

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

PRINTED: 07/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2013
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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 000	<p>INITIAL COMMENTS</p> <p>AMENDED 07/24/13 AMENDED 07/02/13</p> <p>A standard survey was initiated on 06/11/13 with a partial extended survey conducted on 06/14/13 and concluded on 06/15/13. The Health survey identified Immediate Jeopardy on 06/12/13 and was determined to exist on 06/11/13 in 42 CFR 483.26 Quality of Care, F323 Accidents and Supervision at a scope and severity of a "K", 42 CFR 483.76 Administration, F490 at a scope and severity of a "L" and F520 Quality Assessment and Assurance at a scope and severity of a "K". Substandard Quality of Care was identified in 42 CFR 483.25 (F323) Quality of Care. The facility was notified of the Immediate Jeopardy on 06/12/13.</p> <p>The facility documented water temperature ranges for the month of February 2013 as low as 104 and as high as 133 degrees Fahrenheit (F). March water temperatures ranged from 117 to 141 degrees (F). The Maintenance Director revealed he did not know what action was taken to protect the residents from injury due to water temperatures above 110 degrees (F). Random water temperatures in April, May and June 2013 were consistently documented by Maintenance as 109 degrees (F). On 06/11/13 at 11:20 AM, water temperatures obtained as part of the survey process ranged from 128-138 degrees (F) as follows: on the 400 Unit, room 401 was 128 degrees (F), room 403 was 128 degrees (F), room 406 was 138 degrees (F), room 408 was 136 degrees (F), room 409 was 138 degrees (F), room 416 was 138 degrees (F), and the 400 Unit shower room</p>	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Candi Perry* TITLE ADMINISTRATOR (X6) DATE 7/29/13

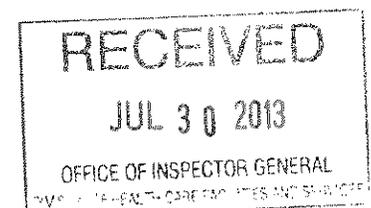
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

RECEIVED
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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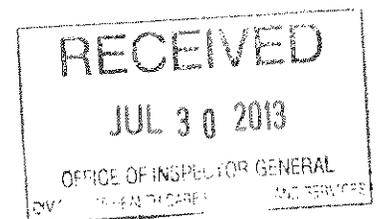
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 000	<p>Continued From page 1</p> <p>was 138 degrees (F). The Maintenance Director admitted to Administration that the water temperatures in the resident care areas that were obtained in April, May and June were made-up and that he had not physically obtained the temperatures of the water.</p> <p>The facility provided an acceptable Allegation of Compliance for the Health survey on 06/13/13 and the Immediate Jeopardy was determined to be removed on 06/15/13 as alleged, prior to exit on 06/16/13. 42 CFR 483.25 Quality of Care, F323 Accidents and Supervision scope and severity was lowered to an "E", 42 CFR 483.75 Administration, F490 Administration scope and severity was lowered to an "F" and F520 Quality Assessment and Assurance scope and severity was lowered to an "E" while the facility continued to implement and monitor the Plan of Correction to ensure compliance.</p> <p>A Life Safety Code survey was initiated on 06/11/13 and concluded on 06/15/13. The Life Safety Code survey identified Immediate Jeopardy on 06/14/13 and was determined to exist on 06/13/13 in 42 CFR 483.70(a) Life Safety Code from Fire (K154) at a scope and severity of an "L". The facility was notified of the Immediate Jeopardy on 06/14/13.</p> <p>On 06/13/13 at 8:15 AM, the sprinkler contractor began contract work to replace sprinkler heads in various locations throughout the facility. The contractor informed the Administrator in Training that he would be putting the system in the test mode, shutting down the sprinkler system at 8:30 AM to do the remedial work. The Administrator in Training failed to inform the Administrator of the</p>	F 000			



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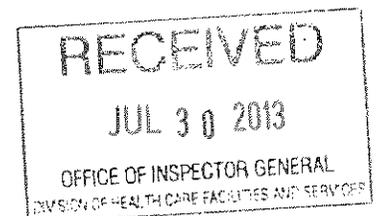
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F 000	Continued From page 2 sprinkler system being shut down and the need to begin the fire watch. Subsequently a fire was discovered at 2:20 PM in an ashtray in the resident smoking area. The automatic sprinkler system had been shut down from 8:30 AM until 3:52 PM, approximately 7.5 hours. The facility identified the sprinkler shutdown at 2:20 PM at the time of the fire due to the fire alarm not sounding. The facility provided an acceptable Allegation of Compliance on 06/16/13 and the Immediate Jeopardy was determined to be removed on 06/16/13 as alleged, prior to exit on 06/15/13. 42 CFR 483.70 (a) K154 scope and severity was lowered to an "F" while the facility continued to implement and monitor the Plan of Correction to ensure compliance.	F 000			
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 155			



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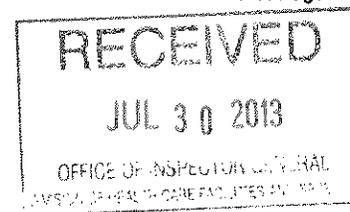
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F 155	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to educate one (1) of eight (8) residents, (Resident #4) who remained in bed all or most of the time, of the consequences of refusal to get out of bed when the resident was capable of being out of bed. Resident #4 would not leave his/her bed except for bathing/shower only and was not educated about the consequences of that decision. The findings include: The facility did not provide a policy related to Resident Education. The facility; however, did provide a written statement with the following explanation, dated 06/14/13: "Booklets presented upon admission on Dehydration, Elopement, Falls, Pain, Pressure Ulcers, Weight loss. All other education is given as needed by the department requested and documented in the progress notes in the chart." Review of the medical record for Resident #4 revealed the facility admitted the resident on 06/21/12 with diagnoses of Depression, Obsessive Compulsive Disorder (OCD), Anxiety State, Hypertension, Ischemic Heart Disease and Osteoarthritis. Review of the last Quarterly Minimum Data Set (MDS) assessment dated 06/15/13 revealed the facility assessed Resident	F 155	F155 1. Resident number 4 was educated on the consequences of not getting out of bed, her family and physician notified on 6/20/13, 6/21/13 and 7/4/13. 2. An audit was completed 7/5/13 to 7/18/13 to identify all residents who refuse medications, treatments, getting out of bed or other recommendations and education will be given immediately to resident and family on the possible consequences of the decision: physical, mental or psychosocial, their physician will be notified. 3. The Director of Clinical Education (DCE) will in-service nursing staff 7/11/13 to 7/24/13 on giving immediate education to residents on the consequences of refusing medications, treatments, getting out of bed or other recommendations and document the education. The DCE will in-service 7/16/13 to 7/24/13 CNA's on the definition of bed mobility and reporting all refusals of care		



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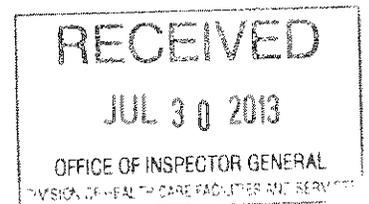
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F 155	<p>Continued From page 4</p> <p>#4 as a fifteen (15) on the Brief Interview for Mental Status (BIMS), a measure of the cognllive status of the resident in which fifteen (15) was the highest score.</p> <p>Continued review of the medical record for Resident #4 revealed no evidence in the Progress Notes from Nursing, Activillies or Social Services related to educating or informing the resident of the consequences of not getting out of bed. Resident #4 did not have a doctor's order for bedrest.</p> <p>Review of the care plan for Resident #4, revision date of 10/29/12 and Target date of 06/13/13, revealed a Focus (Problem) of shearing of skin on the right buttock and noted the resident refused to turn and reposition. There was no intervention for educating the resident of the importance to turn and reposition and the consequences if not done. A physical functioning deficit was listed as a problem with interventions which included Interventions of assisting the resident as needed, but included no interventions to teach the resident about the consequences of his/her immobility. The care plan listed a problem to address the resident's plan to remain in the facility as a resident with a goal to have the psychosocial needs of the resident being met through the next review. There was no evidence of education provided to the resident related to the psychosocial affects of remaining in bed in their room.</p> <p>Observation, on 06/11/13 at 10:00 AM and 3:40 PM, on 06/12/13 at 8:35 AM, 10:42 AM and 12:45 PM and 06/14/13 at 9:40 AM revealed Resident #4 was in bed.</p>	F 155	<p>to their nurse. The DCE will in-service, 7/17/13, activities on educating residents on importance of participating in socialization or activities outside of their room. During the daily progress note review, as well as reports from other disciplines during the daily clinical meeting, the interdisciplinary team will monitor for refusals of care, treatments, medications and other recommendations and validate that education has been given to the resident, family and for physician notification. Competency test for nurses, aides, MDS nurses and activities on in-services.</p> <p>4. QAPI team will meet once a month for 6 months to see how residents are doing that are refusing any type of care or staying in bed and if there is any possibility of a different approach and to monitor for any decline in their physical or mental health. The administrator will review with the DON twice a month, for 6 months, all residents refusing</p>		



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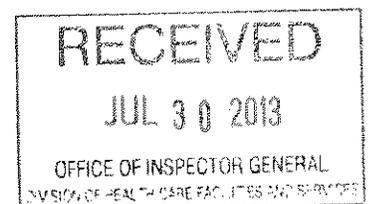
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F 155	Continued From page 5 Interview, on 06/12/13 at 3:30 PM, with Resident #4 revealed prior to being unable to walk, the resident was often out of bed. Continued record review revealed there was no evidence to verify the resident's statement that he/she was unable to walk. The Quarterly MDS, dated 05/15/13, under Activities of Daily Living functional status, the facility had assessed Resident #4 as able to walk in his/her room with the assist of one (1) staff person. Interview, on 06/13/13 at 3:00 PM, with Certified Nursing Assistant (CNA) #8 revealed Resident #4 did not get out of bed except for his/her shower. CNA #8 stated Resident #4 was not taken to the bathroom by wheelchair, as was noted on the care plan, but that the resident remained in bed. CNA #8 revealed her responsibility to Resident #4, as it related to the resident not getting out of bed, was to turn the resident, change the resident, and make sure the resident was dry. The care plan addressed bed mobility training as an intervention by nursing for the physical mobility impairment of Resident #4; however, CNA #8 could not explain what the definition of bed mobility. Interview, on 06/12/13 at 4:05 PM, with Social Services revealed she talked to the residents she was responsible for at a minimum of once every three (3) months. She stated she did not recall the last time she had seen Resident #4 out of bed. She stated they could not force someone to get up, they had to respect their rights. She stated she would look out for the psychosocial needs as a responsibility to the resident when	F 155	any type of care to validate education to the resident and provide the information from this review to the QAPI team as to compliance with the plan of correction. It is ultimately the administrator's job to validate all parts of the POC are implemented and compliance is achieved and continues. 5. Date of compliance 7/27/13		



