/15.</p> <p>Interview, on 08/11/15 at 3:00 PM, with Resident #7 revealed since the resident's admission to the facility, he/she had not received a verbal or written invitation to his/her care plan meetings.</p> <p>Review, of the Resident Care Conference Signature Sheet for Resident #7, revealed a resident care conference was held on 04/28/15 the last meeting, but there was no verification provided by the facility that an invitation was</p>	F 280			



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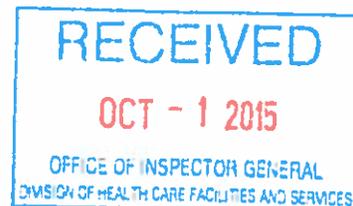
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F 280	<p>Continued From page 15 Issued to the resident prior to the meeting.</p> <p>Interview, on 08/14/15 at 4:30 PM, with the Assistant Director of Nursing revealed she nor the Director of Nursing attended resident care plan meetings. She stated the residents should be invited to their care plan meetings. She stated it was important they attend so they could have input and make recommendations. Also, if there was something they didn't agree with they could tell someone in the meeting. She stated she had not received any complaint from residents regarding not attending or being invited to care plan meetings.</p> <p>4. Review of the clinical record for Resident #6 revealed the facility admitted the resident on 07/22/15 with diagnoses of Cerebrovascular Disease, Encephalopathy and Pressure.</p> <p>Review of Resident #6's Admission Minimum Data Set (MDS) Assessment, dated 07/22/15, revealed Resident #6 had a BIMS score of ninety-nine (99) which meant the resident was not interviewable. Resident #6 was triggered for one (1) pressure sore at a Stage II.</p> <p>Review of Resident #6's Physician Orders, dated 07/24/15 at 10:33 AM, revealed an order for a Prevalon boot to left heel at all times every shift. Review of Resident #6's Physician Orders, dated 07/24/15 at 2:49 PM, revealed an order for a Prevalon boot to right heel at all times every shift.</p> <p>Observation of Resident #6, on 08/11/15 at 2:30 PM, revealed Resident #6 sitting up in wheelchair with blue non skid socks on. Prevalon boots were located on Resident #6's bed and not applies to the resident.</p>	F 280			



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F 280	Continued From page 16 Observation of Resident #6, on 08/12/15 at 11:04 AM, revealed the Resident sitting up in his/her wheelchair. Prevalon boots were not applied to Resident #6's feet resting on a foot board. Review of Resident #6's Comprehensive Care Plan with a focus on pressure, initiated 07/24/15, revealed the care plan was not revised with addition of the Prevalon boots to be placed on both of the resident's feet at all times. Review of Resident #6's Certified Nursing Assistant (CNA) Care Card, no date provided, revealed the care card was not revised with the addition of the Prevalon boots to be placed on both of the residents feet at all times. Interview with CNA #9, on 08/13/15 at 10:45 AM, revealed the CNA Care Card had no information relating to the Prevalon boots needing to be on at all times. CNA #9 stated the nurse told her Resident #6 was to have the Prevalon boots on only while in bed. Interview with the Unit Manager of the Rehab Unit, on 08/13/15 at 10:36 AM, revealed Resident #6 was suppose to have his/her boots on at all times. The Unit Manager stated she updated the CNA Care Cards and reviewed the CNA Care Cards daily. The Unit Manager stated the Comprehensive Care Plans were updated by the nurses on the unit and the Minimum Data Set (MDS) Coordinator. The Unit Manager stated when the nurses obtained new orders they were suppose to update the Comprehensive Care Plan. There was also a morning meeting in which the team updated the Comprehensive Care Plans as well. The Unit Manager stated the Prevalon	F 280			



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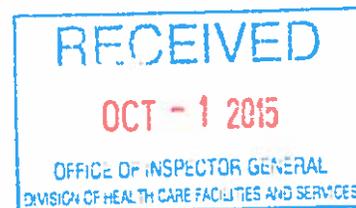
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F 280	Continued From page 17 boots were ordered to prevent the wound from getting worse. The Care Plans should have been updated. Interview with the Assistant Director of Nursing (DON), on 08/14/15 at 4:30 PM, revealed the Unit Managers updated the CNA Care Cards. The MDS Coordinator updated the Nursing Care Plans during the clinical meeting. The ADON stated if Resident #6 did not have his/her boots on the wound could become worse.	F 280			
F 281 SS=J	483.20(k)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. 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 have an effective system in place to ensure the staff utilized preadmission information to ensure assessment and planning to meet the special needs of one (1) of twenty-six (26) sampled residents, (Resident #26) upon admission to the facility. The facility admitted Resident #26 with diagnoses of Spinal Bifida and Hydrocephalus with a shunt. The facility failed to have a plan was in place to monitor the shunt, and monitor for signs or symptoms of injury after the resident sustained a fall in the van during transport to the facility. On 07/17/15, Resident #26 sustained a subdural hematoma during a facility transfer from another nursing home. The transporting staff failed to	F 281			



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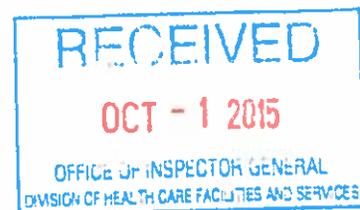
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F 281	<p>Continued From page 18</p> <p>ensure the resident was secured in the van to prevent the resident's scooter from tipping over during a cornering maneuver. After arrival to the facility there was no plan in place to direct the staff in how to monitor the shunt, or monitor for signs or symptoms of potential injury. Interviews with staff revealed the Licensed Practical Nurses should have known about the incident and the shunt to be able to monitor and the MDS Coordinator should have known about the shunt to produce an effective interim care plan for the staff.</p> <p>The facility's failure to have an effective system in place to ensure staff was provided a plan of care to direct the care of a resident upon admission with special needs has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy and Substandard Quality of Care was identified on 08/21/15 and determined to exist on 07/17/15.</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 483.20 Resident Assessment (F281) 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>Interview with the Minimum Data Set (MDS) Coordinator, on 08/21/15 at 1:47 PM, revealed</p>	F 281	<p>F 281</p> <p>1.</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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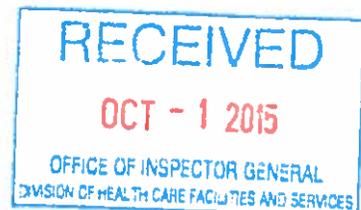
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F 281	<p>Continued From page 19</p> <p>the facility did not have a policy on communicating preadmission information with staff prior to admission. She stated the facility followed the Resident Assessment Instrument (RAI) MDS 3.0 for the care planning process.</p> <p>Review of the RAI MDS Manual, Chapter 4, page 4-7, revealed each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Services provided or arranged by the nursing home must also meet professional standards of quality. Therefore, the facility was responsible for assessing and addressing all care issues that were relevant to individual residents, regardless of whether or not they were covered by the RAI, including monitoring each resident's condition and responding with appropriate interventions. However, the process of completing the MDS and related portions of the RAI did not constitute the entire assessment that may be needed to address issues and manage the care of individual residents.</p> <p>Review of Resident #26's record, revealed the facility admitted the resident on 07/17/15 with diagnoses of Spinal Bifida, and Hydrocephalus with a shunt.</p> <p>Interview with the Director of Admission, on 08/21/15 at 12:40 PM, revealed normally if a resident was being transferred from a nursing home, the nursing home would call with the referral, she gathered all of the clinical observations from the chart, history and physical, face sheet, discharge summary, medication sheets, therapy sheets, nursing notes and Social Services notes. Then fax the information to the</p>	F 281	<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.</p> <p>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.</p> <p>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>		



