

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

PRINTED: 06/19/2014
FORM APPROVAL
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

185095

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____
B. WING _____

(X3) DATE SURVEY
COMPLETED

06/05/2014

NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - HILLCREEK

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

(X4) ID
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SUMMARY STATEMENT OF DEFICIENCIES
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resident, "I got my shower today".

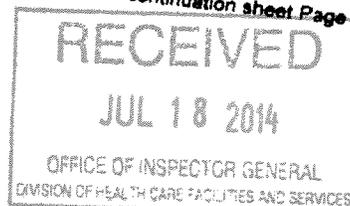
F 312

Clinical record review for Resident #15 revealed the facility admitted the resident on 06/08/12, with diagnoses of Chronic Airway Obstruction, Acquired Torsion Dystonia, Anxiety State, Psychosis, Urinary Frequency, Essential Hypertension, Barrett's Esophagus and Diverticulitis of the Colon. The facility assessed the resident, on 05/09/14, during a quarterly MDS, with a BIMS and determined Resident #15 was cognitively intact with a BIMS score of ten (10) of fifteen (15). The facility assessed the resident's functional status requirement as a one (1) person physical assist during personal hygiene and bathing.

Review of the facility's shower schedule, dated 05/21/14, revealed Resident #15 was scheduled for showers on Wednesday and Friday of each week. Review of the MDS activities of daily living (ADL) reports, dated 04/25/14 through 06/05/14, revealed six (6) showers were documented. Documentation revealed the resident received six (6) of twelve (12) shower opportunities. There were seven (7) days between each shower, dated 04/26/14, 05/03/14, 05/10/14 and 05/17/14. There were thirteen (13) days between showers, dated 05/21/14 through 06/04/14.

Interview with Resident #15, 06/04/14 at 8:20 AM, in his/her room revealed he/she had a shower this morning. The room mate was getting their shower today. His/her shower was on Wednesday and Saturdays, but they don't always give one on the scheduled day.

5. Observation of Resident #20 from the corridor into the resident's room, on 06/4/14 at 8:20 AM,



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revealed the resident's privacy curtain was pulled nearly to the foot of the bed. He/She was laying in the bed with the covers pulled up to the chest with their eyes closed.

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Observation of Resident #20 from the corridor, on 06/03/14 at 11:32 AM, revealed he/she sat in his/her wheelchair near the sink cabinet drawers. He/she reached into the drawer and pulled out a can and sprayed around self.

Clinical record review for Resident #20 revealed the facility admitted the resident on 08/08/12, with diagnoses of Atrial Fibrillation, Chronic Ischemic Heart Disease, Essential Hypertension, Reflux Esophagitis, Nuclear Sclerosis, Polyarthropathy, Hyperplasia of the Prostate and Urinary Retention. The facility assessed the resident, on 05/16/14, during a quarterly MDS, with a BIMS and determined Resident #20 was cognitively intact with a score of fifteen (15) of fifteen (15). The facility assessed the resident's functional status requirement as one (1) person physical assist during personal hygiene and bathing.

Review of the facility's shower schedule, dated 05/21/14 revealed Resident #20 was scheduled for showers on Wednesday and Friday of each week. Review of the MDS activities of daily living (ADL) reports, dated 04/25/14 through 06/05/14, revealed six (6) showers were documented. Documentation revealed the resident received six (6) of twelve (12) shower opportunities. There were eleven (11) days between showers, dated 04/28/14 through 05/07/14. There were ten (10) days between showers, dated 05/07/14 through 05/17/14. There were eleven days between showers, dated 05/24/14 through 06/04/14.

MS-2567(02-99) Previous Versions Obsolete

Event ID: B98311

Facility ID: 100212

If continuation sheet Page 28 of 42

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Interview with Resident #20, on 06/05/14 at 1:20 PM, revealed he/she was supposed to get his showers on Wednesdays and Saturdays. The aides were to busy to get all the showers done sometimes. The resident did not want to get anyone in trouble. The staff were busy and they do not always have time to get all their work done. He/she reported the scheduled shower did not always get done. He/she stated it was often times a week or more between showers.

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

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

Review of the shower schedule for the 100 Unit revealed Resident #6 was not scheduled for routine showers.