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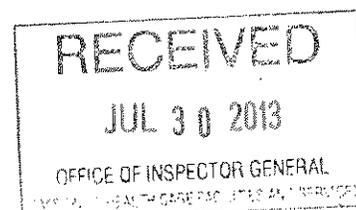
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F 155	Continued From page 6 they chose to remain in bed; however she did not voice a need to explain or teach the resident the psychosocial effects of not getting out of bed. Interview, on 06/12/13 at 4:18 PM, with Licensed Practical Nurse (LPN) #2 revealed Resident #4 would only get out of bed for his/her shower. She stated her responsibility to the resident was to maximize the independence of the resident. LPN #2 stated she had to respect the wishes of the resident. Interview, on 06/12/13 at 4:38 PM, with the Activities Director revealed a resident could not be forced to get out of bed to attend an activity. She revealed the facility could not do anything against the will of the resident. However, she had not offered the resident information about the consequences of not participating in socialization or activities outside of the resident's room to assist the resident in making an informed decision. Interview, on 06/12/13 at 4:50 PM, with the Director of Nursing (DON) revealed the responsibility of nursing to a resident that did not get out of bed was to turn and reposition the resident to prevent skin breakdown. She revealed the staff would encourage a resident to get out of bed but the resident had rights.	F 155			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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.	F 241			



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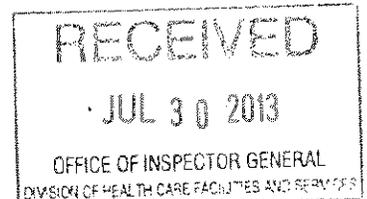
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F 241	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the clinical record and review of the facility's policy and procedures, it was determined the facility failed to provide care for one (1) of the thirty-nine (39) sampled residents (Resident #19). The facility failed to place a covering over the urinary drainage bag for Resident #19.</p> <p>The findings include:</p> <p>1. The facility provided a typed document, dated 06/14/13, signed by the Director of Nursing Services, that revealed the guideline for an indwelling urinary catheter drainage bag cover was not implemented in the guideline manual at this time; however, it was the expectation of the facility to place a covering over the drainage bag as a dignity incentive.</p> <p>Record review for Resident #19 revealed the facility admitted the resident, which was a twenty-five (25) year old person, on 06/12/13 at 1:00 PM. He/she was admitted from an acute care stay with diagnoses of Multiple Closed Pelvic Fracture with a Disrupted Pelvic Circle, a Nontraumatic Rupture of the Bladder, a Closed Fracture of the Calcaneus (Heel), Closed Fracture of Multiple Ribs and Late Effects of a Motor Vehicle Accident.</p> <p>Observation of Resident #19, on 06/13/13 at 12:20 PM, revealed a staff member entered the room with a lunch tray delivery. The uncovered urine collection bag was observed from the hall.</p>	F 241	<p>F241</p> <p>1. Resident # 19 had a foley bag cover placed 7/5/13 by unit manager. 2. An audit was completed 7/5/13 on all residents with foley catheters, and bag covers were put in place to cover the foley as needed. 3. The DCE in-service 7/11/13 to 7/24/13 licensed nurses and CNA's on the importance of providing foley bag covers to the residents with foley's regardless if while in the bed or while the resident is sitting in their wheelchair. During daily room rounds, Department heads, and unit managers are going to check to make sure that residents with foley catheters have the covers. See attached form Any foley bags found to not have covers, will immediately have one placed and the unit manager notified so re-in-servicing and or discipline given to staff providing care. All new admitted residents with foley catheters will automatically be given a foley bag cover for the bed, as well as,</p>		



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F 241	Continued From page 8 Observation of Resident #19, on 06/13/13 at 4:40 PM, revealed a staff member exited the room and the resident's indwelling catheter drainage bag with urine was anchored on the right side of the bed and could be seen from the hall. Interview with Resident #19, on 06/13/13 at 4:55 PM, stated he/she had been in the room since admission and did not know how his/her bag was suppose to be taken care of and he/she hurt too much to be bothered by the catheter. Interview on the 300 Unit, in the Lounge, with Licensed Practical Nurse (LPN) #3, on 06/15/13 at 11:51 AM, revealed he only took care of the resident for a short period on the day he/she was admitted. He stated he was not aware the resident did not have a dignity bag covering the catheter drainage bag. He reported another nurse completed the resident assessment. Interview in the 300 Unit Lounge with Certified Nurse Aide (CNA) #9, on 06/15/13 at 12:12 PM, revealed the catheter drainage bags get a dark colored bag placed over the catheter drainage bag. She stated the nurse had told her to put the covering on Resident #19's catheter. She reported all the drainage bags were supposed to be covered, as this protected the resident's privacy and dignity. Interview on the 300 Unit, at the Nurses Station, with 300 Hall Unit Manager #1, on 06/15/13 at 2:00 PM, revealed she was not aware Resident #19 did not receive a dignity bag over the catheter drainage bag upon his/her admission. She stated the dignity bag was to promote dignity	F 241	the wheelchair, and this will be monitored as part of the admission process by the Unit managers. Competency test were given to ensure understanding of in-services. 4. QAPI team will meet monthly for 6 months to review compliance of foley bag covers and any concerns or issues will be addressed and monitoring continued. The administrator will review the room round sheets, see attached form, for dignity bag usage Monday through Friday for 6 months to validate compliance with the plan of correction. It is ultimately the administrator's job to validate all parts of the POC are implemented and compliance is achieved and continues. 5. Date of compliance 7/27/13		



F241

**GOLDEN LIVING Hillcreek
NON CLINICAL ROUND**

Water and ice not passed?

Is water pitcher damage or dirty?

Is room neat and organized? Bed made?

Bed pan /urinal numbered? Urinal dirty or needs emptied? Placed on bedside table? Bedpan bagged?

Does trash need to be empty? Bags in can?

Resident room door does not shut completely, check only 300 hall for now.

Is privacy curtain clean, no stain?

Call light in place, call light cord has clip?

Over bed light has cord to turn on and resident can reach?

Floor swept and mopped?

Wheelchair/Gerichair dirty? Cushion dirty?

* If resident has foley, is there a dignity bag?

Lights and exhaust fan working in bathroom?

Is resident well groomed, nail care, hair comb, shaved etc?

Medical equipment plugged into electric plug, NO surge protectors or extension cords.

Mattress on floor has clean sheet covering.

Oxygen sign on door frame?

Fall mates torn, dirty?

O2 tubing are dated and bagged?

Room has paper towels, tissue?

RESIDENT CONCERNS

COMPLETED BY _____

Time _____

Date _____

RECEIVED

JUL 30 2013

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES

Inspecting Resident/Patient Rooms

Introduction

To ensure that the resident/patient rooms are as safe and comfortable as possible, routine inspections of the rooms should be done.

General inspection

The following steps should be taken when performing a general inspection on all resident/patient rooms.

Step	Action
1	Check light fixtures to see that fixtures are not loose or dirty.
2	Check condition of doors to make sure they close easily and are free from obstruction.
3	Check bed side rails to ensure proper operation. Make sure they stay in the "up" position until lowered.
4	See that all closet pulls, knobs, and handles are secure and in place.
5	Check televisions for any malfunctions.
6	Pull cubicle curtains and window curtains to see that they move easily in tracks and are hung correctly.
7	Visually check paint, door jams, and door closures, and check wallpaper for damage and tears.
8	Check for insects.
9	In patient room bathrooms check showers, faucets, traps, hoses, and drains for drips or blockage.
10	Check emergency pull cords in resident rooms and bathrooms.
11	Make sure grab bars and towel racks are fastened securely to wall.
12	Check bathroom fan (including isolation room exhaust fans).
13	Flush toilets, make sure toilet seat is securely fastened, and check for leakage and blockage.
14	Check to make sure no extension cords are being used.

Facility #: _____

Facility Name: _____

Date: _____

ADMINISTRATOR CHECK LIST

EXTERIOR

	Acceptable	Action Required	Comments
Entrance at Street	_____	_____	_____
Drives	_____	_____	_____
Curbs	_____	_____	_____
Lawns	_____	_____	_____
Trees/Shrubs/Flowerbeds	_____	_____	_____
Sidewalks	_____	_____	_____
Lawn Furniture	_____	_____	_____
Drainage	_____	_____	_____
Screens & Windows	_____	_____	_____
Siding/Roofedge/Brickwork	_____	_____	_____
Porches	_____	_____	_____
Handrails	_____	_____	_____
Wheelchair Entrances	_____	_____	_____
Doors	_____	_____	_____
Aux Bldgs/Storage Bldgs	_____	_____	_____
Signs	_____	_____	_____
Roof	_____	_____	_____
Eve Troughs/Downspouts	_____	_____	_____
Exterior Lighting	_____	_____	_____
Sprinklers/Plumbing Fixtures/Hoses	_____	_____	_____
Trash Containers (closed)	_____	_____	_____

INTERIOR

VISITOR AREA/LOBBY/FOYER

Ceiling-Tile/Paint/Vinyl	_____	_____	_____
Walls-Vinyl/Paint/Drywall/Block	_____	_____	_____
Floors-Carpet/Tile	_____	_____	_____
Baseboards	_____	_____	_____
Floor Mats	_____	_____	_____
Lighting	_____	_____	_____
Electrical Outlets/Switches	_____	_____	_____
Furniture	_____	_____	_____
Visitor Bathrooms	_____	_____	_____
Soap/Towels	_____	_____	_____
Water Temperature	_____	_____	_____
Ventilation	_____	_____	_____

* Please be specific with location, model numbers, serial numbers, and manufacturer of equipment.

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OFFICE OF INSPECTION
WATERBURY

BATHROOMS/PATIENT SHOWERS/PATIENT BATHS

	Acceptable	Action Required	Comments
Sinks/Toilets/Mirrors	_____	_____	_____
Floors/Walls/Ceiling	_____	_____	_____
Ceramic Tile	_____	_____	_____
Plumbing/Fixtures	_____	_____	_____
Caulking/Seals	_____	_____	_____
Lighting/Receptacles/Switches	_____	_____	_____
Average Water Temperature	_____	_____	_____
Exhaust Fans	_____	_____	_____
Century Tubs	_____	_____	_____
Sprayer Heads/Hoses	_____	_____	_____
Drains	_____	_____	_____
Curtains/Barriers	_____	_____	_____
Grab Bars	_____	_____	_____

KITCHEN

Ceiling	_____	_____	_____
Walls	_____	_____	_____
Floors/Anti-Skid Pads	_____	_____	_____
Doors/Door Jams/Hardware	_____	_____	_____
Baseboards	_____	_____	_____
Sinks/Fixtures	_____	_____	_____
Dish Washer	_____	_____	_____
Fire Systems	_____	_____	_____
Stoves/Ovens/Toasters	_____	_____	_____
Grinders/Mixers/Blenders	_____	_____	_____
Steamers/Steam Tables	_____	_____	_____
Prep Tables/Serving Windows	_____	_____	_____
Refrigerators/Freezers/Temp Gauge	_____	_____	_____
Lighting/Receptacles/Switches	_____	_____	_____
Ceramic Tile	_____	_____	_____
Caulking/Seals	_____	_____	_____
Grease Traps	_____	_____	_____
Grease Filters	_____	_____	_____
Ventilation	_____	_____	_____
Eye Wash Station	_____	_____	_____