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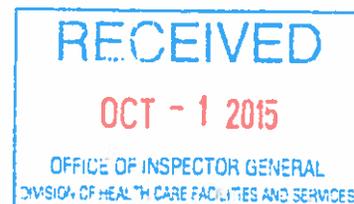
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F 281	<p>Continued From page 20</p> <p>Assistant Director of Nursing (ADON) or Director of Nursing (DON) to review clinical information to see if the facility could meet the needs of the resident.</p> <p>Further interview with the Director of Admission on 08/21/15 at 12:40 PM, revealed the facility normally did not transport residents. The discharging facility would normally provide the transportation. However, the Director of Admission stated Resident #26's admission was not a routine nursing home transfer. She stated the process was rushed, trying to get the residents out of the other facility during a specific time frame, and she was not involved in that transportation process.</p> <p>Interview with the Administrator, on 08/21/15 at 4:37 PM, revealed she was the one who completed an assessment of Resident #26 upon admission to the facility. The Administrator stated Resident #26 was not one of the original residents to be transferred to her facility. Resident #26 wanted to go with a friend (Unsampled Resident G). Resident #26's preadmission assessment was completed on Thursday, 07/16/15. The Administrator stated it was not much of an assessment because the previous facility was trying to get residents out as soon as possible. The Administrator stated Resident #26 was alert and oriented x 3 (person, place and time) and so high functioning she had to ask what was wrong with the resident. The Administrator asked Resident #26 was he/she totally independent and Resident #26 stated he/she could transfer him/herself from scooter to bed and bed to scooter.</p> <p>Review of Resident #26's nursing notes,</p>	F 281	<p>3. 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 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 the UM 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. These audits will be documented on a check sheet. The check sheet will be reviewed by the ED and DON weekly</p>		



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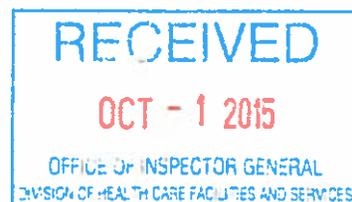
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F 281	<p>Continued From page 21</p> <p>completed by the DON, on 07/17/15 at 1:30 PM, revealed Resident #26 was transferred to the facility on a bus when Resident #26's wheelchair tilted over en route. Resident #26 stated he/she did not hit his/her head. Resident #26 did complain of a migraine headache that he/she had prior to leaving the discharging facility. No other apparent injury was noted. Continued review of the clinical record revealed there was no interim care plan developed for Resident #26 related to the monitoring of the resident's shunt or the fall sustained during transport.</p> <p>Interview with the Administrator, on 08/21/15 at 4:37 PM, revealed she did not have a plan of care for Resident #26 until the resident arrived to the facility. There was a twenty-four (24) hour period to complete an assessment. The Administrator stated she informed the Unit Manager on the 100 hall to watch the resident closely after the fall.</p> <p>Interview with the Unit Manager of the 100 hall, on 08/21/15 at 1:11 PM, revealed Resident #26 came to the facility around lunch time and asked about pain medication for a complaint of a headache, which he/she had all day. The Unit Manager stated the Administrator and ADON, informed her that Resident #26 had fallen out of his/her scooter while in transport to the facility. The Unit Manager stated Resident #26's nurse started the neurological checks, which was the facility's protocol when a fall was un-witnessed. The Unit Manager further stated she asked the Advanced Practical Registered Nurse (APRN) if she could have an order for the neurological checks, but he never gave a yes or no answer. However, review of the clinical record revealed there were no neuro-checks documented as completed by nursing staff.</p>	F 281	<p>and then monthly. These validate that they are doing their checks as stated.</p> <p>4. New admissions records will be audited by the DON/ ADON or the unit managers/Nurse 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 UM upon identification of untimely or omitted assessment/IPOC by a nurse.</p>		



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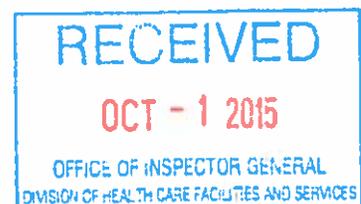
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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	
F 281	Continued From page 22 interview with the Advanced Practice Registered Nurse (APRN), on 08/14/15 at 12:50 PM, revealed he completed a neuro check on Resident #26 and the neuro check was not alarming. Resident #26 gave appropriate responses. The APRN stated it was the facility's practice to do neuro-checks on un-witnessed falls. He believed the ADON informed him Resident #26 fell on their bottom and that the fall was witnessed. The APRN stated if the fall was unwitnessed he would have encouraged the nurses to complete neuro-checks because of the shunt. Further interview with the Unit Manager of the 100 hall, on 08/21/15 at 1:11 PM and 3:30 PM, revealed the ADON did not inform her of the need for special care with Resident #26 and she was not afforded the opportunity to get a report from the prior facility in regards to the history of Resident #26. The Unit Manager stated she would have wanted to know Resident #26 had Spinal Bifida and Hydrocephalus with a shunt. She stated when a resident developed a Hematoma things could change rapidly. The Unit Manager stated she did not initiate a care plan upon admission. There should have been a plan to monitor Resident #26's vitals and over all status. Continued interview with the Unit Manager of the 100 hall, on 08/21/15 at 3:30 PM, revealed LPN #9 knew what had happened to Resident #26 and was responsible to report to the oncoming nurse. The Unit Manager stated she informed LPN #9 to make sure she monitored Resident #26 and that Resident #26 had chronic headaches.	F 281			



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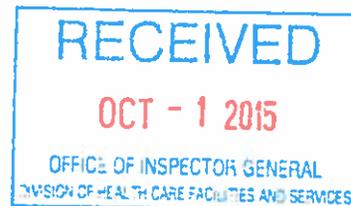
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 281	Continued From page 23 Interview with the Licensed Practical Nurse (LPN) #9, on 08/14/15 at 2:15 PM, revealed the Unit Manager completed Resident #26's admission. LPN #9 stated she took some vitals for the Unit Manager and placed some medications into the computer system. She remembered giving report to the oncoming nurse about a fall with a transfer and the fact that Resident #26 hit his/her head. LPN #9 stated she completed a pain assessment and administered Baclofen for muscle spasms, but no neuro-checks were completed. Interview with Registered Nurse (RN) #5, on 08/14/15 at 9:40 AM, revealed she took report from LPN #9 and did not recall any information about Resident #26 having a fall. She stated she did not receive a good report and noticed in Resident #26's chart that he/she had a history of migraines, shunt with Hydrocephalus and Spinal Bifida. RN #5 stated Resident #26 was able to verbalize that he/she had sustained a fall in the facility van but did not hit his/her head. Per interview, if the resident did hit their head, they were to get another nurse and assess the resident. RN #5 stated if a fall was not witnessed the nursing staff must assume that the resident could have hit their head, and neuro-checks were to be initiated. RN #5 stated LPN #9 did not report to her that Resident #26 was to have neuro-checks. RN #5 stated when they provided neuro-checks to residents she assessed the resident's pupils for reaction to light and if there was any weakness. Review of Resident #26's record, revealed only one (1) neuro check was provided by the APRN on 07/17/15 with no time provided. No other neuro-checks were documented.	F 281			



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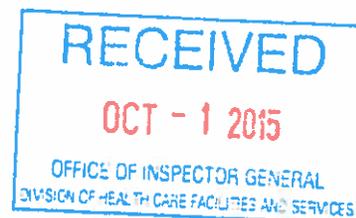
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F 281	<p>Continued From page 24</p> <p>Continued interview with RN #5 on 08/14/15 at 9:40 AM, revealed Resident #26 verbalized he/she needed to go to the hospital. RN #5 obtained Resident #26's blood pressure as 178/116 and the resident was transferred to the hospital at 4:29 PM.</p> <p>Review of the twenty-four (24) hour report, dated 07/17/14, revealed Resident #26 was admitted from another facility on the 7-3 shift and sent out to the hospital on the 3-11 shift. There was no documentation of a fall or special instructions for monitoring Resident #26's shunt.</p> <p>Interview with the MDS Coordinator, on 08/21/15 at 1:47 PM, revealed it should have been known Resident #26 was coming with a plan in place for him/her. She stated she would have developed a plan such as monitoring Resident #26's shunt for signs and symptoms of infection, fluid on the brain, swelling, taking vitals and monitoring for headaches. There would also be a neurological care plan because it had to do with the brain. The MDS Coordinator stated had she known the resident's history of a shunt and the fall she would have had the opportunity to develop a care plan that was more individualized. However, she did not know about the fall until after the resident went to the hospital.</p> <p>Review of Resident #26's Emergency Room visit, on 07/17/15 at 5:32 PM, revealed Resident #26 presented with a sharp, throbbing headache and a pain level of nine (9) out of ten (10) (one (1) no pain to ten (10) being the worst pain). The resident stated that he/she was on his/her mobility scooter in the van when his/her husband went around a corner, causing his/her scooter to tip over. Resident #26 stated that he/she struck</p>	F 281			