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

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Interview with LPN #6, on 06/05/14 at 4:10 PM, revealed the bath and skin report were completed by the CNA with each resident bath and turned in to the assigned nurse. She stated the CNA's were responsible for performing resident nail care on bath days. She further stated the resident's nurse was responsible for ensuring care had been performed. LPN #6 stated she was unable to find any CNA Bath and Skin Reports for Resident #6.

7. Observation and interview with Resident #18, on 06/05/14 at 1:10 PM, revealed the resident was sitting in a wheelchair watching TV in his/her room. The resident appeared pleasantly confused during conversation. A thick, white substance was noted on the resident's teeth.

Review of the clinical record for Resident #18 revealed the facility admitted the resident on 03/04/08 with diagnoses of Congestive Heart Failure, Pressure Ulcer, Hypothyroidism, Dementia, Hypertension, and Diabetes Mellitus. Review of the quarterly Minimum Data Set (MDS) assessment dated 05/16/14 revealed the facility assessed the resident with short- and long-term memory problems and moderately impaired decision making. The facility assessed the resident's functional status as requiring extensive assistance of two plus (2+) assist with hygiene and bathing.

Review of the CNA Care Plan revealed the CNA was responsible to ensure Resident #18 received oral care each shift.

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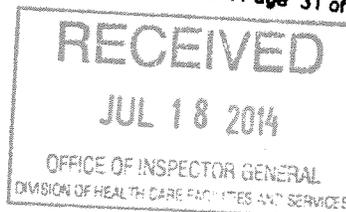
8. Observation of Unsampled Resident B, on 06/05/14 at 8:35 AM, revealed the resident was sitting in a wheelchair, outside the room, dressed for the day. The resident was observed to have long facial hair under the chin.

Interview with Unsampled Resident B, on 06/05/14 at 8:35 AM, revealed staff did not offer to shave the resident. The resident stated daily shaving was completed at home to control the hair.

Interview with Certified Nurse Aide (CNA) #2, on 06/05/14 at 2:20 PM, revealed she had no problem with getting the showers completed on the scheduled shift. She stated the staffing changed a few months ago and now there is no problem getting their work completed. They always get the showers done. The CNAs are to report any scheduled showers not completed during their shift to the nurse and to the oncoming CNA at the end of their shift.

Interview with CNA #10, assigned to the 300 Unit, on 06/05/14 at 5:45 PM, revealed she completed oral care with the residents needing assistance when the resident was going to bed.

Interview with CNA #9 on the 100 Unit, on 06/05/14 at 5:57 PM, revealed she completed oral care after dinner and when they are going to bed. The dentures were put in a cup to soak overnight. Their mouth is cleaned with sponges soaked in water. The residents were offered a mouth wash with the oral care.



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Interview with CNA #5, on 06/05/14 at 2:20 PM,
revealed showers were to be given twice a week
according to the shower schedule which included
shaving and nail care for non-Diabetics, she
further stated if residents were Diabetic the
CNA's were to report long nails to the staff nurse
so they could be trimmed.

Interview with LPN #9, on 06/05/14 at 2:25 PM,
revealed the CNA's completed the shower sheets
and reported any problems to the staff nurse then
the Director of Nursing (DON) kept the completed
shower sheets to review.

Interview with LPN #6, on 06/05/14 at 4:15 PM,
revealed bath and skin sheets were to be
completed by the CNA on the resident's
scheduled shower days and further stated she
reviewed the sheets to ensure residents care was
provided and was not aware of any concerns.

Interview with Assistant Director of Nursing
(ADON), on 06/05/14 at 4:00 PM, revealed the
importance of providing personal care such as
showers, shaving, and nail care preserved dignity
and good hygiene because the skins was first line
of defense with infection.

F 371 483.35(i) FOOD PROCURE,
SS=F STORE/PREPARE/SERVE - SANITARY

F 371

The facility must -

- (1) Procure food from sources approved or
considered satisfactory by Federal, State or local
authorities; and
- (2) Store, prepare, distribute and serve food
under sanitary conditions

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This REQUIREMENT is not met as evidenced
by:

Based on observation, interview, record review,
and review of the facility's policies Storage of
Refrigerated Food, Frozen Food, Cleaning
Schedule and Summary Report of Meetings, it
was determined the facility failed to ensure food
stored in the refrigerator was labeled and dated.
The facility failed to ensure the storage rack
holding clean pots and pans were covered with a
clean protective cover and was not in contact with
trash containers. In addition, the facility failed to
ensure the walls behind the prep tables were not
spattered with a brownish yellow substance and
the plastic storage container that held clean
utensils did not contain crumbs and soiled paper
liner.