Date: _____

DINING

Ceiling-Tile/Composition	_____	_____	_____
Walls-Paint Vinyl/Composition	_____	_____	_____
Floor-Tile/Carpet	_____	_____	_____
Baseboards	_____	_____	_____
Doors/Door Frames/Hardware	_____	_____	_____
Tables/Chairs/Chair Glider	_____	_____	_____
Drapes/Curtains	_____	_____	_____
Window/Screens	_____	_____	_____
Serving Table/Counters	_____	_____	_____
Coffee Maker/Ice Maker	_____	_____	_____
Lighting/Receptical/Switches	_____	_____	_____
Ventilation	_____	_____	_____

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 OFFICE OF THE
 DIRECTOR

DAYROOM/T.V. ROOMS/CRAFT & RECREATION AREAS

	Acceptable	Action Required	Comments
Ceiling-Tile Composition	_____	_____	_____
Walls-Paint/Vinyl/Composition	_____	_____	_____
Floor-Tile/Carpet	_____	_____	_____
Baseboards	_____	_____	_____
Doors/Door Frames/Hardware	_____	_____	_____
Tables/Chairs/Desk/Furniture	_____	_____	_____
Drapes/Curtains	_____	_____	_____
Windows/Screens	_____	_____	_____
Equipment	_____	_____	_____
Ventilation	_____	_____	_____
Lighting/Fixtures	_____	_____	_____

LAUNDRY

Ceiling-Tile/Composition	_____	_____	_____
Walls	_____	_____	_____
Floor	_____	_____	_____
Baseboards/Wall Corner Protection	_____	_____	_____
Doors/Door Frames/Hardware	_____	_____	_____
Tables/Chairs	_____	_____	_____
Washers	_____	_____	_____
Dryers	_____	_____	_____
Electrical Switches/Receptacles	_____	_____	_____
Lighting	_____	_____	_____
Sinks/Plumbing/Fixtures	_____	_____	_____
Drains/Traps	_____	_____	_____
Caulking/Seals	_____	_____	_____
Ventilation	_____	_____	_____
Ceramic Tile	_____	_____	_____
Eye Wash Station	_____	_____	_____

UTILITY/WORK ROOMS

Ceilings	_____	_____	_____
Walls	_____	_____	_____
Floors	_____	_____	_____
Baseboards/Wall Protection/Corner Guides	_____	_____	_____
Work Tables/Counters	_____	_____	_____
Wood Work & Storage Surfaces No Porous	_____	_____	_____
Seals & Caulking	_____	_____	_____
Exhaust	_____	_____	_____
Lighting/Fixtures/Safety Guards	_____	_____	_____

VENTILATION

Kitchen Supply Air/Exhaust/Temperature	_____	_____	_____
Laundry Supply Air/Exhaust/Temperature	_____	_____	_____
Clean Storage Air In (Supply)	_____	_____	_____
Dirty/Chemical Storage Air Out (Exhausted)	_____	_____	_____
Bathrooms/Showers Air Out (Exhausted)	_____	_____	_____
All Exhaust Fans Working	_____	_____	_____

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 1000 ...

MISCELLANEOUS

	Acceptable	Action Required	Comments
Fire Alarms/Smoke Detectors/Sprinklers	_____	_____	_____
Emergency Generator	_____	_____	_____
Telephones/Call Systems/Door Alarms	_____	_____	_____
Enough Hot Water	_____	_____	_____
Heat	_____	_____	_____
Air Conditioning	_____	_____	_____
Dishwasher Temperature Entries	_____	_____	_____
Preventative Maintenance Logs Current	_____	_____	_____
Maintenance Logs Current	_____	_____	_____
Boiler, Elevator, Miscellaneous	_____	_____	_____
Certificates Current	_____	_____	_____

Completed By: _____

Date: _____

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100 N. HEALTH ST.
SPRINGFIELD, IL 62762

ADMINISTRATIVE/WORK AREAS

	Acceptable	Action Required	Comments
Ceilings-Tile/Paint/Vinyl	_____	_____	_____
Walls-Vinyl/Paint/Drywall/Block	_____	_____	_____
Floors-Carpet/Tile	_____	_____	_____
Baseboards	_____	_____	_____
Corners/Wall Protection	_____	_____	_____
Counters Caulked	_____	_____	_____
Soap/Towels	_____	_____	_____
No Storage Under Sinks	_____	_____	_____
Drains/Plumbing	_____	_____	_____
* Doors/Closers	_____	_____	_____
Lighting	_____	_____	_____
Electric Receptacles/Switches	_____	_____	_____
Storage Cabinets	_____	_____	_____
Cupboards	_____	_____	_____
Desks/Drawers/Hardware	_____	_____	_____
Chairs	_____	_____	_____
Call System	_____	_____	_____
Intercoms	_____	_____	_____
Alarms	_____	_____	_____
Curtains/Drapes/Shades	_____	_____	_____
Floor Plans/Evacuation Routes	_____	_____	_____
Equipment	_____	_____	_____
Ventilation	_____	_____	_____

HALLS

Ceilings-Tile/Paint	_____	_____	_____
Walls-Vinyl/Paint/Drywall/Block	_____	_____	_____
Handrails	_____	_____	_____
Floors-Carpet/Vinyl	_____	_____	_____
* Doors/Door Frames/Hardware	_____	_____	_____
Baseboards	_____	_____	_____
Fire Extinguishers (ABC)	_____	_____	_____
Evacuation	_____	_____	Date: _____
Plans Posted	_____	_____	_____
Lighting	_____	_____	_____
Electrical Outlets/Switches	_____	_____	_____
Ventilation	_____	_____	_____

PATIENT ROOMS

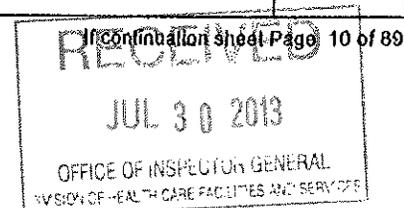
Ceiling-Tile/Paint	_____	_____	_____
Walls-Vinyl/Paint/Drywall	_____	_____	_____
Floors-Carpet/Vinyl	_____	_____	_____
Baseboards	_____	_____	_____
Windows/Screens	_____	_____	_____
Electric Outlets/Switches	_____	_____	_____
Nightlights/Bed Lights/Gen. Lights	_____	_____	_____
Curtains-Windows/Privacy	_____	_____	_____
Furniture/Beds	_____	_____	_____
Closets/Closet Doors	_____	_____	_____
Nurse Call System	_____	_____	_____
Ventilation	_____	_____	_____

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 OFFICE OF INSPECTOR GENERAL
 1000 PENNSYLVANIA AVENUE, N.W.
 WASHINGTON, D.C. 20540

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

PRINTED: 07/24/2013
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 06/16/2013
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 9 for the resident.	F 241	F253	
F 253 SS=E	<p>Interview with the Director of Nursing Services, on 06/15/13 at 2:15 PM, revealed the expectation was for the catheter drainage bag to be covered with a dignity bag. She reported, she did not have a specific guideline for the dignity bag; however, the expectation was that each resident should have the catheter drainage bag covered.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure residents had orderly and comfortable interiors in forty-nine (49) rooms out of sixty-eight (68) rooms observed on the 100, 200 and 400 Units. Wall paper was noted to be coming apart at the seams and/or hanging from the walls. Dresser drawers were noted to be missing handles, off the track, chipped and scarred. Doors to resident rooms were scuffed, chipped and scraped. Painted walls were scuffed and chipped. Footboards were noted to be broken. A mattress on the floor was torn and stained. Tile was missing from the floors of bathrooms and shower rooms. The 400 Activity Room refrigerator was soiled inside and the carpet was soiled and stained. The vinyl flooring in the front hallway was bubbled up and coming loose from</p>	F 253	<p>1. Room 230 had a door name plate ordered 7/21/13 and will be placed as soon as received. The 400 unit shower room tile will be re-grouted by 7/24/13. The 400 unit activity room refrigerator was cleaned 7/19/13. The missing tile in the shower of room 408 will be replaced by 7/24/13. The mattress on the floor in 106 was cleaned and covered 7/18/13. The foot board on bed 136-1 will be repaired by 7/24/13. The over bed light pull cord for bed 137-2 was replaced on 6/25/13.</p> <p>A capital approval has been processed by the corporate office to replace all carpet on 100, 200, 400 and main dining areas and to replace the floor in main hall where it is bubbled up, to replace or remove wall paper in rooms 101, 104, 108,110,127,206,207,208,232,401,404,406,407,408,410,411, 412,413,414, to repair walls and paint in rooms 100,105,115,133,134,405, to repair or remove the built in</p>	



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: 186095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2013
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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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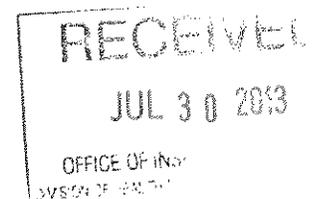
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	<p>Continued From page 10</p> <p>the floor. Carpets throughout the facility were stained and soiled. Room 230 did not have a name plate outside the door. The residents' names were written on a soiled torn paper sign.</p> <p>The findings include:</p> <p>The facility did not provide a policy for maintenance of the facility's resident rooms.</p> <p>Observation of the facility, on 06/11/13 at 10:22 AM, revealed Room 230 did not have a name plate outside the door. The names of the residents were written on a piece of soiled torn paper taped to the wall. The wall paper in Room 232 was peeling off the wall behind the bed and the entry door was scuffed and chipped. The dresser drawers were peeling and chipped in Rooms 228, 232 and 237. The doors were chipped and scuffed in Rooms 229, 228, 235, 236 and the Beauty Shop.</p> <p>Observation of the facility, on 06/12/13 at 8:55 AM, revealed wall paper coming apart at the seams and peeling from the walls in Rooms 401, 404, 406, 407, 408, 410, 411, 412, 413 and 414. In addition, the Shower Room floor tile was missing grout, the Activity Room carpet was soiled and stained, the refrigerator in the Activity Room was soiled with dried spills and debris on the inside and the tile was pulled away from the wall in the shower in Room 408. The paint in Room 405 was bubbled up on the wall. The carpeting on the 400 Unit hallway was stained and soiled.</p> <p>Observation of the facility, on 06/12/13 at 9:15 AM, revealed wall paper coming apart at the</p>	F 253	<p>dresser drawers in 101, 107, 114, 127, 132, 134, 213, 228, 232, 237 and to repair the doors that are chipped/scuffed/scratched for rooms 117, 129, 131, 133, 134, 139, 141, 211, 219, 228, 229, 232, 235 and beauty shop, this work will also be completed by Schaefer General Contracting Services, work to begin 7/22/13 and to continue for 30 weeks. Project manager and oversight is Jarrod Degenhard, Regional Director Facility Maintenance Goldenliving.. See attached contract.</p> <p>2. An audit was completed 7/10/13 of all rooms on 100, 200 and 400 looking for the following issues, missing room name plates, were ordered, bed foot boards missing were replaced, mattresses or fall mats on floor dirty or torn (were cleaned and covered or new ordered, unit resident refrigerators needing cleaning</p>	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