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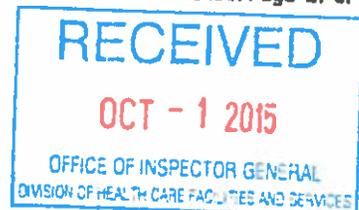
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F 281	<p>Continued From page 25</p> <p>his/her head. The resident also complained of pain radiating down the neck, nausea and vomiting six (6) times, photophobia (abnormal intolerance to visual perception of light), phonophobia (fear of loud sounds). Resident #26 developed a left hemispheric subdural hematoma measuring up to one (1) centimeter (cm) in maximal thickness.</p> <p>Interview via telephone with the Medical Doctor, who completed the hospital Discharge Summary, on 08/21/15 at 9:09 AM, revealed Resident #26 sustained a Post Traumatic Subdural Hematoma which played a role in Resident #26's decline. The pain radiating down his/her neck and complaints of nausea and vomiting were contributed by his/her fall and the hematoma he/she sustained. The cause of Resident #26's death was related to the hematoma. The Medical Doctor stated Resident #26 sustained an Acute Hematoma which meant it occurred the day of admission.</p> <p>Review of the Discharge Summary from the hospital, revealed Resident #26 expired, on 08/01/15 at 3:00 PM, related to complications from the subdural hematoma.</p> <p>The facility alleged the removal of Immediate Jeopardy by implementing the following:</p> <ol style="list-style-type: none"> 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. 	F 281			



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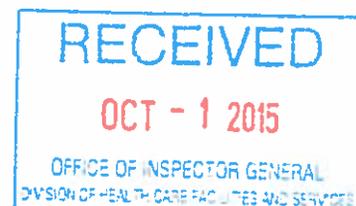
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F 281	Continued From page 26 3. On 07/17/15, the Assistant Director of Nursing notified the Executive Director of the fall Resident #26 had sustained and that an investigation into the incident had started. 4. On 07/17/15, the Executive Director interviewed 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. 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	F 281			



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F 281	<p>Continued From page 27</p> <p>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.</p> <p>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.</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>	F 281			



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F 281	<p>Continued From page 28</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>	F 281		
	<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> <p>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.</p>			
	<p>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</p>			

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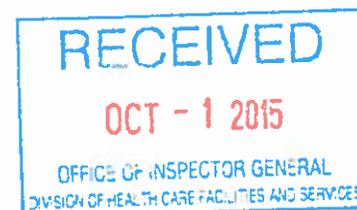
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F 281	<p>Continued From page 29 completed. In addition, these employees' files would be audited quarterly for four (4) quarters and then annually.</p> <p>19. The Quality Assurance Performance Improvement Committee met on 08/23/15 with the following 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.</p> <p>The State Survey Agency validated the removal of Immediate Jeopardy on 08/29/15 as follows:</p> <ol style="list-style-type: none"> 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. 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. 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 	F 281			



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F 281	<p>Continued From page 30</p> <p>Director, Assistant Director of Nursing and another resident who had been on the bus, as she initiated an investigation of the incident.</p> <p>5. Review of the admission assessment titled Clinical Health Status, dated 07/17/15, revealed an assessment of Resident #26 was conducted.</p> <p>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.</p> <p>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.</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</p>	F 281			



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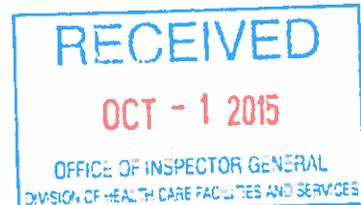
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F 281	Continued From page 31 assessments. Interview, on 08/29/15 at 2:50 PM with the MDS Coordinator revealed she reviewed care plans of the four (4) residents identified with falls within twenty-four (24) hours of admission, and determined the residents' care plans did not need to be updated.	F 281		
	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.			
	Review of the document titled, Summary Report of Meeting: Nursing Lecture, dated 08/21/15, 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.			
	Interview on 08/29/15 at 3:05 PM with the Corporate Director of Clinical Services revealed			



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F 281	Continued From page 32 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. 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.	F 281			



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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 281	<p>Continued From page 33</p> <p>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.</p> <p>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 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.</p> <p>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</p>
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F 281	
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3115 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 281	<p>Continued From page 34</p> <p>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.</p> <p>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.</p> <p>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</p>	F 281			



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F 281	<p>Continued From page 35</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>13. Interview, on 08/29/15 at 1:20 PM with the Executive Director, revealed she and the</p>	F 281		



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F 281 Continued From page 36
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 safe resident transport and proper use of the van's wheelchair lock-down system.

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.

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

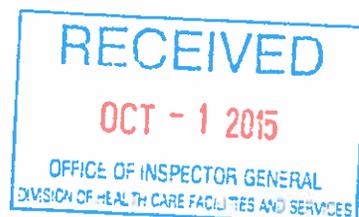
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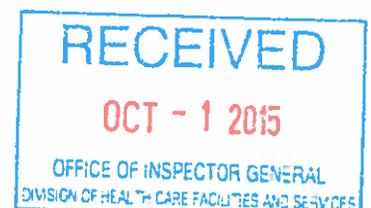
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F 281	<p>Continued From page 37</p> <p>the Director Of Assessment/Minimum Data Set Nurse prior to transporting a resident who had a lap tray affixed to his/her wheelchair. The Director of Resident Assessment/Minimum Data Set Nurse stated she referred 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 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,</p>	F 281			



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F 281	Continued From page 38 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 281			
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 ensure one (1) of twenty-six (26) sampled residents care plan interventions were followed. Observations of Resident #3 revealed the staff failed to ensure there were fall mats or wheel chair alarms in the resident's room. The findings include: The facility did not provide a policy related to	F 282			



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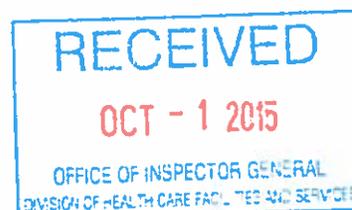
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F 282	Continued From page 39 following comprehensive care plans. Review of the clinical record for Resident #3, revealed the resident was admitted to the facility on 02/27/14 with diagnoses of Communicating Hydrocephalus, Diabetes Type II, Disorganized type Schizophrenia, and Acquired Hemolytic Anemia's.	F 282		
	Review of the Annual Minimum Data Set (MDS) Assessment for Resident #3 dated 02/25/15 revealed falls triggered as an area of concern that may warrant interventions on the Care Area Assessment Summary. The Quarterly MDS Assessment, dated 06/08/15, revealed the facility assessed Resident #3 to be totally dependent on staff for his/her Activities of Daily Living and totally dependent on staff for transfers. The resident scored a ten (10) out of fifteen (15) on the Brief Interview for Mental Status (BIMS) meaning the resident was interviewable. Review of the Falls Incident Reports revealed Resident #3 had non-injurious falls on 03/15/15, when he/she tried to get out of bed unassisted, on 05/11/15, after he/she rolled out of bed, and on 5/15/15, when he/she was trying to get out of bed unassisted.		<p>F282</p> <p>1. Resident # 3 CP and cna care plan was updated to reflect accurate information for this resident. The fall mats and W/C alarm was no longer needed and the order was D/C'd.</p> <p>2. All residents have the potential to be affected by this practice. All residents were reviewed by the UM and their CNA care Records were updated for accuracy 08/13/15 by the UM. All were correct. All resident CP were reviewed by the MDS RN's between 08/13/15 and 09/15/15 for accuracy. All were correct.</p> <p>3. All resident's daily new orders will be reviewed in the daily morning clinical meeting by the IDT team. The MDS coordinators will update the CP daily with any changes to reflect an accurate CP. The UM's will update the cna care records daily with any changes to reflect an accurate care record for the cna's use.</p> <p>4. The UM will randomly select 4 residents per week for 4 weeks to audit the CP compared to the orders for accuracy and the cna care record for accuracy. Then monthly for 4 months. 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>	09/30/15
	Review of the Comprehensive Care Plan for Resident #3 initiated on 07/18/14 and last reviewed on 08/11/15 with a target date for 09/28/15, revealed the resident was to have bilateral fall mats and a tab alarm to his/her wheelchair due to a history of falls, and impaired mobility. These interventions were initiated on 11/11/14. Review of the Certified Nursing Assistant (CNA)			