The findings include:

Review of the facility's policy regarding Storage of
Refrigerated Foods, not dated, revealed all items
not stored in the original container must be
labeled and noted with a use by date according to
the storage chart, and used or discarded within
the allowed days. Refrigerated foods were to be
monitored daily for expiration dates or the use by
dates and all outdated items immediately
discarded. It is the responsibility of the Director
of Dining or designee to ensure that all
refrigerated food was properly stored, used, or
disposed of according to the guidelines.

Review of the facility's policy regarding Storage of
Frozen Foods, not dated, revealed extra portions
of frozen food must be labeled with the specific

1. Walls above the counter in the dishwasher
room and Walls behind the prep tables that
stored the microwave were cleaned
immediately by the dietary aide and checked
by the DDS. The plastic container that stored
the clean utensils was thrown away
immediately by the dietary aide and checked
by the DDS. The utensils washed and stored
away by the dietary aide and checked by the
DDS. The plastic zip top storage bag with
corned beef was thrown away immediately by
the dietary aide and checked by the DDS.
Plastic containers of grapes, onions and
tomatoes were thrown away by the dietary aide
immediately and checked by the DDS.
The wall behind the prep table that held the
coffee makers was cleaned by the dietary aide
immediately and checked by the DDS.
The side of the reach in refrigerator was
cleaned immediately by the dietary aide and
checked by the DDS. The trash can was
emptied on 06-03-14 by the dietary aide and
checked by the DDS. The storage rack cover
was thrown away by the DDS on 06/04/14. The
pots and pans and storage rack were cleaned on
06/04/14 by the staff dishwasher and checked
by the DDS.

07/18/14

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product name, date frozen and a use by date. Frozen food stock was to be rotated on a first in/first out (FIFO) system. In addition, the Director of Dining Services or designee was responsible for ensuring all frozen food was properly stored and used or disposed of according to guidelines (temperature-specific degree per state regulations).

Review of the facility's policy for Cleaning Schedules, not dated, revealed an effective cleaning schedule must be developed and posted for each piece of equipment and all areas that required routine cleaning in the Dining Services Department. The cleaning schedule list would include the item, frequency, and position accountable for the cleaning process. The Director of Dining Services was responsible for developing, posting and enforcing cleaning schedules and monitoring the completion of assigned cleaning tasks to ensure a sanitary environment.

Review of the facility's Summary Report of Meetings, dated 5/21/14 at 12:45 PM, revealed the dietary staff were trained on dietary policy and procedure, including labeling and dating of stored food.

Observation of the kitchen, on 06/03/14 at 8:20 AM, revealed a brown and black substance on the walls above the counter in the dishwasher room. Further observation revealed a brown substance on the walls behind the prep tables that stored the microwave and the slicer. In addition, a plastic container that stored clean utensils, contained crumbs and a soiled paper liner.

2. All Residents could potentially be at risk related to this practice.

3. The cleaning schedules were reviewed and revised by the DDS to include items cited on 06/29/14 and will be implemented on 06/30/14 by the DDS. All dietary staff in serviced on 06/27/14 or 06/30/14 by the DDS on the new cleaning schedules. All dietary staff in serviced by the DDS on proper labeling and dating of food items on 06/27/14 or 06/30/14

4. The kitchen will be monitored daily by the cook and DDS or lead cook for following cleaning schedules, and Labeling and dating of food to be proactive. The cook will follow up daily that the cleaning schedule is completed and all items are labeled and dated correctly. This is done by the completion and review of the opening and closing checklist for cooks. The DDS or lead cook then also follows up daily to ensure that schedules and policies are being followed by checking items herself and that the cooks have completed their checklists. On a daily basis if there are items found to be out of compliance the DDS or lead cook immediately will correct and in-service the dietary staff. She then will communicate these findings daily to the ED. The ED will then report these findings to QAPI monthly for 4 months. The RD will do weekly audits of the dietary department for 4 weeks, then monthly for 3 months, to check for cleanliness of the walls in the department and that the food is properly labeled and dated. The RD findings from the audits will be reported to the DDS. The RD will report the findings to the QAPI committee monthly for 4 months.

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Interview with the Food Service Manager (FSM), on 06/03/14 at 8:35 AM, revealed the plastic container of utensils collected more crumbs because of its location on the lower shelf of the prep table. She stated the storage container should be cleaned weekly.