PRINTED: 07/24/2013
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 06/15/2013
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)	(X6) COMPLETION DATE	
F 253	<p>Continued From page 10</p> <p>the floor. Carpets throughout the facility were stained and soiled. Room 230 did not have a name plate outside the door. The residents' names were written on a soiled torn paper sign.</p> <p>The findings include:</p> <p>The facility did not provide a policy for maintenance of the facility's resident rooms.</p> <p>Observation of the facility, on 06/11/13 at 10:22 AM, revealed Room 230 did not have a name plate outside the door. The names of the residents were written on a piece of soiled torn paper taped to the wall. The wall paper in Room 232 was peeling off the wall behind the bed and the entry door was scuffed and chipped. The dresser drawers were peeling and chipped in Rooms 228, 232 and 237. The doors were chipped and scuffed in Rooms 229, 228, 235, 236 and the Beauty Shop.</p> <p>Observation of the facility, on 06/12/13 at 8:55 AM, revealed wall paper coming apart at the seams and peeling from the walls in Rooms 401, 404, 406, 407, 408, 410, 411, 412, 413 and 414. In addition, the Shower Room floor tile was missing grout, the Activity Room carpet was soiled and stained, the refrigerator in the Activity Room was soiled with dried spills and debris on the inside and the tile was pulled away from the wall in the shower in Room 408. The paint in Room 405 was bubbled up on the wall. The carpeting on the 400 Unit hallway was stained and soiled.</p> <p>Observation of the facility, on 06/12/13 at 9:15 AM, revealed wall paper coming apart at the</p>	F 253	<p>dresser drawers in 101, 107, 114, 127, 132,134,213,228, 232,237 and to repair the doors that are chipped/scuffed/scratched for rooms 117,129,131,133,134,139,141,211,219, 228,229,232,235 and beauty shop, this work will also be completed by Schaefer General Contracting Services, work to begin 7/22/13 and to continue for 30 weeks. Project manager and oversight is Jarrod Degenhard, Regional Director Facility Maintenance Goldenliving. The center will be requesting a waiver from CMS since work will not be completed by 90 days after annual survey exit. See attached contract.</p> <p>2. An audit was completed 7/10/13 of all rooms on 100, 200 and 400 looking for the following issues, missing room name plates, were ordered, bed foot boards missing were replaced, mattresses or fall mats on floor dirty or torn(were cleaned and covered or new ordered, unit resident refrigerators needing cleaning</p>		



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

PRINTED: 07/24/2013
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 06/15/2013
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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 253	<p>Continued From page 11</p> <p>seams and peeling from the walls in Rooms 101, 104, 108, 110 and 127. A mattress on the floor in Room 106 was torn and stained, dresser drawers were chipped and scratched in Rooms 101, 107, 114, 127, 132 and 134. The dresser drawers in Room 114 had no handle. Doors in Rooms 117, 129, 131, 133, 134, 139 and 141 were scratched and chipped. Painted walls were chipped and scratched in Rooms 100, 105, 115, 133 and 134. In addition, the foot board on the bed in Room 136-1 fell off the bed frame. Room 137-2 had no pull cord for the over bed light. The dresser drawer in Room 101 was off the track. The carpet in the 100 hallway was stained, soiled and had areas of a bleach-like color. The vinyl flooring on the front hallway was bubbled up and detaching from the floor.</p> <p>Observation of the facility, on 06/12/13 at 9:44 AM, revealed the wall paper was peeling off the walls in Room 206, 207 and 208. Dresser drawers were chipped and scratched in Room 213. The entry doors to Rooms 219 and 211 were chipped and scratched.</p> <p>Interview with the Housekeeping Supervisor, on 06/14/13 at 3:13 PM, revealed the odors in the facility come from leaking toilets. She said maintenance tries to keep them all caulked around the base but so many leak. She stated the carpets looked soiled and stained. They had a schedule for cleaning and the carpets are currently cleaned weekly. She further reported that bleach gets spilled on the carpets and it's hard to get carpets really clean.</p> <p>Interview with Resident #4, on 06/12/13 at 11:40 AM, revealed the room could be nicer if things</p>	F 253	<p>were cleaned, lights above bed missing pull cord had replaced, shower floors missing tiles or grout were repaired, all other issues of wallpaper peeling, painting in rooms, resident room doors chipped/scratched/scuffed, or dresser drawers, soiled and stained carpet are to be addressed in corporate capital approved work by Schaefer General Contracting Services as above.</p> <p>3. An all staff in-service was completed by administrator 7/23/13 on the importance of taking care of center and reporting into computer program "building engines" any needed repairs in resident's rooms or any other area of the center for tracking purposes. Maintenance director once hired will follow his daily preventative maintenance program checks to monitor for resident rooms repair needs and repairs request in building engines. See attached PM form. Administrator will monitor building engines for completion of work orders and daily walking rounds 5 days a</p>	
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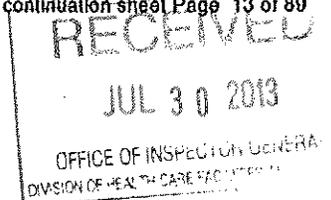
JUL 30 2013

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 07/24/2013
FORM APPROVED
OMB NO. 0938-0391

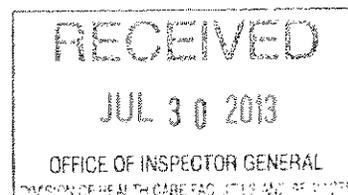
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/16/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP 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 253	Continued From page 12 were fixed up. He/she stated the room needed paint and the carpets needed to be replaced. Continued interview on 06/13/13 at 11:55 AM, revealed the rooms were in need of repairs to dresser drawers and the wall paper. Interview with Licensed Practical Nurse (LPN) #1, on 06/13/13 at 12:10 PM, revealed repairs were requested utilizing a work order given to maintenance. She stated she had not requested repairs for wall paper or furnishings from maintenance. She stated she thought maintenance saw the problems and would repair them when able. Interview with the Director of Nursing, on 06/13/13 at 1:40 PM, revealed she made maintenance rounds on a dally basis and notified them of issues such as broken side rails and beds. She stated she was not sure why resident rooms were not repaired. Interview with the Administrator, on 06/13/13 at 2:40 PM, revealed there was an adequate budget and manpower to implement needed repairs and it was a matter of getting maintenance to do the job.	F 253	week to look for maintenance concerns, see attached Administrator check form. 4. QAPI will review the monthly summary report of work orders and preventive maintenance completed for compliance and trends, this will be an on going monthly QAPI topic for at least one year. Project manager and oversight is Jarrod Degenhard, Regional Director Facility Maintenance for Goldenliving who will ensure work is completed by the end of 30 weeks from July 22, 2013 5. Date of compliance 7/27/13		
F 254 SS=E	There was no Maintenance Director to interview. 483.16(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by:	F 254			



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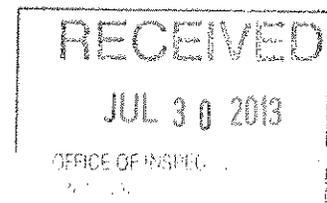
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 254	<p>Continued From page 13</p> <p>Based on observations and interviews it was determined the facility failed to provide the residents with an adequate supply of washcloths for resident use. One (1) of thirty-nine (39) sampled residents, (Resident #25), and three (3) of four (4) unsampled residents (Residents A, B and C), indicated the facility did not have enough washcloths to meet the needs of the residents.</p> <p>The findings include:</p> <p>The facility did not provide a policy for towels and washcloth availability.</p> <p>Observation, on 06/12/13 at 11:00 AM, revealed the linen cart on the 100 Hall with washcloths on the cart. However, there were fewer washcloths noted than the supply of other available linens.</p> <p>Interviews, on 06/12/13 at 10:00 AM, during the Group Interview revealed Resident B stated the facility did not have enough washcloths. Resident B stated they go so fast and Resident A revealed he/she agreed with Resident B and believed the facility ran out of washcloths.</p> <p>Interview, on 06/13/13 at 7:45 AM, with Resident C revealed the facility did not have a ready supply of washcloths. He revealed there were times when he would have to wait for laundry to wash more washcloths before receiving a washcloth.</p> <p>Interview, on 06/13/13 at 7:37 AM, with Resident #25 revealed a towel was used in place of a washcloth when a washcloth was not available.</p> <p>Interview, on 06/12/13 at 11:00 AM, with Licensed Practical Nurse (LPN) #1 revealed at times there</p>	F 254	<p>F254</p> <ol style="list-style-type: none"> 1. Housekeeping has completed a washcloth audit and an order has been submitted on 7/13/13 and received. Another washcloth order was submitted 7/21 for back up to par level. 2. All residents in the center are at risk for not having enough wash cloths. 3. A par level for the center has been established for washcloths, by the Housekeeping supervisor, this level includes a back up supply in storage, that allows for plenty of wash clothes until next order comes in. The par level in the center is 250 dozen wash clothes, with 100 dozen in back up storage. The administrator will monitor wash cloth orders monthly to ensure par levels are being met. Monthly resident council will be asked about wash cloth supplies. The ED will in-service nursing staff on 7/23/13 to inform ED or DON if adequate wash cloths are not available. 		



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F 254	<p>Continued From page 14</p> <p>would not be enough washcloths or towels available and she would go to the laundry to get more.</p> <p>Interview, on 06/13/13 at 4:55 PM, with Social Services revealed during the survey a resident had spoken to her about the lack of washcloths. Social Services stated the facility has had issues related to the washcloths.</p> <p>Interview, on 06/14/13 at 10:25 AM, with the Assistant Housekeeping Manager revealed the washcloths come in once a month. She stated the facility gets more than enough washcloths, it was when they were put out for resident use, the numbers go down (the number of washcloths).</p> <p>Interview, on 06/12/13 at 10:50 AM, with Central Supply revealed when the supply of towels or washcloths get low, the facility reorders them. He revealed he was not the person responsible to place the order. The Administrator in Training (AIT) was responsible to order the towels and washcloths.</p> <p>Interview, on 06/12/13 at 10:52 AM, with the Administrator in Training (AIT) revealed the Housekeeping Manager would give him a monthly report on the level or number of washcloths that were available and the AIT would order more to get the facility back up to a certain par level. The AIT revealed stock was reordered as needed, and no extra stock was kept at the facility. He stated it was not frequent, but it did occasionally happen that washcloths were not available.</p> <p>Interview, on 06/12/13 at 10:52 AM, with the</p>	F 254	<p>4. A QAPI monthly team meeting will review for 6 months that wash cloth orders have maintained par levels, any resident council concerns on wash clothes and any grievances on wash cloths. Any needed changes will be made to address any concerns.</p> <p>5. Date of compliance 7/25/2013</p>		