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F 282	<p>Continued From page 40</p> <p>Care Guide, not dated, revealed Resident #3 was to have an alarm to his/her wheelchair and did not mention the use of fall mats as intervention to prevent falls.</p> <p>Observations of Resident #3, on 08/11/15 at 1:40 PM, 2:20 PM, 3:05 PM, 5:10 PM, and on 08/12/15 at 12:10 PM, and 1:15 PM, revealed the resident sitting in his/her wheelchair and did not have an alarm on the chair. Observations of Resident #3, on 08/12/15 at 7:45 AM, 09:00 AM, and 10:00 AM, revealed the resident was in bed and there were no fall mats on either side of the resident's bed.</p> <p>Interview with Resident #3, on 08/12/15 at 1:15 PM, revealed the resident did not remember the last time he/she saw fall mats in his/her room or an alarm on his/her wheelchair.</p> <p>Interview with CNA #1, on 08/13/15 at 9:45 AM, revealed she looked at the CNA care guide to see what devices a resident needed. She stated she knew the resident was to have the alarms and fall mats to prevent falls; however, she did not know where Resident #3's wheelchair alarms or fall mats were or when she last saw them.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 08/13/15 at 2:30 PM, revealed the Inter-Disciplinary Team (IDT) goes to the resident's room during care plan meetings to make sure the resident has the equipment they need. The last care plan date was 06/08/15. She verified the fall mats and alarm were not in the resident's room. She stated she did not know where the chair alarm or fall mats were.</p>	F 282			



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F 282	Continued From page 41 Interview with Minimum Data Set Coordinator, on 08/14/15 at 7:25 AM, revealed fall mats and wheelchair alarms were nursing interventions and were added to care plans after a resident fall. She stated if fall mats and wheelchair alarm were on Resident #3's care plan, then they should be in the resident's room. Attempted interview with the Unit Manager revealed she was on vacation.	F 282			
F 314 SS=D	Interview with the Assistant Director of Nursing, on 08/14/15 at 8:32 AM, revealed the Unit Managers ensured interventions were in place for residents when they do their rounds on the unit. She stated interventions on the care plan should be reflected in the resident's room. She stated fall mats helped prevent injuries from falls and wheelchair alarms alerted staff when a resident attempted to transfer unassisted. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility	F 314			



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F 314	<p>Continued From page 42</p> <p>failed to ensure one (1) of twenty-six (26) residents, Resident #6 was provided the necessary treatments to promote healing to his/her heel.</p> <p>The findings include:</p> <p>Review of the Prevention of Pressure Ulcer Policy and Procedure, effective 01/26/15, revealed the purpose of the procedure was to prevent skin breakdown and the development of pressure sores. The assessment guidelines detailed equipment used for pressure sore prevention included heel protectors. The procedure detail included use of elbow and heel protectors as necessary, and, use of pressure reducing or relieving devices as necessary. Documentation guidelines stated preventive equipment used should be documented. The procedure further stated the care plan should include a list of pressure reducing or relieving surfaces.</p> <p>Review of the clinical record for Resident #6 revealed the facility admitted the resident on 07/22/15 with diagnoses of Cerebrovascular Disease, Hypothyroidism, Metabolic Encephalopathy, Chronic Heart Failure and Pressure.</p> <p>Review of Resident #6's Admission Minimum Data Set (MDS) Assessment, dated 07/22/15, revealed the facility assessed Resident #6 with a BIMS score of ninety-nine (99) which meant the resident was not interviewable. Resident #6 was triggered for one (1) pressure sore at a Stage II.</p> <p>Review of Resident #6's Wound Evaluation Flow Sheet, dated 07/23/15 at 3:19 PM, revealed Resident #6 had pressure to the right heel, length</p>	F 314	<p>F 314</p> <ol style="list-style-type: none"> 1. Resident #6 immediately had the prevalon boots placed on them by the Um upon determination that they were not on the resident. This resident has now been D/C'd. 2. All residents in the facility have the potential for being affected by this deficient practice. An audit of all residents was conducted on 08/13/15 by the unit managers too ensure that all residents that had any ordered treatment to help in the treatment of preventing or healing pressure sores interventions were in place. 3. An in service was held on 09/15/15 - 09/17/15 for all nursing staff on providing all ordered treatments to residents to help in the treatment of preventing or healing pressure sores. The IDT team including the Executive Director (ED), Unit Managers (UM), Staffing Coordinator, Assistant Director of Nursing (ADON) conducted this in-service. 4. The four Unit managers will randomly select 4 residents per week (for a total of 16) for 4 weeks, then monthly for 4 months, to check that the resident has their ordered treatments in place to help in the treatment of preventing or healing pressure sores. The UM will report their 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. 	09/30/15	



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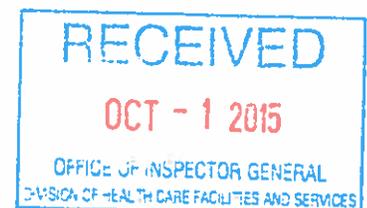
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F 314	Continued From page 43 4.8, width 3.2 and staged at a Stage II, which meant partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough or an intact or open/ruptured serum-filled blister. Interview and observation with Registered Nurse (RN) #4, on 08/13/15 at 11:09 AM, revealed Resident #6's left heel was fluid filled, but had hardened.	F 314			
	Review of Resident #6's Physician Orders, dated 07/24/15 at 10:33 AM, revealed an order for a Prevalon boot to left heel at all times every shift. Review of Resident #6's Physician Orders, dated 07/24/15 at 2:49 PM, revealed an order for a Prevalon boot to right heel at all times every shift. Review of Resident #6's Pressure Sore Care Plan, initialed 07/24/15, revealed the Prevalon boots were not updated to the care plan to be placed on both of the resident's feet at all times. In addition, the CNA Care Card, not dated, revealed the Prevalon boots to be placed on both of the residents feet at all times was not on the care card. Observation, on 08/11/15 at 2:30 PM, of Resident #6 revealed Resident #6 was sitting up in a wheelchair without the Prevalon boots on instead the resident was wearing blue, non-skid socks. The Prevalon boots were located on Resident #6's bed. Observation of Resident #6, on 08/12/15 at 11:04 AM, revealed the resident was sitting up in his/her wheelchair. Resident #6 was watching a moving at this time on his/her computer. Resident #6 did				



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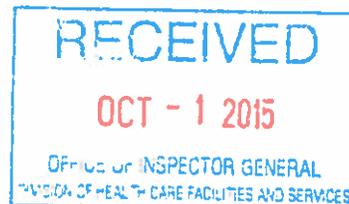
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/29/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 314	Continued From page 44 not have on Prevalon boots at this time, just non-skid socks. Resident #6's feet were resting on a foot board. Interview with Certified Nursing Assistant (CNA) #9, on 08/13/15 at 10:45 AM, revealed the nurse informed her to place Prevalon boots on Resident #6's feet only when in bed. CNA #9 stated she was aware Resident #6 had pressure to his/her feet, but was not aware the Prevalon boots were to be placed on Resident #6's feet at all times. Interview with the Unit Manager of the Rehab Unit, on 08/13/15 at 10:36 AM, revealed the Prevalon boots were suppose to be on Resident #6's heels at all times to offset the pressure to his/her heel. The Unit Manager stated she was trying to prevent the wound from becoming worse. Observation of wound care, on 08/13/15 at 11:09 AM, revealed the wound to the left heel was observed to be hardened and not fluid filled. Interview with the Assistant Director of Nursing, on 08/20/15 at 10:09 AM, revealed assistive devices should be utilized to prevent pressure. The Unit Manager was to monitor the pressures daily and report on them in the morning meetings.	F 314			
F 323 SS-J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323			