Observation of the kitchen, on 06/03/14 at 8:40 AM, revealed a plastic zip top storage bag in the walk-in freezer labeled as corned beef with a use by date of 04/09/14. Further observation of the walk-in refrigerator revealed one (1) plastic storage container of grapes that were not dated, as well as, one (1) plastic storage container of sliced onions and one (1) plastic storage container of sliced tomatoes with a use by date of 06/01/14.

Observation of the kitchen, on 06/03/14 at 2:25 PM, revealed splattered black and brown substances on the wall behind the prep table that held the coffee makers, as well as, on the side of the reach-in refrigerator located next to the prep table.

Observation of the kitchen, on 06/03/14 at 2:30 PM, revealed an over filled trash can pushed tightly against a storage rack of clean pots and pans. Further observation of the storage rack revealed a heavily soiled, grayish-black discoloration of the protective cover.

Interview with the Food Service Manager (FSM), on 06/05/14 at 10:50 AM, revealed she was aware of the black and brown substance on the wall of the dish room. She stated she was working with the Administrator in obtaining a contractor to paint the kitchen. The FSM stated she had notified the Administrator regarding

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painting the kitchen, as well as, submitted a two-page list of needed kitchen repairs. She also stated the walls of the dish room and behind the prep tables should be wiped down daily. The FSM revealed each of the kitchen staff were assigned daily kitchen tasks and stated the Administrator had reviewed dietary policy and procedure with dietary staff during a recent mandatory meeting. She also revealed she had created a new kitchen-cleaning schedule, but the kitchen staff had not been in serviced on the change. The FSM stated she had recognized the condition of the protective cover on the storage rack for clean pots and pans and revealed the facility had purchased new shelves to replace the existing rack and cover. In addition, she stated the trash can should not have been pushed up against the storage rack of clean pots and pans. She indicated the clean pots and pans were going to be relocated to a new storage area away from the area of the back door where the trash cans were stored. The FSM further revealed she was responsible for monitoring the storage and disposal of refrigerated and frozen food. She stated she monitored the shelves of the refrigerator and freezer daily for outdated food. The FSM stated there was a potential for foodborne illness as a result of serving outdated food.

F 371

Interview with the Administrator, on 06/05/14 at 3:30 PM, revealed she routinely did rounds in the kitchen and had noticed the kitchen needed to be reorganized.

431 483.60(b), (d), (e) DRUG RECORDS,
S=E LABEL/STORE DRUGS & BIOLOGICALS

F 431

The facility must employ or obtain the services of

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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

185095

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____
B. WING _____

(X3) DATE SURVEY
COMPLETED

06/05/2014

NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - HILLCREEK

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

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
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PROVIDER'S PLAN OF CORRECTION
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F 431 Continued From page 36

F 431

07/18/14

a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and review of the facility's policies Medication Storage, Blood Glucose Monitor Decontamination and the Material Safety Data Sheet, it was determined the

1. Nurse # 1 and all nursing staff was immediately, on 06/05/14 by the Director of Clinical Education (DCE), in-serviced regarding policy and procedure for allowing only licensed nursing personal or pharmacy personal into the medication rooms. The Clorox wipes were immediately removed from the medication carts and labeled.

2. All residents in the facility receiving glucometer checks and or receiving medications have the potential for being effected by the deficient practice. All med rooms were secured and locked. No other non licensed nursing staff or non pharmacy personal were allowed in the medication rooms.

3. The nursing Staff will be in-serviced on 06/27/14 - 06/30/14 by the IDT team regarding the Clorox wipes and the handling and passing off keys to secure medication rooms. The facility has also purchased new individual bleach wipes for each medication cart.

4. The Unit managers will randomly select 2 nurses per week for 4 weeks to check that they have the proper bleach wipes on their med carts with labels. They will also ask the nurses what the guidelines are for access into the med room. The DON/ADON will report any negative findings to QAPI committee monthly.

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facility failed to ensure the chemical wipes utilized on seven (7) of ten (10) medication carts were properly labeled with identifying information. The chemical wipes were used to disinfect blood glucose meters. In addition, the facility failed to secure the medication room for four (4) of four (4) medication rooms. A nurse provided medication room keys to a staff member not lawfully authorized to administer medications.

F 431

The findings include:

1. Review of the facility's Medication Storage Policy, Section 4.1 Storage of Medication, dated December 2008, revealed the medication supply was accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications.