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F 254	Continued From page 15 Administrator revealed she was not aware of any concerns related to insufficient supply of towels or washcloths.	F 254	F274 1. Resident #4 had her MDS reviewed and changed into a significant change and submitted 6/29/13. Resident #5 significant change has been completed and submitted 7/10/13..		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) 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 complete a Significant Change Minimum Data Set (MDS) assessment for two (2) of thirty-nine (39) sampled residents (Residents #4 and #5). Residents #4 and #5 displayed declines in functional status without a Significant Change assessment completed. The findings include: Review of the facility's policy regarding Resident Assessment revealed the facility utilized the	F 274	2. An audit was completed 7/5/13 to 7/18/13 on the residents living on the long term care units, to check for changes with the MDS for the past 9 months. Any residents found to have had a significant change will have a new MDS completed. 3. The senior MDS nurse, for the company in-serviced the MDS coordinators and interdisciplinary team on recognition of significant change on 7/12/13. Competency test were given to ensure understanding of significant change-service During daily clinical meeting the nurses notes, physician orders and other resident's information will be reviewed for the possibility of a significant change. The daily clinical meeting is attended by DON, ADON, unit managers, MDS		

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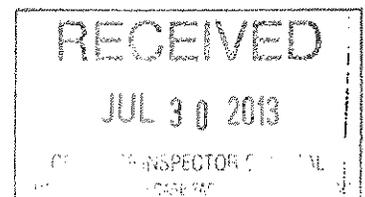
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STATE OF OHIO

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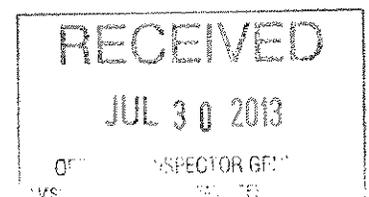
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F 274	<p>Continued From page 16</p> <p>Resident Assessment Instrument (RAI) 3.0 Manual. The definition of Significant Change revealed a decline in the resident's condition was a decline in two (2) or more areas which included: any decline in an Activity of Daily Living (ADL) physical functioning area where a resident was newly coded as extensive assistance, total dependence, or activity did not occur since last assessment; resident's incontinence pattern changed or there was a placement of an indwelling catheter; or an overall deterioration of the resident's condition had occurred.</p> <p>Interview with MDS Coordinator #1, on 06/13/13 at 1:50 PM, revealed the facility utilized the Resident Assessment Instrument (RAI) 3.0 Manual as the facility policy.</p> <p>1. Review of the clinical record for Resident #5 revealed the facility admitted the resident with diagnoses of Hypertension, Osteoarthritis, and Dementia with Delusions. The facility completed an Annual MDS assessment on 07/12/12 which revealed the resident had cognitive impairments, required limited assistance for transfers and ambulation and was occasionally incontinent of bowel and bladder. On 02/14/13, the facility completed a Quarterly MDS assessment which revealed the resident required extensive assistance with transfers, had not been ambulated in the last seven (7) days and was incontinent of bowel and occasionally was incontinent of bladder.</p> <p>Further review of the clinical record for Resident #5 revealed the resident was hospitalized on 03/30/13 after a fall. The hospital record revealed the resident required surgical intervention related</p>	F 274	<p>nurse, RD, SSW, discharge planning nurse and therapy. The MDS coordinators are also going to evaluate residents based upon SBAR's (situation, background, assessment and response to share information on a resident in a concise and structured format) and previous MDS's quarterly to monitor for significant changes when completing the MDS for the resident based upon the normal quarterly MDS schedule.</p> <p>4. The QAPI team will meet monthly for 6 months to review that significant changes in residents are being captured in their MDS. The administrator will meet once a month, for 6 months, with center's senior MDS nurse to review that plan of correction is being followed and significant changes in residents are being captured on their MDS and report this to the QAPI team for validation that the plan of correction is being followed. It is ultimately the administrator's job to validate all parts of the POC are</p>	



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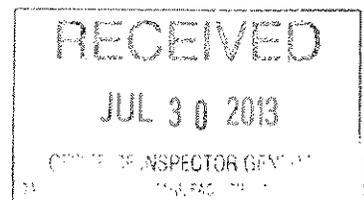
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F 274	<p>Continued From page 17 to a fracture of the left hip.</p> <p>Review of Resident #5's Quarterly MDS assessment, completed by the facility on 04/11/13, revealed Resident #5 was non-ambulatory, required total assistance with transfers, was totally bathed and dressed and was incontinent of bowel and bladder. In addition, the resident returned to the facility with a pressure ulcer on the sacrum. The facility did not complete a Significant Change MDS assessment based on the decline in the ability to walk, the decline in the ability to transfer, and the presence of a new pressure ulcer.</p> <p>Observation of Resident #5, on 06/11/13 at 10:40 AM, revealed the resident was in bed with the head of the bed elevated and the resident was awake. The resident was positioned on the left side with pillows and was disoriented to time and place.</p> <p>Interview with Licensed Practical Nurse (LPN) #17 who was taking care of Resident #5, on 06/11/13 at 10:40 AM, revealed the resident had declined since the fractured hip in March 2013. She stated the resident was no longer able to walk or assist with transfers. She stated staff provided total care for the resident.</p> <p>Interview with Certified Nurse Aide (CNA) #11, on 06/11/13 at 3:35 PM, revealed Resident #5 required total care with all needs and had declined in the last six (6) months.</p> <p>Interview with MDS Coordinator #1, on 06/13/13 at 1:20 PM, revealed Resident #5 had declined and a Significant Change MDS should have been</p>	F 274	<p>implemented and compliance is achieved and continues.</p> <p>5. Date of compliance 7/ 27/ 13</p>		



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F 274	<p>Continued From page 18</p> <p>completed related to the decline; however, revealed it had not been completed. The MDS Coordinator stated although she had been in the department since April 2013, the rest of the MDS staff were new to the facility.</p> <p>Interview with the Director of Nursing, on 08/13/13 at 1:20 PM, revealed the MDS Coordinators were new. She stated MDS Significant Changes were judgement calls.</p> <p>2. Record review revealed the facility admitted Resident #4 on 06/21/13 with diagnoses of Depression, Obsessive Compulsive Disorder, Anxiety State, Hypertension, Ischemic Heart Disease and Osteoarthritis. The facility assessed Resident #4 as a fifteen (15) on the Brief Interview for Mental Status (BIMS), a measure of the cognitive status of the resident in which fifteen (15) was the highest score, during the last Quarterly Minimum Data Set (MDS) assessment on 05/15/13.</p> <p>Review of the MDS, dated 06/28/12, the Admission assessment for Resident #4, revealed the facility assessed the resident to need limited assistance on the MDS, in the areas of transferring, dressing, hygiene, bathing, bowel and bladder, all with a one person physical assist.</p> <p>Review of the Quarterly MDS, dated 02/28/13, revealed the facility assessed that Resident #4 required extensive assistance in dressing, bowel and bladder and required the physical assist of one person. This was a newly coded extensive assist in three (3) areas of ADL physical functioning and should have triggered a Significant Change assessment, there was no</p>	F 274			



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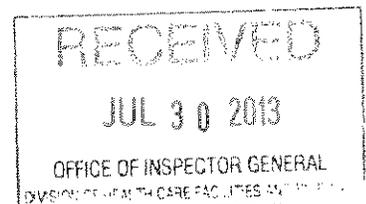
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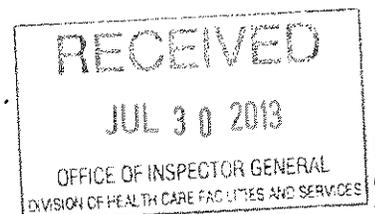
F 274	<p>Continued From page 19</p> <p>evidence a significant change was identified, or assessed for the two (2) week period or a Significant Change assessment completed.</p> <p>Review of the last Quarterly MDS, dated 05/15/13, revealed the facility assessed the resident as having total dependence in dressing, hygiene, bowel and bladder, with the physical assist of one person. This change in four (4) areas of the resident's ADL physical functioning required a Significant Change assessment. However, there was no evidence a significant change was identified, assessed for the two week period or that a Significant Change assessment was completed.</p> <p>Observations, on 06/11/13 at 10:00 AM and 3:40 PM, on 06/12/13 at 8:35 AM, 10:42 AM and 12:46 PM and on 06/14/13 at 9:40 AM revealed Resident #4 was in bed.</p> <p>Interview, on 06/12/13 at 4:05 PM, with Social Services revealed she could not recall the last time she saw Resident #4 out of bed other than for his/her shower. She revealed the resident had some psychiatric issues and when the resident had returned from a psychiatric hospital, he/she only stayed in his/her room. Social Services stated the change after the psychiatric hospital stay was coded on the MDS that Resident #4 did not get up out of bed.</p> <p>Interview, on 06/12/13 at 4:18 PM, with Licensed Practical Nurse (LPN) #2 revealed Resident #4 was assessed on 08/28/12 as continent when he/she was admitted to the facility; however, the CNAs now change the adult brief of Resident #4 when wet.</p>	F 274		
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F 274	Continued From page 20 Interview, on 06/12/13 at 4:38 PM, with Activities staff revealed Resident #4 had transitioned from the Rehabilitation Unit to Long Term Care (LTC). Activities revealed it was after the transfer to LTC that Resident #4 no longer came out of his/her room and remained in bed. Interview, on 06/13/13 at 12:30 PM, with MDS Registered Nurse (RN) #2 revealed if there was a change in the coding of the section of the MDS on functional status and a change in status under Bowel and Bladder on the MSD assessment, the resident would require a Significant Change assessment. However, a Significant Change assessment could not be located in the record. Interview, on 06/13/13 at 2:00 PM, with the MDS Coordinator #1 revealed she was responsible for the completion and accuracy of the MDS and revealed she was not aware of the requirement for a Significant Change assessment. She revealed she had worked in the facility during the decline of Resident #4, but was not in the role of an MDS nurse. She stated she was trained for her position for two (2) weeks with the employee that had the position prior to her. She revealed she had also completed webinars, and a regional person came once a week for her training and the facility had a manual.	F 274			
F 280 SS=D	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.	F 280			



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F 280	Continued From page 21 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure three (3) of thirty-nine (39) sampled residents (Residents #4, #5, and #16) had revisions made to care plans as required. The findings include: The facility provided Chapter 4: Care Area Assessment (CAA) Process and Care Planning from the Resident Assessment Instrument (RAI) User Manual Version 3.0 as their Care Plan Policy. The policy revealed federal requirements supported a nursing home's ongoing responsibility to assess residents. The policy continued, stating the care plan must include	F 280	F280 1. Resident #4 on 6/26/13 had updates to pressure ulcer, depression, anxiety, behavior and hydration care plans, Resident #16 on 7/5/13 had update to pressure ulcer careplan and resident # 5 had update to pressure ulcer careplans on 6/12/13. 2. An audit of all resident's care plans was completed 7/5/13 to 7/18/13 and corrections made as needed. 3. Senior MDS nurse in-serviced the interdisciplinary team, MDS coordinators and unit managers on the importance of creating a care plan that address the problems of the resident, measurable goals, and to delete old areas of concerns from the care plan as updating occurs on 7/12/13. A competency test was given. Based upon daily review of SBARS (situation, background, assessment and response to share information on a resident in a concise and structured format), care plans	