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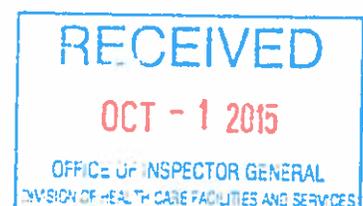
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F 323	Continued From page 45 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to have an effective system in place to ensure two (2) of twenty-six (26) sampled residents. Resident #26 and Resident #3 received assistive devices to prevent accidents. The staff failed to ensure Resident #26 was secured in a van for transport resulting in an injury. In addition, the staff failed to ensure Resident #3 was provided the assistive devices as care planned. On 07/17/15 the facility staff transported Resident #26 in a facility van from another nursing home. The staff failed to secure the resident via all available safety restraints. 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. The facility failed to complete a Situation Background Assessment Recommendation (SBAR) form for Resident #26 until the resident was sent to the hospital. The facility also failed to document the fall on the twenty-four hour report; therefore, nursing staff was not all aware of the fall or the details related to the fall the resident sustained. The facility's failure to have an effective system in place to provide adequate supervision to ensure resident safety during facility transport has caused or is likely to cause serious injury, harm,	F 323	F 323 1. Resident was 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. 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. 2. Residents that ride in the facility van can potentially be affected by this practice. There were 2 other residents in transport during this transport. Their restraints were immediately checked by the Maintenance Director to verify proper placement and secure. None were found not secure. 3. There is pictured instruction on the QRT "Restraint" System in the van for easy access for all that ride in the van to see. Maintenance Director was re-trained by the Activities Director on the QRT "Restraint" System and the Resident Transport Policy on 7/28/15.	09/30/15



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F 323	<p>Continued From page 46</p> <p>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 483.25 Quality of Care (F323) 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> <ol style="list-style-type: none"> 1. Review of the Falls Management Guidelines, reviewed 06/26/15, revealed following a resident's fall, the licensed nurse assesses the resident for injuries (including neuro checks if indicated) and provides necessary treatment and initiates the Change in Condition Report - Post Fall/Trauma. The physician and resident's representative would be notified and the appropriate interventions would be initiated. The licensed nurse initiated the DQI Quality Control Report. The Interdisciplinary Team reviewed the Change of Condition Report - Post Fall/Trauma and made additional recommendations within 72 hrs of the fall. <p>Review of the facility's witnessed, unwitnessed fall protocol, dated 08/14/15, revealed any fall that was seen by another person, alert and oriented x three (3) was considered a witnessed fall. This person could be another resident, visitor, staff member, etc. that seen the fall. If they could</p>	F 323	<p>All van drivers and assistants, for a total of 4 drivers were re-trained on the QRT "Restraint" System and the Resident Transport Policy by the activities director on 07/28/15. Review of the Resident Transport Policy and competency check-off with all the van drivers and assistants will occur quarterly x 4 then annually by the activities director. New</p> <p>assistants that have not been trained will be trained by the activities director on the QRT "Restraint" System and Resident Transport Policy prior to transport of any resident. The system we will use to ensure each resident is safely transported based on their individual needs will be based on the resident's individual needs, mobility and chair type. The activity director will look at the clinical assessment and discuss with the charge nurse the individual needs of the resident. They will determine the best way to transport the resident safely. 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. Drivers and Assistants files have been reviewed on 08/23/15 by the ED and HRG, to ensure all training and competency check-off have been completed.</p> <p>The following policies were reviewed on 08/23/15, resident transport policy, Accident Investigation, and Interdisciplinary Care Plans, by the ED, ADON, and activities director and no changes were made to the policies.</p>		



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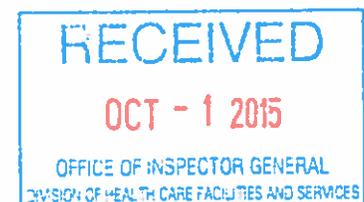
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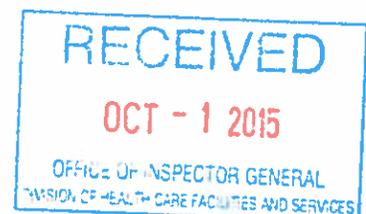
F 323	<p>Continued From page 47 report they saw the fall it would be considered witnessed.</p> <p>Review of the Neurological (Neuro) Checks Policy, reviewed 12/18/14, revealed it was the policy of the facility to conduct neurological checks on residents clinically appropriate (whenever there was a question of a head injury or a change in neurological status or level of consciousness). Each facility should establish a protocol for the frequency. Neurological checks should be performed per physician order.</p> <p>Review of the clinical record for Resident #26 revealed the facility admitted the resident on 07/17/15 with diagnoses of Spina Bifida with Hydrocephalus with a shunt, Hypothyroidism and Nausea and Vomiting, Unspecified Essential Hypertension and Chronic Headaches. Physician ordered medications were Plavix (to prevent blood clots) 75 milligrams (mg) daily, Aspirin (treat pain, fever and inflammation) 81 mg daily and Maxolt (migraine headaches) 10 mg as needed for headache.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 08/13/15 at 10:00 AM and at 5:00 PM, revealed on 07/17/15 between 11:30 AM and 12:00 PM, she and the Maintenance Director went to pick up three (3) residents, Resident #26 and Unsampled Residents F and G, from another facility and utilized the facility's own company van.</p> <p>Interview with the Maintenance Director, on 08/13/15 at 3:30 PM, revealed he placed Resident #26 onto the van with no help from the ADON. The Maintenance Director stated he placed Resident #26, who was in a three (3) wheel scooter, in the fourth spot behind the</p>	F 323	<p>4. The unit managers will audit the 24 hour report daily x 2 weeks, BI weekly X 2 weeks, and Weekly times x 2 weeks, then ongoing randomly to ensure that falls are included (written) on the 24 hour report. The 24 report will also be brought to the morning clinical meeting daily to be reviewed by the IDT team for fall information. Van driver employee files will be audited quarterly x4 then annually by the HRG or ED to ensure training and check offs on the van safety and the QRT trainings are completed quarterly. The ED will report her findings to the QAPI meetings monthly. 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 323	Continued From page 48 driver's seat. He attached two (2) belts to the rear two (2) wheels and attached two belts to the front one (1) wheel of Resident #26's scooter. The Maintenance Director was able to adjust for lightness, though he had a difficult time adjusting the belts to the front wheel. Further interview with the Maintenance Director, on 08/13/15 at 10:30 AM, revealed he did not remember securing Resident #26's seatbelt.	F 323			
	Interview with the ADON, on 08/20/15 at 10:09 AM, revealed she did not double check to make sure Resident #26's seat belt was secured. Continued interview with the ADON, on 08/13/15 at 10:00 AM, revealed when the van took off they were half way down the street when she heard a noise, and the Maintenance Director, driving the van, stopped the van and noticed Resident #26 was sitting on the floor on his/her bottom. The ADON stated she got up and went to Resident #26 who stated he/she did not hit his/her head, but that it scared him/her. The ADON assessed Resident 26's range of motion. The Maintenance Director and the ADON assisted Resident #26 back into his/her scooter. The ADON then made sure Resident #26 scooter was secured, locked and stayed at Resident #26's side the remainder of the trip. Resident #26 stated nothing hurt him/her just a headache that he/she had all day. Interview, on 08/13/15 at 04:35 PM, with Unsampled Resident G, whom the facility assessed with a Basic Interview for Mental Status (BIMS) score of fifteen (15) meaning the resident was interviewable, revealed he/she was riding in the new facility's van from the "old facility", on 07/17/15, when he/she heard a "thump" noise				



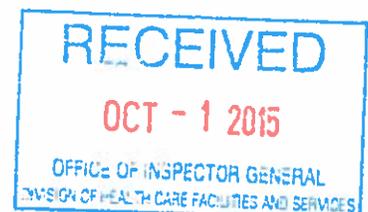
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F 323	Continued From page 49 and he/she turned around and saw Resident #26 still positioned in his/her wheelchair turned over to the right side on the floor. Unsampled Resident G stated that he/she did not witness the incident because he/she was sitting in front of Resident #26. Unsampled Resident G stated the van did not have any type of accident and the driver must have turned a corner when this incident happened. Unsampled Resident G stated that Resident #26 did tell him/her, that he/she hit his/her head during that fall.	F 323		
	Attempted interview with Unsampled Resident F, on 08/13/15 at 4:25 PM, revealed the resident did not remember anything about the incident with Resident #26. Continued interview with the ADON, on 08/13/15 at 10:00 AM, revealed the Advanced Practical Registered Nurse (APRN) did an assessment of Resident #26 upon arriving to the facility. Interview with the APRN, on 08/13/15 at 10:11 AM and on 08/14/15 at 12:50 PM, revealed he completed an assessment of Resident #26 and found that Resident #26 had chronic headaches and was on Imitrex for headaches. The APRN stated he completed a neuro check on Resident #26 and found Resident #26 had no drift (inability to maintain a static position), smiled appropriately, had no slurred speech, and pupils were reactive to light. Per interview, the neuro check was not alarming and Resident #26 gave appropriate responses. Review of the APRN's assessment of Resident #26, on 07/17/15, revealed the chief complaint was a headache. Per the APRN's assessment, the resident was transferred from the discharging			