Observation of the medication room, on 06/05/14 at 8:45 AM, revealed the Dietician unlocked and opened the medication room door with a set of keys obtained from Licensed Practical Nurse #1. Observation from the window of the med room door revealed an emergency drug box, IV fluid box and a grey box with medications sitting on the counter.

Review of the Injectable Emergency Supply PAR list provided by the facility for Box Number INJ006 included eighteen (18) prescription medications for a total of fifty-seven (57) medications accessible.

Review of the Oral Emergency Supply PAR list provided by the facility for Box Number PO033 included thirty-one (31) prescription medications for a total of two hundred sixty (260) medications accessible.

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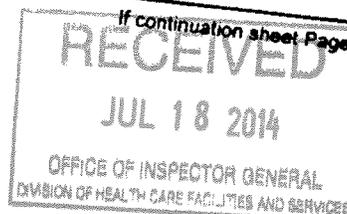
F 431

Review of the Oral Emergency Supply PAR list provided by the facility for Box Number PO007 included thirty-one (31) prescription medications for a total of two hundred sixty (260) medications accessible.

Interview with the Dietician, on 06/05/14 at 8:50 AM, revealed she accesses the medication rooms as needed to obtain resident charts. She stated the charts are kept in the medication rooms and she has obtained them as she has needed. She stated she has always obtained the keys and went into the medication rooms to get the charts. She reported she obtained the keys from Licensed Practical Nurse (LPN) #1. She was not sure if she had done something wrong.

Interview with LPN #1 at the 200 Unit nurses station, on 06/05/14 at 2:10 PM, revealed she provided the Dietician with the medication room keys. LPN #1 stated she had provided her keys to the Dietician to get charts and the Certified Nurse Aides (CNA) to get their supplies out, such as lotions. She stated the keys should keep the medication room secure. She further stated the emergency medication supply was kept in the medication room as well.

Interview with the Assistant Director of Nurses (ADON) in the 200 Unit medication room, on 06/05/14 at 2:20 PM, revealed the medication room should be kept locked and only persons approved to pass medications or pharmacy personnel should be allowed in the medication room. She stated the medications from pharmacy were delivered to this secured room waiting for proper storage. The emergency kit and intravenous fluids are kept in the medication



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room.

F 431

2. Review of the Blood Glucose Monitor
Decontamination policy, dated June 2012,
revealed the purpose was to implement a safe
and effective process for decontaminating the
blood glucose monitors. Monitors were to be
cleaned and disinfected with wipes following use
on each resident.

Review of the Material Safety Data Sheet from
the Clorox Company for the Product: Clorox
Healthcare Bleach Germicidal Wipes, dated
September 2011, revealed the liquid caused
moderate eye irritation and to call a doctor. If
ingested; call a doctor or poison control center.
Irritation may occur with skin contact and if it
persists call a doctor. In addition, for prolonged
exposure wear safety glasses, rubber or
neoprene gloves.

Observation of medication carts on the 100, 200,
and 400 units, on 06/05/14 at 3:25 PM, revealed
wet wipes inside a clear sealed plastic zipper
storage bag with Clorox Bleach Wipes
handwritten on the outside of the bag without a
date filled, ingredients, first aid information, and
special protection for handling and precautions.

Interview with License Practical Nurse (LPN) #7
in the 100 Unit medication room, on 06/05/14 at
3:25 PM, revealed blood glucose monitors were

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STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431 Continued From page 40

cleaned with Clorox wipes that were taken from a large container and placed in plastic zipper bags and the nurse that pulled the wipes for the medication cart wrote Clorox or Bleach wipes on the outside of the bag. LPN #7 stated the plastic bags did not contain information about the wipes, when the wipes were placed in the bag nor was an expiration date noted on the bag and should be listed.

F 431

Interview with Registered Nurse (RN) #1, on 06/05/14 at 3:20 PM, revealed the system for the facility was to pull bleach wipes and place them in plastic bags. She stated the plastic bags should be labeled to identify the product with fill and expiration dates.

Interview with Assistant Director of Nursing (ADON), on 06/05/14 at 4:00 PM, revealed the plastic bags used for blood glucose cleaning, (Clorox wipes) should be identified with a label of contents and include a fill and expiration date on the plastic bag.