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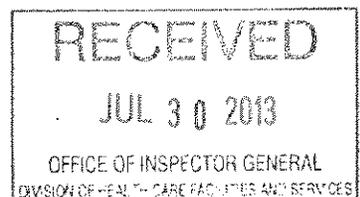
PRINTED: 07/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2013
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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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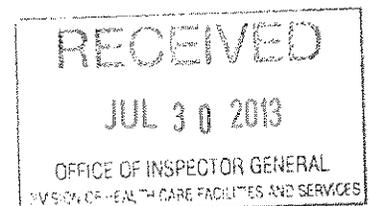
F 280	<p>Continued From page 22</p> <p>measurable objectives and time frames and must describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The care plan must be reviewed and revised periodically, and services provided or arranged must be consistent with each resident's written plan of care. The policy further revealed, based on the review of the comprehensive assessment, the Interdisciplinary Team (IDT) and the resident and/or the resident's representative determine the areas that required care plan interventions, and develop, revise or continue the individualized care plan.</p> <p>1. Observation of Resident #5, on 06/11/13 at 10:40 AM, revealed the resident was in bed on the left side propped with pillows. Speaking with the resident at this time revealed the resident was alert and disoriented to time and place.</p> <p>Review of the clinical record for Resident #5 revealed the facility admitted the resident with diagnoses of Dementia with Delusions and Hypertension. The facility completed a Quarterly Minimum Data Set (MDS) assessment on 04/11/13 which revealed the resident required total care for transfers, dressing, hygiene and bathing. The resident was not ambulatory. The resident sustained a fractured hip in March 2013.</p> <p>Review of the comprehensive care plan for Resident #5 revealed the facility did not address the change in the resident's care needs and had goals that the resident would maintain the current level of physical function, dated 03/01/11 and the resident would continue with current ability to transfer, dated 05/29/13; however, the MDS</p>	F 280	<p>will be updated as needed by the MDS nurse. DON will monitor 5 charts a week for a month, 3 charts a week for next 30 days and 2 chart a week for next 30 days to validate care plans are correct. For next 3 months care plans will be reviewed during daily clinical meeting to validate they are correct.</p> <p>4. QAPI team will meet monthly to review DON's care plan audits for first 3 months and then review the daily clinical meeting notes as to care plans being updated for compliance. The Administrator will meet monthly with DON for 6 months to review care plan audit findings to ensure compliance with the plan of correction and this information will be reviewed with QAPI team monthly. It is ultimately the administrator's job to validate all parts of the POC are implemented and compliance is achieved and continues.</p> <p>5. Date of compliance 7/27/13</p>	
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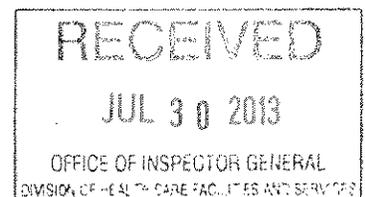
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 280	<p>Continued From page 23</p> <p>revealed the resident required total assistance to transfer and was not ambulatory. The care plan further instructed staff to assist the resident with oral care, nail care, incontinence, and activities of daily living as needed. Review of the MDS revealed the resident required total assistance with dressing, hygiene, bathing, and incontinence. There was no documented evidence the facility revised the care plan to address the resident's need for total care for bathing and dressing. In addition, the care plan goal, dated 03/01/11, developed for the resident was for there to be no falls with related injuries. Review of the hospital notes, from admission on 03/30/13, revealed the resident had fallen and sustained a fractured hip. The facility implemented an intervention to attach an alarm to the wheelchair on 03/26/13. There was no documented evidence that the facility revised the care plan goal to prevent falls.</p> <p>2. Review of the medical record for Resident #4 revealed the facility admitted the resident with diagnoses of Depression, Obsessive Compulsive Disorder, Anxiety State, Hypertension, Ischemic Heart Disease and Osteoarthritis. The facility assessed Resident #4 as a fifteen (15) on the Brief Interview for Mental Status (BIMS), a measure of the cognitive status of the resident in which fifteen (15) was the highest score, during the last Quarterly Minimum Data Set assessment on 06/15/13.</p> <p>Review of the Plan of Care for Resident #4 revealed, under the focus (problem) of physical functioning deficit revealed Resident #4 had changes assessed by the facility MDS on 06/15/13 in the areas of transferring, toileting,</p>	F 280			



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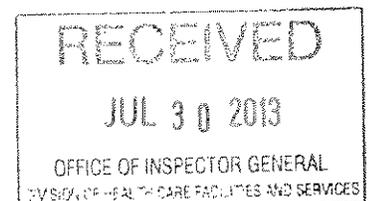
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F 280	Continued From page 24 bowel, bladder, hygiene and dressing. These were changes that occurred since the previous MDS assessment on 02/26/13. However, with the exception of a half rail to aid in bed mobility, all of the interventions had remained the same on the care plan. The focus of at risk for falls did note a fall on 12/06/12. However, taking the resident to the bathroom by wheelchair was an intervention and Resident #4 no longer got out of bed except for his/her shower/bath. Furthermore, the resident remaining in bed was not addressed on the care plan. A focus, initiated 07/11/12, to have Resident #4 as a full code status revealed an intervention was to obtain an Advanced Directive with a physician order and resident/responsible party signature. The care plan was not updated to remove the intervention as the order was received and listed on the chart in June 2012. Under the focus Impaired cardiovascular status, initiated 07/11/12, an intervention was lab work or X-rays as ordered by the physician; however, there was nothing noted as to what lab work was needed for what problem or what the facility planned to X-ray. A focus of pressure ulcer actual or at risk had an intervention for treatment as ordered which was initiated 07/11/12; however, the care plan was not individualized to state what the treatment was for the resident. A focus for Resident #4 was at risk for wound infection related to picking at his/her skin. An intervention was to have a psychiatric evaluation and treatment. Resident #4 was currently under the care of Psychiatry and had already been evaluated. However, the intervention, initiated 01/08/13, remained on the care plan. Throughout the care plan, with an initiation date of 07/11/12, there was no revision date. The following general interventions that	F 280			



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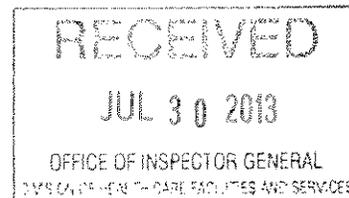
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F 280	Continued From page 25 were to be provided did not describe how the intervention was to help the resident, as was revealed in the facility policy: Rehab services per physician order, Labs as ordered, Monitor vital signs as needed, Administer antibiotics as ordered, Diet as ordered, Administer medications as ordered, Treatments as ordered, Follow standard precautions refer to Living Center Infection Control Manual, Assistive devices as needed, Anticoagulants as ordered and Task segmentallon as indicated. 3. Review of the medical record for Resident #16 revealed the facility admitted the resident with diagnoses of Parkinson's Disease, Renal Insufficiency, Orthostatic Hypotension, Anemia and Arthritis. Resident #16 had been admitted to Hospice on 03/19/13. The facility assessed Resident #16 as a six (6) on the Brief Interview for Mental Status (BIMS) during the last Quarterly Minimum Data Set assessment on 03/28/13. Review of the care plan for Resident #16 revealed a focus (problem) of ill fitting dentures; however, the care plan listed no goal or interventions related to the dentures. The focus of alteration in elimination had an intervention of rehab services per physician order. Resident #16 was in Hospice and did not receive any rehab. The care plan contained the following interventions that were to be provided and were not described to show how the intervention was to help the resident, as was revealed in the facility policy: Assistive devices as needed, Diet as ordered, Medications as ordered, Refer to rehab as needed, Referral to therapy (the type of therapy was not listed), Lab work as ordered by the physician and Treatments as ordered.	F 280			



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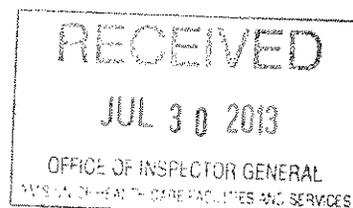
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F 280	Continued From page 26 Interview, on 06/13/13 at 2:40 PM, with the Second Shift House Supervisor Licensed Practlcal Nurse (LPN) #11 revealed her responsibility related to any resident's care plan was: when there was a fall; a change in condition; skin issue or an incident during her shift; a new intervention would be added to the care plan and she was to review it. She stated she looked at the care plans frequently for accuracy. She stated the purpose of a goal on the care plan was to be measurable in terms of time. She revealed a goal may be extended when the care plan was reviewed if more time was needed to reach that goal. She stated interventions on the care plan were to be specific to the resident. She revealed she was trained in nursing school on care plans and through working on the care plans. Interview, on 06/13/13 at 12:30 PM, with Minimum Data Set (MDS) Registered Nurse (RN) #2 revealed her role in the care plan was to make sure the care plan was appropriate for that resident. If it was a Quarterly review, she stated, she was to make sure that the care plan was appropriate for that quarter. She revealed for annual or significant change in resident's condition, she would review the new triggers and decide if the triggered concern needed to be carried over to the care plan. She stated if a goal was attained or unattainable, it would be re-evaluated. She stated interventions on the care plan were to be resident specific. MDS RN #2 had been in her position for less than one month. Interview, on 06/13/13 at 2:00 PM, with MDS RN #1 revealed a focus area was an identified area of concern. She revealed a goal for the focus	F 280			



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F 280	<p>Continued From page 27</p> <p>would be what you would like to happen within the next review period, the outcome. She stated a goal was to be realistic and measurable and an intervention was a step used to reach a goal. She stated if an intervention had been completed, it would be removed from the care plan to keep the care plan current. However, she stated at the facility, they had always kept the interventions on the care plan for no given reason. She revealed an intervention such as Diet as ordered, was not individualized. She was also new to her position in MDS.</p> <p>Interview, on 06/13/13 at 3:10 PM, with LPN #2 revealed her responsibility for the care plan was to relay information about the resident, implement goals and encourage the resident. She revealed the MDS team reviewed the care plans quarterly and the Unit Manager was to review the care plans between quarterly reviews. She stated the only time she updated a care plan was if there was an incident or an issue with the resident's skin. LPN #2 stated care plan goals should be specific to the resident and to the situation. She stated an intervention that was completed should be removed from the care plan. It was revealed that the facility had care plans for the specific needs of the residents and for communication between the physician, nursing and other staff members. She revealed her training on the care plan was computer and hands on training.</p> <p>Interview, on 06/13/13 at 4:55 PM, with Social Services revealed the focus on a care plan was to be a present concern and the goal realistic. She revealed a goal was to be measurable within a given time frame and an intervention was to be current and related to the resident.</p>	F 280			



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F 280	Continued From page 28 Interview, on 06/15/13 at 3:20 PM, with the Director of Nursing revealed she reviewed the care plans, as did the MDS nurses and the Unit Managers. She stated at the care plan meeting, the care plan was totally reviewed. She stated the majority of interventions were to be specific but you were allowed generic interventions as a reminder to the nurses. She gave the example, if physical therapy as ordered was on the care plan, it would be a reminder for the nurse. She revealed if what was on the care plan was not ordered, as in physical therapy, you do not have to worry about it. She stated "You can have a million interventions if they relate to the resident. It is OK to have generic ones as reminders." However, the facility policy stated the care plan must be "individualized". The DON stated if an intervention was on the care plan, tried and failed, it can stay on the care plan. The DON revealed a goal on the care plan was to be realistic and related to the resident.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309			