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F 323	<p>Continued From page 50</p> <p>facility with complaints of a headache. Per the note, during transportation, Resident #26 fell out of the scooter. Resident #26 stated he/she did not hit their head, only hit their bottom. Resident #26 reported he/she had chronic headaches and had one before they left the facility. The resident had no complaints of dizziness or nausea or vomiting. Resident #26 stated he/she had not received a pain pill. Review of the documents sent with Resident #26 stated the resident had a long history of headaches and a recent change of Migraine medications. A headache was reported on the left side with a pain level of six (6) out ten (10). There were no vision changes reported by the resident. Vitals signs were obtained as followed; blood pressure 140/86; pulse 78; temperature 98.2; and, oxygen saturation was 98 percent (%). Resident #26 was assessed as alert and oriented times three (3) (person, place and time).</p> <p>Review of Resident #26's Admission Assessment, dated 07/17/15 at 12:45 PM, revealed no identified skin concerns. Resident #26 verbalized a pain score of nine (9) out of ten (10), caused from the resident's headache, which felt severe, constant, aching and affected his/her day to day activities.</p> <p>Further review of the resident's clinical record revealed no documentation of the resident's fall, nor completion of SBAR form at the time of admission to the facility. Even though the facility's policy and procedure stated the Change in Condition Report - Post Fall/Trauma would be initiated, there was no documented evidence this report was completed.</p> <p>Interview with the ADON, on 08/13/15 at 5:00 PM,</p>	F 323			



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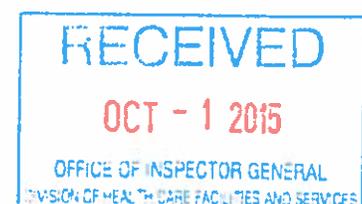
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F 323	<p>Continued From page 51</p> <p>revealed there was no SBAR completed after the fall occurred and there should have been one.</p> <p>Interview with the Licensed Practical Nurse (LPN) #9, on 08/14/15 at 2:15 PM, revealed when Resident #26 was admitted, the Unit Manager helped with Resident #26's admission. LPN #9 stated she obtained vitals for the Unit Manager and placed some medications into the computer system. LPN #9 stated she remembered giving report to the oncoming nurse about a fall with a transfer and the fact that Resident #26 hit her head. LPN #9 stated this was reported to her by the Unit Manager. LPN #9 stated she did complete a pain assessment on Resident #26 and administered scheduled Baclofen for muscle spasms, but no neuro checks were documented.</p> <p>Interview with Registered Nurse (RN) #5, on 08/14/15 at 9:40 AM, revealed she took report from LPN #9 and did not recall any information about Resident #26 having a fall. RN #5 stated when she received her change of shift report, LPN #11 working as a Certified Nursing Assistant (CNA) the day of the incident, stated Resident #26 was looking for his/her nurse. When RN #5 approached Resident #26 he/she complained of a horrible headache and that the previous nurse gave him/her medication for pain at 2:00 PM and it was not working. Resident #26 stated he/she was starting to feel nauseated. Resident #26 then asked RN #5 could he/she have his/her Phenergan (anti-nausea medication). RN #5 administered the Phenergan dose and encouraged Resident #26 to lay down and place a cold wash cloth on his/her head. RN #5 stated fifteen (15) to twenty (20) minutes later while she was at her medication cart, LPN #11 approached RN #5 and stated Resident #26 was vomiting in a</p>	F 323			



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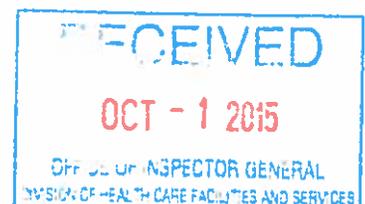
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F 323	<p>Continued From page 52</p> <p>garbage can. RN #5 entered Resident #26's room and observed Resident #26 with dry heaves and a small amount of vomit in the garbage can. Once the resident calmed down, RN #5 stated she went to review Resident #26's chart and found Resident #26 had a history of Migraines, and a Shunt with Hydrocephalus and Spina Bifida.</p> <p>Continued interview with RN #5, on 08/14/15 at 9:40 AM, she asked Resident #26 if the headache felt like one of his/her migraines and Resident #26 stated "No". When asked where the pain was coming from, Resident #26 stated the whole left side of his/her face, head and neck area. RN #5 asked Resident #26 if anything had happened that day and did Resident #26 hit his/her head. Resident #26 stated he/she fell earlier in the day. RN #5 asked Resident #26 if he/she had sustained a fall in the facility. Resident #26 stated "No". The RN further questioned the resident if he/she fell at the other facility. Resident #26 stated "No". Resident #26 stated when the van was turning a corner, his/her scooter fell over in the van. RN #5 asked when the scooter fell over in the van did the resident hit their head. Resident #26 stated "No", he/she would have remembered that, but it jarred him/her pretty good. Resident #26 stated he/she thought they needed to go to the hospital. RN #5 obtained Resident #26's blood pressure as 178/116.</p> <p>Continued interview with RN #5, on 08/14/15 at 9:40 AM, revealed she completed a neurological (neuro) check on Resident #26 and found that his/her pupils were reactive to light, and no weakness in the extremities. However, review of Resident #26's record revealed only one (1)</p>	F 323			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/29/2015
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	Continued From page 53 neuro check was completed by the APRN on 07/17/15 with no time documented. Continued interview with RN #5, on 08/14/15 at 9:40 AM, revealed she could not remember if she wrote an order to send Resident #26 to the hospital. RN #5 stated Resident #26 was sent to the hospital about 4:15 PM to 4:30 PM for treatment.	F 323			
	Interview with the ADON, on 08/13/15 at 5:00 PM, revealed there was no Physician order to send Resident #26 out to the Emergency Room. Review of the twenty-four (24) hour report, dated 07/17/14, revealed only that Resident #26 was admitted from another facility on the 7-3 shift. There was no record of a fall or special instructions for monitoring Resident #26's shunt. Interview with the DON, on 08/21/15 at 2:29 PM, revealed she had not recognized that the order for transport to the hospital was not written or the fact that there was no SBAR for the fall. Review of Resident #26's SBAR, completed after the resident was transferred to the hospital for complaints of pain, dated 07/17/15 at 4:29 PM, revealed Resident #26 complained of severe headache, nausea and vomiting with left side of head, face and neck pain, vomiting, and the skin was cool and clammy. Vitals signs were: blood pressure 176/118; temperature 97.6; pulse 70; and, respirations 16. Resident #26 requested to be sent to the hospital. Review of Resident #26's Emergency Room visit, on 07/17/15 at 5:32 PM, revealed Resident #26 presented with a sharp, throbbing headache, pain				



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F 323	<p>Continued From page 54</p> <p>rated at a nine (9) out of a one (1) to ten (10) pain scale. The resident stated that he/she was on his/her mobility scooter in van when his/her husband went around a corner, causing his/her scooter to tip over. Resident #26 stated that he/she struck his/her head. The resident was on his/her way to a new nursing home. The resident also complained of pain radiating down the neck, nausea and vomiting six (6) times, photophobia (abnormal intolerance to visual perception of light), and phonophobia (fear of loud sounds). Resident #26 developed a left hemispheric subdural hematoma measuring up to one (1) centimeter (cm) in maximal thickness.</p> <p>Review of the Discharge Summary from the hospital, revealed Resident #26 expired on 08/01/15 at 3:00 PM related to complications with the subdural hematoma.</p> <p>Interview with the Medical Doctor, who completed the hospital Discharge Summary, on 08/21/15 at 9:09 AM, revealed Resident #26 sustained a Post Traumatic Subdural Hematoma which played a role in Resident #26's decline. The pain radiating down his/her neck and complaints of nausea and vomiting were contributed by his/her fall and the hematoma he/she sustained. The cause of Resident #26's death was related to the hematoma. The Medical Doctor stated Resident #26 sustained an Acute Hematoma which meant it occurred the day of admission.</p> <p>Interview with the Medical Director, on 08/13/15 at 3:05 PM, revealed the Administrator informed him of the accident that occurred with Resident #26. The clamps came undone on the scooter and Resident #26 fell in the facility van. The Medical Director stated he was told by the</p>	F 323		