F 463 483.70(f) RESIDENT CALL SYSTEM -
SS=E ROOMS/TOILET/BATH

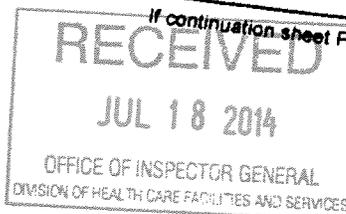
F 463

The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to ensure three (3) of three (3) restrooms on the 400 Therapy Unit were equipped with emergency pull cords.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220	

(X4) ID PREFIX TAG F 463	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 463	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 07/18/14
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F 463 Continued From page 41

The findings include:

The facility did not provide a policy on emergency call system.

Observation, on 06/02/14 at 10:00 AM, during the initial tour revealed three (3) of three (3) restrooms on the 400 unit were unlocked and accessible to residents. The three restrooms did have a push button call system, but were without emergency pull cords.

Interview with the Administer, on 06/05/14 at 1:10 PM, revealed she did not realize the three (3) restrooms on the 400 unit did not have pull cords and felt the maintenance assistant was doing the best he could without a maintenance director.

1. These (3) three restrooms are now locked and are for staff and or visitor use only. We made the change to All public restrooms, (There are only 3 more), they will be locked and will be for staff or visitor use only. This will ensure the restrooms are not resident accessible.

2. All residents in the facility had the potential for being effected by the deficient practice. No resident harm occurred.

3. All public bathrooms in the facility that were resident accessible were checked on 06/06/14 for the working call lights in the bathroom. All were found in working order.

4. The Maintenance Director will randomly select one public bathroom, monthly for 4 months to check that the door is locked and the that the key is properly secured so the resident cannot access the bathroom. The Maintenance Director will report any negative findings to QAPI committee monthly for 4 months.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GOLDEN LIVING CENTER HILLCREEK B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1970, 1984</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two (2) levels, Type III Protected.</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments in the Upper Level and three (3) in the Lower Level.</p> <p>FIRE ALARM: Complete fire alarm system.</p> <p>SPRINKLER SYSTEM: Complete automatic, dry sprinkler system; pipe schedule design.</p> <p>GENERATOR: Type II, 350 KW generator, fuel source is diesel, installed new in 2007.</p> <p>A Life Safety Code Survey was conducted on 06/03/14. The Survey began using the 2786S, short form. Concerns were identified affecting egress and the survey was then changed to the 2786R standard form. The facility was found not in compliance with the requirements for participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Exec. Dir.	(X6) DATE 6/29/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

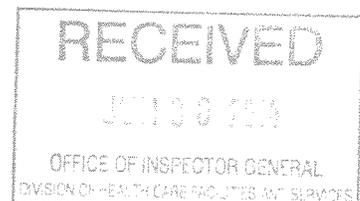
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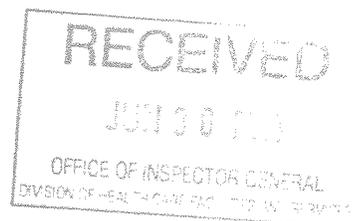
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K 000	Continued From page 1	K 000			
K 027 SS=D	<p>Deficiencies were cited with the highest scope and severity of an E level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors, located in a smoke barrier, would resist the passage of smoke in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to effect two (2) of three (3) smoke compartments located in the Lower Level, residents, staff and visitors. The facility has one-hundred and seventy-two (172) certified beds and the census was one-hundred and sixteen (116) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/03/14 at 8:57 AM, with the Executive Director and the Maintenance Assistant revealed the cross-corridor doors located in the</p>	K 027	<p>K 027</p> <ol style="list-style-type: none"> 1. The cross-corridor doors located in the lower level 400 unit were adjusted to close completely on 06/03/14. 2. An audit of all facility corridor doors was completed on 06/03/14. All the other corridor doors did close completely with no gaps. 3. Maintenance will complete once a month checks on all corridor doors to ensure that they close completely. 4. Maintenance will report the findings of the monthly checks to the QAPI team. The QAPI team meets monthly. Each month, the team will review the results of these checks to ensure that the doors close completely. This will be completed for 4 months to ensure compliance and resident safety. 	07/15/14	