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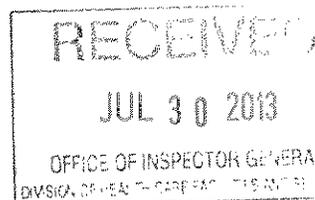
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F 309	<p>Continued From page 29</p> <p>by: Based on observation, interview, record review, the review of the facility's guidelines, it was determined the facility failed to provide necessary care and services to one (1) of the thirty-nine (39) sampled residents (Resident #31). The facility did not ensure Resident #31 received an Electromyography test (EMG) for nerve conduction that was ordered in November of 2012.</p> <p>The findings include:</p> <p>Review of the facility's policy, Red Line Guideline, revised 09/2007, revealed the supervisor or nurse would check the chart for orders after a physician visits. Orders would be placed in the computer and noted on the MAR, TAR, Calendar, INR sheets, etc. Appropriate parties would be notified, i.e. Pharmacy, physician's office, dietary, therapy, etc. The nurse would make an entry in the computer progress notes that the physician was in and any new determinations made. When a physician visits the residents in the facility, the nurse would note the visit on the 24 hour report sheet. The Nurses would check assigned charts for potential missed orders that were not picked up and input them in the computer. The Nurses would check the lab sheets, consults, physician orders, and progress notes. If there are new orders, they would be entered into the computer, the staff would follow through with implementation, red line, date and initial after the last order.</p> <p>1. Review of the clinical record for Resident #31 revealed the facility admitted the resident with diagnoses of Chronic Pain, Carpal Tunnel</p>	F 309	<p>F309</p> <ol style="list-style-type: none"> 1. Resident #31 had an appointment with the hand surgeon on September 4, 2013 2. An audit was done 7/15/13 to 7/18/13 on all residents charts to ensure no orders have been missed. 3. The DCE will in-service, 7/17/13 to 7/24/13 the nurses on putting all physician orders into point click care so they it can be reviewed at the daily clinical standup meeting, along with SBARs (situation, background, assessment and response to share information on a resident in a concise and structured format). Competency test given. All physicians and nurse practitioners will be required to exit with a nurse, so nurse is aware of new orders. Each nurses station will set up a calendar to audit 5 charts a day for missed physician's orders for staff RN and staff LPN, this will be on going. Unit managers will do random weekly chart audits for 	

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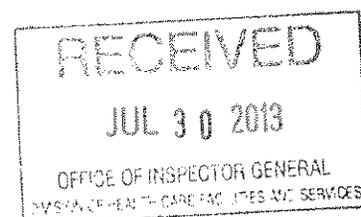
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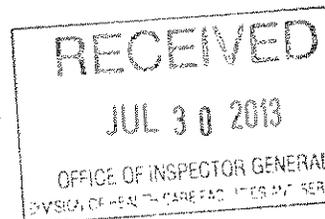
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F 309	<p>Continued From page 30</p> <p>Syndrome, Anxiety, Depression, and surgery to the cervical neck region. Utilizing the Minimum Data Set (MDS), dated 06/01/13, the facility assessed the resident as being cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14. The facility assessed the resident as being impaired in both lower extremities and requiring extensive assistance with mobility, transferring, dressing, toileting, and hygiene.</p> <p>Observation and interview with Resident #31, on 06/14/13 at 2:00 PM, revealed the resident was sitting in a motorized scooter and reporting pain in his/her hands, rating it a five (5) out of a ten (10) on the pain scale with 10 being the worst pain. The resident reported having Carpal Tunnel Syndrome which had required surgery in 2012. The resident reported having continued pain and numbness in the hands. The resident reported he/she was supposed to have had an EMG to determine the cause of numbness, but it was never done.</p> <p>Continued review of the Resident #31's clinical record revealed a consultation, dated 11/13/12 from the resident's hand surgeon recommending an EMG to both upper extremities and then return for a follow up appointment. There was no indication the consultation had been acknowledged or initiated. A letter from the resident's neurologist, dated 01/23/13, requested the resident to contact and schedule the EMG. A notation was made at the bottom that the EMG was scheduled to be completed 02/22/13. The physician's Progress Note, dated 03/21/13, revealed the resident was still complaining of pain in hands and the Physician wrote an order to call as to why the resident had not had their follow up</p>	F 309	<p>charts a week and this will be on going.</p> <p>4. The QAPI team will meet monthly for 6 months to review all monitoring for missed physicians orders and that compliance is being maintained. The Administrator will review the random chart audits with DON monthly for 6 months to ensure compliance with plan of correction and this information will be reviewed with QAPI team. It is ultimately the administrator's job to validate all parts of the POC are implemented and compliance is achieved and continues.</p> <p>5. Date of compliance 7/27/13</p>		



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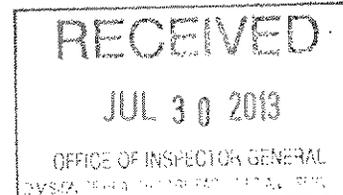
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 309	<p>Continued From page 31</p> <p>appointment with the hand surgeon. The order was not signed off indicating it was implemented. The Physician's Progress Note, dated 05/02/13, revealed the resident's EMG had never been done and the resident continued to complain of pain. The Physician then ordered to consult a different neurologist to schedule an EMG.</p> <p>Interview with Licensed Practical Nurse (LPN) #10, on 06/14/13 at 3:19 PM, revealed she did not know when the physician's orders were written as they were not dated or timed, but revealed the chart was not red lined indicating a chart check was completed which should have caught the missed orders.</p> <p>Interview with the 200 Unit Manager where the Resident #31 resided, on 06/14/13 at 2:10 PM, revealed she was not aware of any previous orders for consults, follow ups, or an EMG prior to 05/02/13. The Unit Manager revealed she did not check Physician Progress Notes, therefore she did not know that a prior EMG was ordered and never completed. The Unit Manager retrieved the calendar, went through the pages, reported the EMG was not completed in February as scheduled, and she had not been able to reach the second consulted physician to schedule another EMG. The Unit Manager immediately called the physician and arranged an appointment. Continued interview with the Unit Manager revealed she should have followed up with the physicians to ensure the resident's test was completed. After reviewing the resident's clinical record, the Unit Manager confirmed the physician orders had not been transcribed and inflated. The Unit Manger revealed all orders should be dated and timed once the order was</p>	F 309			



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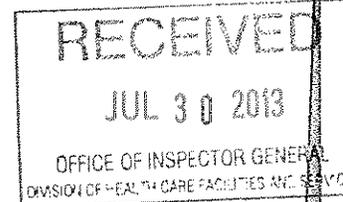
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F 309	Continued From page 32 completed. The Unit Manger revealed she was aware the resident's physician did not flag the chart once orders were written and should have made a point to check those charts to ensure orders were not missed. Interview with the Director of Nursing Service (DNS), on 06/15/13 at 9:36 AM, revealed the facility did have a problem with not taking off orders; therefore, she had initiated printing off all orders entered into the computer in a 24 hour lme period, every day, and reviewing them to ensure they were initiated. However, the DNS revealed this system was dependant upon the orders actually being transcribed into the computer. Therefore, if an order was missed and never taken off, the current system would not ensure they were actually completed. The DNS revealed there was a potential for the resident to decline by not receiving the appropriate testing and treatment.	F 309			
F 323 SS=K	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. This REQUIREMENT is not met as evidenced by:	F 323			



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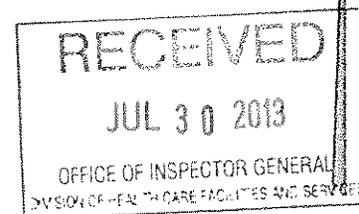
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F 323	<p>Continued From page 33</p> <p>Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure a safe environment as it related to maintaining safe water temperatures in resident care areas. The facility failed to ensure the facility's hot water system was maintained at a temperature to ensure water temperatures in resident care areas did not exceed regulatory requirements. The facility failed to identify, adjust and/or repair the hot water system when monitored hot water temperatures consistently remained above 110 degrees Fahrenheit in resident care areas for three (3) of four (4) resident units.</p> <p>The facility documented water temperatures as obtained on 02/10/13 and ranged from 104 degrees (F) to 110 degrees (F). On 02/17/13, the records revealed water temperatures ranged from 125 degrees (F) to 133 degrees (F) on the 400 Unit. The next water temperature log was completed on 03/17/13 and revealed water temperatures ranged from 117 degrees (F) to 133 degrees (F). Room 100 was 120 degrees (F), room 141 was 118 degrees (F), the 100 shower room was 117 degrees (F), room 201 was 124 degrees (F), room 239 was 121 degrees (F), room 400 was 126 degrees (F) and the 400 shower room was 126 degrees (F). The Maintenance Director revealed he did not know what action was taken to protect the residents on the 400 Unit from injury due to water temperatures above 110 degrees (F). Water temperatures on 04/30/13 in room 100/101 were 109 degrees (F), room 114/115 were 109 degrees (F), room 128/129 were 109 degrees (F), room 200/201 were 109 degrees (F), room 228/229 were 109 degrees (F), room 300/301 were 109</p>	F 323	<p>F323</p> <p>Upon notification of the temperatures in excess of 110 F on June 11, 2013. The center completed the following:</p> <ol style="list-style-type: none"> 1. Individual therapist were assigned to each of the five resident's rooms on the 400 hall and monitored to make sure the resident did not use the sink. 2. The nurse supervisor on the 400 unit gave each of the 5 residents hand sanitizer to use. 3. Maintenance Director turned off the water on 400 hall. 4. The 5 residents on 400 hall were moved to the 300 unit. Effected rooms 401,406,409,415,416) 5. Vendor, Chris with Advanced Mechanic came to center to determine the problem and find the issue to be the "out mixing valve", temperature could not be adjusted and a new mixing valve was ordered to be delivered overnight. 6. In-servicing to the department heads, nursing department (RNs, LPNs, CNAs and shift 		