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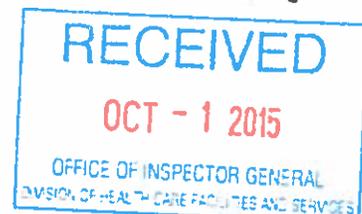
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F 323	<p>Continued From page 55</p> <p>Administrator that Resident #26 had hit his/her head, which caused a subdural hematoma. He stated with the resident having a Hydrocephalic diagnosis increased Resident #26's risk for bleeding. Also the fact that Resident #26 was on a medication called Plavix also heightened the residents risk for bleeding.</p> <p>Interview with the Administrator, on 08/14/15 at 1:00 PM, revealed she found out about the fall from the ADON and the Maintenance Director. Both of them informed the Administrator that they heard a noise, turned around and saw that Resident #26 was on the floor of the van. The scooter was still in its up right position and Resident #26 was found sitting beside the scooter on the floor. The Administrator stated the ADON assessed Resident #26 and the resident stated he/she did not hit their head. However, per interview with the Medical Director, the Administrator had told him the resident hit their head.</p> <p>Further interview with the Administrator, on 08/14/15 at 3:20 PM, revealed the ADON and Maintenance Director asked Unsampled Resident G if Resident #26 hit his/her head and he/she stated "no" and Unsampled Resident G stated he/she witnessed the fall. The Administrator stated the ADON felt that the fall was witnessed because Unsampled Resident G stated he/she saw the fall. However, interview with Unsampled Resident G revealed the resident did not witness Resident #26 fall.</p> <p>Continued interview with the Administrator, on 08/14/15 at 3:20 PM, revealed Resident #26 was alert and oriented times three (3) (person, place and time) and he/she also stated he/she did not</p>	F 323		



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F 323	<p>Continued From page 56</p> <p>hit their head. The Administrator stated a resident or visitor could be a witness to a fall. The Administrator did not obtain any statements from the two (2) residents who were transported in the facility van.</p> <p>Continued interview with RN #5, on 08/14/15 at 9:40 AM, revealed when a fall occurred, she was to make sure the resident was okay, look for injuries, identify what happened when the fall occurred and what caused the fall. She would try to identify if the resident hit their head and if the resident did hit their head, they were to get another nurse and assess the resident. RN #5 stated if a fall was not witnessed the nursing staff must assume that the resident could have hit their head, and neuro checks were to be initiated. However, RN #5 revealed LPN #9 did not report to her that Resident #26 was to have neuro checks.</p> <p>Interview with the APRN, on 08/13/15 at 10:11 AM and on 08/14/15 at 12:50 PM, revealed it was the facility's practice to do neuro checks on unwitnessed falls. He believed the ADON informed him Resident #26 fell on their bottom and that the fall was witnessed. The APRN stated if the fall was unwitnessed he would have encouraged the nurses to complete neuro checks because of the shunt.</p> <p>Further interview with RN #5, on 08/14/15 at 9:40 AM, revealed the ADON came to the nurses station asking about Resident #26 and stated that it was scary what happened to Resident #26. The ADON stated when the van went to turn a corner or curve Resident #26 fell over with his/her scooter.</p>	F 323			



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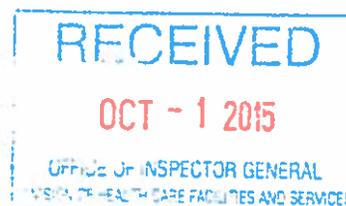
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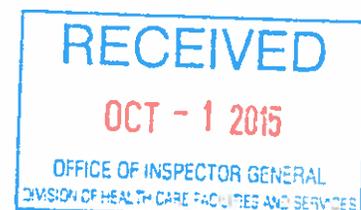
F 323	<p>Continued From page 57</p> <p>Continued interview with the Administrator, on 08/14/15 at 3:20 PM, revealed the fall process was to assess the resident, notify the family and doctor, fill out an incident report, SBAR and a post fall report. These forms go to the morning meeting and the morning meeting staff review what happened, what interventions were put into place to prevent the accident from happening again. The Administrator stated she was not in the facility when the team (consisting of the DON, ADON, Activities, Nursing Managers, Dietary and Social Services) went over the investigation. The Administrator stated the team looked to see if notifications were completed. She stated it was hard to complete an investigation with the resident not present in the building. The facility could not provide any recommendations made by the team for Resident #26's fall.</p> <p>Review of the facility's investigation, dated 07/17/15 at 12:15 PM, revealed it contain only statements from the ADON and the Maintenance Directors. There were no statements from Unsampled Residents F or Unsampled Resident G. Further review revealed no documented evidence the facility investigated the incident to determine the root cause of the fall.</p> <p>Interview with the DON, on 08/21/15 at 2:29 PM, revealed it was the Administrator's responsibility to identify if the accident involving Resident #26 needed to be reviewed more closely.</p> <p>Review of the facility's Resident Transport Policy, dated 08/01/11, revealed the purpose of the policy was to promote the safety of residents during transport in company vehicles and to minimize resident injury associated with vehicle accidents. All vans used to transport residents</p>	F 323		
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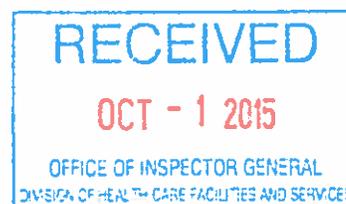
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F 323	<p>Continued From page 58</p> <p>were required to be equipped with the QRT (no definition) "Restraint" System as manufactured by Q'Straint. The written instruction sheet would be placed on a clipboard or in a plastic sleeve for easy reference at all times. All resident wheelchairs would be secured using the QRT "Restraint" system and all residents would be secured with the lap and shoulder restraint before movement of the van. All van drivers and assistants would be trained using the instruction material and video before transporting residents in the van. Training would include a demonstration of the use of the restraint system. Initial and annual training would be documented and placed in the employees personnel file.</p> <p>Review of the QRT Securement system, by Q-Restraint, revealed step 1: was to ensure the belt was in a straight line from anchor to wheelchair. Step 2: attach lap and shoulder belt. Never rely on the chair's own lap belt unless it was an approved occupant restraint. Q-Restraint recommended Tri-wheeler users be transferred to an ambulatory seat.</p> <p>Interview with the Maintenance Director, on 08/13/15 at 4:40 PM, revealed Resident #26's scooter did not tip over in the van because of the one (1) wheel to the front of the scooter. He stated when he attached the belts to the one (1) wheel, the belts were tight. There was no conversation with the ADON about how to place belts onto the residents wheelchair. The Maintenance Director stated nothing happened on the van to cause Resident #26 to fall.</p> <p>However, further interview with the Maintenance Director, on 08/13/15 at 3:30 PM, revealed Resident #26 fell out of his/her scooter and the</p>	F 323			



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F 323	<p>Continued From page 59</p> <p>scooter stayed secured. The Maintenance Director stated he was not trained on the use of the belts when he transported Resident #26 in the van. He stated he did not use a seat belt to secure Resident #26 in his/her seat, nor the belts that were provided on the van. He stated he received training about a week or two after Resident #26's fall.</p> <p>Interview with the ADON, on 08/13/15 at 5:00 PM, revealed she had not been trained or in-serviced on the van and had not been on the van before 07/17/15.</p> <p>Interview with the Activity Director, on 08/13/15 at 3:52 PM, revealed she had been driving the van for one (1) year and two (2) months. The Activity Director stated she was asked to make sure staff were trained, after the fall with Resident #26. The Activity Director stated when a resident was in a three (3) wheel scooter the resident should be transferred to a seat and the scooter locked because the three (3) wheel scooter was hard to secure.</p> <p>Interview with the Administrator, on 08/14/15 at 1:00 PM, revealed prior to the transport on 07/17/15, she had not asked the Maintenance Director if he was trained on the use of the van and she was not sure if he was trained on the use of the belts on the van. The Administrator stated the thought never crossed her mind to ask those questions.</p> <p>Review of the Maintenance Director's driving record, revealed he had a valid drivers license and no accident violations. There was no record of the video training or any other van training until after the incident occurred.</p>	F 323			