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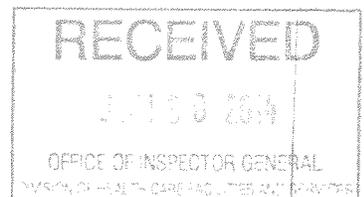
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K 027	<p>Continued From page 2</p> <p>Lower Level, 400 Unit, would not completely close when tested. The pair of doors could not close completely and resist the passage of smoke in the event of an emergency.</p> <p>Interview, on 06/03/14 at 8:59 AM, with the Executive Director and the Maintenance Assistant revealed they were not aware the pair of doors would not completely close and would not be capable of resisting the passage of smoke in the event of an emergency. The pair of doors had functioned properly during the most current fire drill conducted on 05/30/14.</p> <p>The census of one-hundred and sixteen (116) was verified by the Executive Director on 06/03/14. The findings were acknowledged by the Executive Director and Director of Nursing Services during the Exit Conference on 06/03/14.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>Reference: NFPA 80 (1999 Edition)</p> <p>Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.</p>	K 027		
K 034 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Stairways and smokeproof towers used as exits</p>	K 034		



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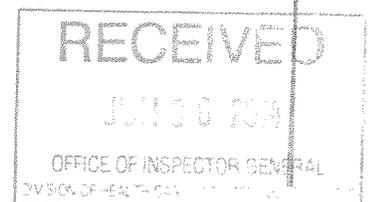
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
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K 034	Continued From page 3 are in accordance with 7.2. 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure stairwells were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to effect two (2) of three (3) smoke compartments in the Lower Level and four (4) of eight (8) smoke compartments in the Upper Level, residents, staff and visitors. The facility has one-hundred and seventy-two (172) certified beds and the census was one-hundred and sixteen (116) on the day of the survey. The findings include: Observation, on 06/03/14 at 9:03 AM, with the Executive Director and the Maintenance Assistant revealed nine (9) boxes of toilet paper were stored under the stairs within the one (1) hour, fire rated stair enclosure located at the end of the Lower Level, 400 Unit, discharging from the Upper Level, 300 Unit. Interviews, on 06/04/14 at 9:05 AM, with the Executive Director and the Maintenance Assistant revealed they were not aware combustible supplies were being stored within the one (1) hour fire rated stair enclosure and acknowledged the potential hazard created by using a stair enclosure for storage. Observation, on 06/03/14 at 9:17 AM, with the Executive Director and the Maintenance Assistant revealed four (4) industrial floor buffers were	K 034	K 034 1. The nine boxes of toilet tissue were removed on 06/03/14 from underneath the stairs at the end of the lower level 400 unit. The four industrial floor buffers were removed on 06/03/14 from underneath the stairs at the lower level 200 unit. 2. An audit of all facility stairwells, underneath of stairs, was completed on 06/03/14. No other items were found stored in these areas. 3. Maintenance will complete once a month checks of all facility stairwells, underneath of stairs, to ensure no items are stored in these areas. 4. Maintenance will report the findings of the monthly checks to the QAPI team. The QAPI team meets monthly. Each month, the team will review the results of these checks to ensure that there are no items stored in those areas. This will be completed for 4 months to ensure compliance and resident safety.	07/15/14



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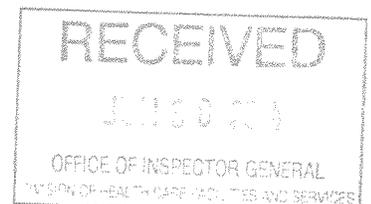
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GOLDEN LIVING CENTER HILLCREEK B. WING _____		(X3) DATE SURVEY COMPLETED 06/03/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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K 034	<p>Continued From page 4</p> <p>stored under the stairs within the one (1) hour, fire rated stair enclosure located between the Lower Level 200 Unit and the 400 Unit, discharging from the Upper Level, 300 Unit.</p> <p>Interviews, on 06/04/14 at 9:19 AM, with the Executive Director and the Maintenance Assistant revealed they were not aware maintenance equipment were being stored within the one (1) hour fire rated stair enclosure and acknowledged the potential hazard created by using a stair enclosure for storage.</p> <p>The census of one-hundred and sixteen (116) was verified by the Executive Director on 06/03/14. The findings were acknowledged by the Executive Director and Director of Nursing Services during the Exit Conference on 06/03/14.</p> <p>NFPA 101 (2000 edition)</p> <p>7.2.2.5.3* Usable Space.</p> <p>There shall be no enclosed, usable space within an exit enclosure, including under stairs, nor shall any open space within the enclosure be used for any purpose that has the potential to interfere with egress.</p> <p>Exception: Enclosed, usable space shall be permitted under stairs, provided that the space is separated from the stair enclosure by the same fire resistance as the exit enclosure. Entrance to such enclosed usable space shall not be from within the stair enclosure. (See also 7.1.3.2.3.)</p>	K 034		
K 038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section</p>	K 038		