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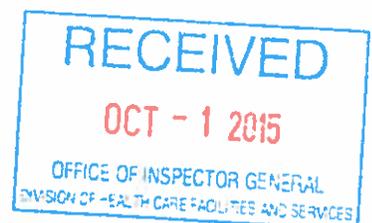
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F 323	Continued From page 60 Review of the Summary Report of Meeting Lecture, dated 07/28/15 after the incident with Resident #26, revealed the Maintenance Director was educated on transporting residents in the facility van. All residents must be secured properly in seat belts. All wheelchairs must be secured properly. If the electric scooter did not fit in the wheelchair lock down, then the resident must be transferred into a wheelchair that did fit for transport. The ADON's signature was not present on the meeting report summary as being trained. Interview with the DON, on 08/21/15 at 2:29 PM, revealed she was the staff member who came up with the Lecture for the Maintenance Director as it related to transporting residents on the facility van. The DON stated she was not sure if the tie down to the wheels was good enough or secure enough when she wrote the lecture. The DON stated she held the training on the transporting of residents because she recognized there was a potential to affect other residents. The Maintenance Director was educated to transfer the resident out of the scooter into a chair. 2. Review of the clinical record for Resident #3 revealed the facility admitted the resident on 02/27/14 with diagnoses of Communicating Hydrocephalus, Diabetes Type II, Disorganized type Schizophrenia, and Acquired Hemolytic Anemia's. Review of the Annual Minimum Data Set (MDS) Assessment for Resident #3, dated 02/25/15, revealed the Care Area Assessment Summary triggered falls as an area of concern that may warrant interventions. The Quarterly MDS dated	F 323			



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F 323	<p>Continued From page 61</p> <p>06/08/15, revealed the facility assessed Resident #3 to be totally dependent on staff for his/her Activities of Daily Living and totally dependent on staff for transfers. The resident scored a ten (10) out of fifteen (15) on the Brief Interview for Mental Status meaning the resident was interviewable.</p> <p>Review of Resident #3's Comprehensive Care Plan last revised on 08/11/15 with a target date of 09/28/15, revealed the resident had a history of falls, and impaired mobility. He/she was to have bilateral fall mats and a tab alarm to his/her wheel chair. These assistive devices were initiated on 11/11/14.</p> <p>Review of the Falls Incident Reports revealed Resident #3 had a non-injurious fall on 03/15/15, when he/she tried to get out of bed unassisted, on 05/11/15, after he/she rolled out of bed, and on 05/15/15, when he/she was trying to get out of bed unassisted.</p> <p>Observations of Resident #3, on 08/11/15 at 1:40 PM, 2:20 PM, 3:05 PM, 5:10 PM, and on 08/12/15 at 12:10 PM, and 1:15 PM, revealed the resident did not have an alarm on his/her wheelchair while sitting in it watching television.</p> <p>Observations of Resident #3, on 08/12/15 at 7:45 AM, 09:00 AM, and 10:00 AM, revealed the resident was in bed and there were no fall mats on either side of the resident's bed.</p> <p>Interview, on 08/12/15 at 1:15 PM, with Resident #3 revealed the resident did not remember the last time he/she saw fall mats or a wheel chair alarm in his/her room.</p> <p>Interview, on 08/13/15 at 9:45 AM, with CNA #1</p>	F 323			



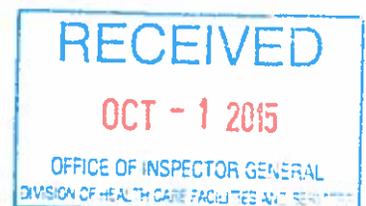
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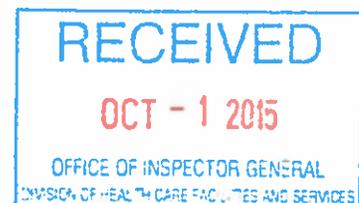
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F 323	<p>Continued From page 62</p> <p>revealed she did not know where Resident #3's wheelchair alarm or fall mats were or when she last saw them. She stated she was aware of Resident #3's history of falls. She stated fall mats were used to prevent injury from falls and wheelchair alarms alerted staff when a resident tried to get up unassisted. She further stated she looked at the CNA care guide to see what assistive devices a resident needed.</p> <p>However, review of the CNA care guide, not dated, revealed Resident #3 was a fall risk, utilized a chair and bed alarm, but there was no mention of the fall mats to be used.</p> <p>Interview, on 08/13/15 at 2:30 PM, with LPN #1 revealed she remembered Resident #3's wheelchair alarm sounding on either 08/09/15 or 08/10/15 when the resident leaned forward to reach for the television remote control. She further stated she was pretty sure she remembered the fall mats being on the floor at the same time. She stated she was aware of Resident #3's fall history. LPN #1 verified the assistive devices were not in the resident's room and stated she did not know where the assistive devices were located.</p> <p>Interview, on 08/14/15 at 7:25 AM, with MDS Nurse #1 revealed fall mats and wheel chair alarms were nursing interventions added to care plans after a resident's fall. She stated if fall mats and wheelchair alarms were on Resident #3's care plan, then they should be in the resident's room.</p> <p>Interview, on 08/14/15 at 8:32 AM, with the ADON revealed the Unit Managers ensured assistive devices were in place for residents when they do</p>	F 323		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/29/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 63 their rounds on the unit. She stated assistive devices listed on the resident's care plan should be reflected in the resident's room. She stated fall mats helped prevent injuries from falls and wheel chair alarms alerted staff when a resident attempted to transfer unassisted. The facility alleged the removal of Immediate Jeopardy by implementing the following:	F 323			
	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.				



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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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F 323	<p>Continued From page 64</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	F 323		
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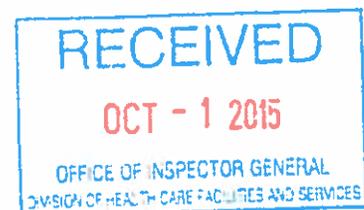
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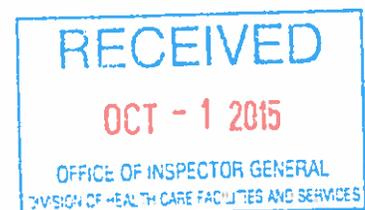
F 323	<p>Continued From page 65</p> <p>admission to ensure the identified needs, interventions or equipment would be in place at the time of admission, which included communicating the resident's needs to the Unit Managers.</p> <p>11. The Unit Managers would ensure that the interventions, special needs 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</p>	F 323		
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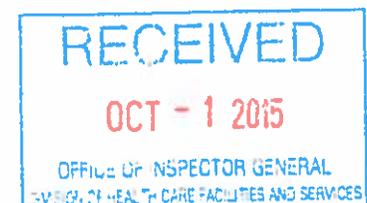
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F 323	Continued From page 66 training was provided by the facility's Activities Director. 16. Facility personnel authorized to transport residents would be retrained quarterly for four (4) quarters and annually, thereafter. 17. Safe resident transport 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	F 323			



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F 323	<p>Continued From page 67 his/her fall in the van.</p> <p>2. Review of the Advanced Registered Nurse Practitioner's documented assessment, dated 07/17/15, revealed Resident #26 was assessed by the ARNP.</p> <p>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.</p> <p>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.</p> <p>5. Review of the admission assessment titled Clinical Health Status, dated 07/17/15, revealed an assessment of Resident #26 was conducted.</p> <p>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.</p> <p>7. Review of an aggregate list of resident falls,</p>	F 323			



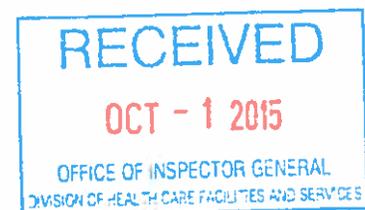
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F 323	<p>Continued From page 68</p> <p>titled Total Events by Type, dated 02/22/15 to 08/22/15, revealed the facility's Assistant Director of Nursing identified four (4) residents, in addition to Resident #26, who had fallen within twenty-four (24) hours of their admission to the facility.</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</p>	F 323		



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F 323	<p>Continued From page 69 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, revealed the training was provided to forty-nine (49) licensed nurses and had signed they received the training.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	F 323		



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F 323 Continued From page 70
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.

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 initialing 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

F 323



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F 323	Continued From page 71 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 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.	F 323		
	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			

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F 323	<p>Continued From page 72</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Interview, on 08/29/15 at 3:42 PM, with the Assistant Director of Nursing revealed she would</p>	F 323			



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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
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F 323	<p>Continued From page 73</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>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</p>	F 323		
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