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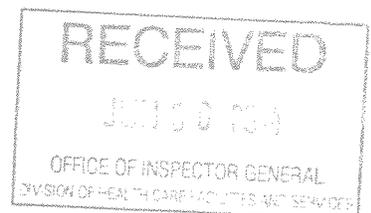
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K 038	Continued From page 5 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments in the Lower Level and one (1) of eight (8) smoke compartments in the Upper Level, residents, staff and visitors. The facility has one-hundred and seventy-two (172) certified beds and the census was one-hundred and sixteen (116) on the day of the survey. The facility failed to ensure doors equipped with delayed egress had the proper signage displayed for egress. The findings include: Observation, on 06/03/14 at 9:33 AM, with the Executive Director and the Maintenance Assistant revealed the exit access doors located at the end of the Lower Level, 400 Unit were equipped with delayed egress locks, but did not display the proper signage on the doors. Interviews, on 06/03/14 at 9:35 AM, with the Executive Director and the Maintenance Assistant revealed they were not aware the delayed egress doors did not display the proper signage required for doors equipped with delayed egress	K 038	K 038 1. The exit doors located at the end of the lower level, 400 unit, had the proper signage placed on 06/03/14. The exit access door located off the main dining room in the upper level had the proper signage placed on 06/03/14. 2. All other exit doors were checked for proper signage on 06/03/14. All other doors had the proper signage. 3. Maintenance will complete a monthly check of the exit doors to ensure that the doors have the proper signage. 4. Maintenance will report the findings of the monthly checks to the QAPI team. The QAPI team meets monthly. Each month, the team will review the results of these checks to ensure that the doors have the proper signage. This will be completed for 4 months to ensure compliance and resident safety.	07/15/14



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K 038	<p>Continued From page 6 hardware.</p> <p>Observation, on 06/03/14 at 10:46 AM, with the Executive Director and the Maintenance Assistant revealed the exit access door located off of the Main Dining Room in the Upper Level, was equipped with delayed egress hardware, but did not display the proper signage on the door.</p> <p>Interviews, on 06/03/14 at 10:48 AM, with the Executive Director and the Maintenance Assistant revealed they were not aware the delayed egress door did not display the proper signage required the door equipped with delayed egress hardware.</p> <p>Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat</p>	K 038		



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K 038	Continued From page 7 detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 038			

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K 064 K 064 SS=D	Continued From page 8 NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the installation of portable fire extinguishers per National Fire Protection Association (NFPA) standards. The deficiency had the potential to effect one (1) of three (3) smoke compartments located in the Lower Level, residents, staff and visitors. The facility is certified for one-hundred and seventy-two (172) beds and the census was one-hundred and sixteen (116) on the day of the survey. The findings include: Observation, on 06/03/14 at 8:30 AM, with the Executive Director and the Maintenance Assistant revealed a portable fire extinguisher was sitting directly on the floor, underneath a handicapped accessible, countertop, sink located in the Rehab Lounge. Interview, on 06/03/14 at 8:32 AM, with the Executive Director and the Maintenance Assistant revealed the portable fire extinguisher had been mounted on the wall, but was in the process of being relocated within the room. They stated it should not be sitting directly on the floor with the	K 064 K 064	K 064 1. The portable fire extinguisher was removed and mounted on the wall on 06/13/14. 2. All other fire extinguishers in the facility were checked to make sure they were mounted on the wall. All were mounted on the wall appropriately. 3. Maintenance will complete a monthly check of all fire extinguishers to ensure they are mounted on the wall. 4. Maintenance will report the findings of the monthly checks to the QAPI team. The QAPI team meets monthly. Each month, the team will review the results of these checks to ensure that the fire extinguishers are mounted on the wall. This will be completed for 4 months to ensure compliance and resident safety.	07/15/14	



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K 064	Continued From page 9 hazardous potential of being knocked over. The census of one-hundred and sixteen (116) was verified by the Executive Director on 06/03/14. The findings were acknowledged by the Executive Director and the Director of Nursing Services during the Exit Conference on 06/03/14. Actual NFPA Standard: Reference NFPA 10 (1998 Edition). 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064			