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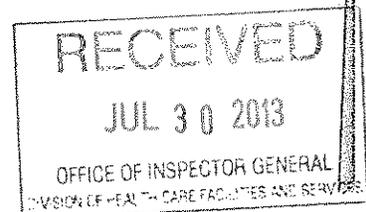
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F 323	<p>Continued From page 34</p> <p>degrees (F), room 326/327 were 109 degrees (F), room 400/401 were 109 degrees (F), room 415/416 were 109 degrees (F). Water temperatures were next monitored on 05/14/13 and showed all resident room water temperatures randomly tested were 109 degrees (F). Water temperatures were next monitored on 05/20/13 and the resident room water temperatures selected randomly were 109 degrees (F). Water temperatures were next monitored on 06/08/13 and the resident room water temperatures selected randomly were 109 degrees (F). On 06/11/13 at 11:20 AM, water temperatures were obtained as part of the survey process and ranged from 128-138 degrees (F) as follows: on the 400 Unit, room 401 was 128 degrees (F), room 403 was 128 degrees (F), room 406 was 138 degrees (F), room 408 was 138 degrees (F), room 409 was 138 degrees (F), room 415 was 138 degrees (F), room 416 was 138 degrees (F), and the 400 Unit shower room was 138 degrees (F). The Maintenance Director admitted to Administration that the water temperatures in the resident care areas that were obtained on 4/30/13, 05/14/13, 05/20/13 and 06/08/13 were made-up and he had not monitored the temperatures of the water.</p> <p>The facility's failure to have an effective system in place to provide supervision to prevent accidents has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 06/12/13 and determined to exist on 06/11/13. The facility was notified of the Immediate Jeopardy on 06/12/13.</p> <p>An acceptable Allegation of Compliance (AOC)</p>	F 323	<p>supervisors), therapy department and any support staff (business office, supply clerk and medical records) that are involved in the manager on duty program and daily monitoring of temperatures until a new full-time maintenance director can be found was completed by the Dietician, Jessica Sullivan and Director of Clinical Education, Jeanne Viers. (The only staff doing hot water temperature checks is Curtis Dykes (Supply Clerk), Mark Bowman (assistant administrator), Jessica Sullivan (Dietician), Jeanne Viers (Director of Clinical Education), Cindi Simpson (Administrator), Cathy Tucker (3-11pm shift supervisor), Tanisha Stokes (11-7pm shift supervisor), Sherry Wallace (3-11pm supervisor), Robin Coder (11-7pm supervisor). The in-service of the hot water temperature plan included how to use the thermometers, how to calibrate the thermometer before each temperature is recorded and to contact administrator and</p>		



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F 323	<p>Continued From page 35</p> <p>was received on 06/14/13 and the State Agency validated the Immediate Jeopardy was removed on 06/15/13 as alleged, prior to exit on 06/15/13 with remaining noncompliance at a scope and severity of an "E" while the facility monitors the water temperatures to ensure appropriate repairs and preventative interventions are put in place to protect the residents from the risk of burns, skin or body tissue injuries.</p> <p>In addition, it was determined the facility failed to follow their policy regarding Fire Protection System Impairments by initiating a fire watch after the automatic sprinkler system had been shutdown for repairs.</p> <p>On 06/13/13 at 8:15 AM, the sprinkler contractor began contract work to replace sprinkler heads in various locations throughout the facility. The contractor informed the Administrator-in-Training that he would be putting the system in the test mode, shutting down the sprinkler system at 8:30 AM to do the remedial work. The Administrator-in-Training failed to inform the Administrator of the sprinkler system being shut down and the need to begin the fire watch. Subsequently a fire was discovered at 2:20 PM in an ashtray in the resident smoking area. The automatic sprinkler system had been shut down from 8:30 AM until 3:52 PM, approximately 7.5 hours. The facility identified the sprinkler shutdown at 2:20 PM at the time of the fire.</p> <p>The facility failed to alert staff of the facility's vulnerability during the test mode of the sprinkler system and failed to ensure a fire watch was initiated during this time which placed the residents at risk and caused or was likely to</p>	F 323	<p>assistant administrator if temperatures above 110F,(who then will adjust temperature on the twin hot water tanks mixing valve that services 100, 200 and 300 units), to inform staff and residents (residents with dementia or lack understanding would be removed from room, water turned off or placed on one on one monitoring) that the sink or shower room could not be used and to post a sign above that sink or shower room that it is not to be used until temperature re-checks are done and determined to be at or below 110F, temperatures will be checked every four hours by one of the above in-serviced staff members. None of the above staff will be allowed to work after June 13, 2013 if they have not received the above in-service. 7. Temperature checks were began 6-11-13 at 7pm and continued every 4 hours throughout the night. Any temperatures recorded over 110 F, were immediately called to the administrator and assistant</p>		



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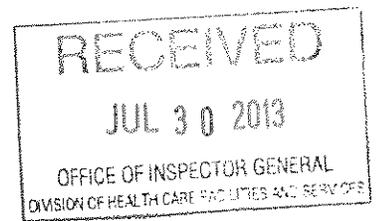
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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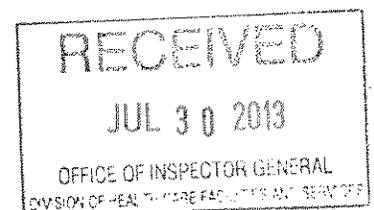
F 323	<p>Continued From page 36</p> <p>cause the residents serious injury, harm, impairment or death. Immediate Jeopardy was identified on 06/14/13 and determined to exist on 06/13/13.</p> <p>An acceptable Allegation of Compliance was received on 06/15/13 and the State Agency validated the Immediate Jeopardy was removed on 06/15/13 as alleged prior to exit on 06/15/13. The scope and severity was lowered to an "F" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's policy regarding Maintaining Water Temperatures, undated, revealed the water temperatures would be maintained within the allowable ranges as regulated by the State. Water temperatures would be checked and recorded in resident bathrooms, showers and rooms daily. One (1) to two (2) rooms on each unit would be monitored. The thermostats on the water heaters were to be set to obtain the correct temperature. <p>Observation of the water temperatures in the resident care areas on 06/11/13 at 11:20 AM, revealed water temperatures ranging from 128-138 degrees (F) Fahrenheit as follows: on the 400 Unit, room 401 was 128 degrees (F), room 403 was 128 degrees (F), room 406 was 138 degrees (F), room 408 was 136 degrees (F), room 409 was 138 degrees (F), room 415 was 138 degrees (F), room 416 was 138 degrees (F),</p>	F 323	<p>administrator. Temperatures were adjusted on the twin hot water tanks mixing valve that services 100, 200 and 300 units, some time was allowed to pass and temperatures were rechecked for 110F compliance. During this time the staff and resident of that room was notified to not use the sink/shower room. Once recheck was completed and 110 F compliance was met, resident and staff were notified they could use the sink/shower rooms.</p> <ol style="list-style-type: none"> 8. Maintenance Director suspended pending termination. 9. Administrator reviewed all hot water temperatures logged to verify that this plan continues to be followed, some temperatures still above 110F, but plan followed to ensure residents safety. 10. There have been no changes to our hot water temperature test policy and this was reviewed by administrator. Please see attached policy. <p>1. June 12, 2013 continued to do random hot water temperatures</p>	
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F 323	<p>Continued From page 37 and the 400 Unit shower room was 138 degrees (F).</p> <p>Interview with the Maintenance Director, on 06/11/13 at 11:30 AM, revealed he adjusted the hot water heater to bring the temperatures down to 110 degrees (F) or lower on the 400 Unit. He stated the water temperatures were never this high and the nursing staff was responsible to check the water temperatures in resident rooms on a daily basis. He stated he checked the water temperatures every week and had received training from the former Maintenance Director on taking temperatures and adjusting the heaters to ensure water temperatures were between 100 degrees (F) and 110 degrees (F). He stated he did not know what action was taken to protect the residents on the 400 Unit from injury due to water temperatures above 110 degrees (F).</p> <p>Interview with the Administrator, on 06/11/13 at 11:40 AM, revealed the hot water on the 400 Unit was turned off and the five (5) residents on the unit were being transferred to the 300 Unit. She stated the facility was not sure how long it would take to resolve the high water temperature issues and the residents had agreed to move. She stated the Maintenance Director was responsible for monitoring the water temperatures in resident care areas on a daily basis. She stated he had assured her that the water temperatures were monitored.</p> <p>Review of the water temperature logs maintained by the Maintenance Director revealed water temperatures were obtained throughout the facility in a random manner by maintenance. Water temperatures on 04/30/13 in room 100/101</p>	F 323	<p>every 4 hours throughout the center. Adjustments made to twin hot water tanks mixing valve as needed. Staff and residents notified to discontinue the use of sink/shower room until notified water temperatures were at or under 110 F. Signs placed above the sink/shower rooms as a reminder.</p> <p>2. Advanced mechanic put new mixing valve on 400 unit hot water tank, monitored water temperatures until 110 F compliance was met. The center continued to monitor the 400 unit water temperatures.</p> <p>3. Advanced Mechanic also examined the 2 twin hot water tanks that service 100, 200 and 300 unit and determined the mixing valve was not adequate size to temper the water sufficiently and a larger mixing valve was ordered to be delivered as soon as possible, tentatively delivery and installations June 17, 2012.</p> <p>4. Water temperatures continued to be checked every 4 hours throughout the night, with</p>		



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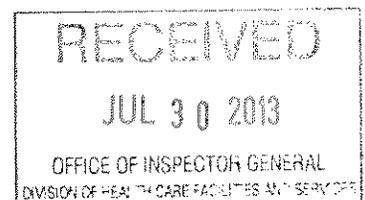
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F 323	<p>Continued From page 38</p> <p>were 109 degrees (F), room 114/115 were 109 degrees (F), room 128/129 were 109 degrees (F), room 200/201 were 109 degrees (F), room 228/229 were 109 degrees (F), room 300/301 were 109 degrees (F), room 326/327 were 109 degrees (F), room 400/401 were 109 degrees (F), room 415/416 were 109 degrees (F). Water temperatures were next monitored on 05/14/13 and showed all resident room water temperatures randomly tested were 109 degrees (F). Water temperatures were next monitored on 05/20/13 and the resident room water temperatures selected randomly were 109 degrees (F). Water temperatures were next monitored on 06/08/13 and the resident room water temperatures selected randomly were 109 degrees (F).</p> <p>Observation of water temperatures throughout the facility resident care areas, on 06/11/13 at 11:40 AM, by the maintenance man and the surveyors revealed no other unit had water temperatures in excess of 110 degrees (F).</p> <p>Interview with the Administrator, on 06/11/13 at 12:40 PM, revealed the facility utilized weekend managers on Saturdays and Sundays. She stated several department heads told her that they were instructed to randomly check water temperatures in resident care areas related to problems with water temperatures being in excess of 110 degrees (F) sometime in February 2013. She stated the previous Administrator and the Administrator in Training had given these instructions to the weekend managers and she had located a file with records of the temperatures. She stated she would search her office for additional water temperature logs.</p>	F 323	<p>notification to administrator and assistant administrator and temperatures were adjusted to the twin hot water tanks mixing valve that services 100, 200 and 300 units. Time was allowed to pass and temperatures were rechecked for 110F compliance. During this time the staff and resident of that room was notified to not use the sink/shower room. Once recheck was completed and 110 F compliance was meet, resident and staff were notified they could use the sink/shower rooms.</p> <p>5. Called retired 20 year past maintenance director for his historical input on hot water tanks, he suggested the call to "Schardein Mechanical," a prior vendor who had worked in the center for many years for additional suggestions. Scheduled to come to center 6/13/13. No new suggestions.</p> <p>6. Administrator reviewed all hot water temperatures logged to verify that this plan continues to be followed, some temperatures still above 110F, but plan</p>	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
(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	<p>Continued From page 39</p> <p>Review of the water temperature logs documented by the department heads working as weekend managers revealed the first set of water temperatures were obtained on 02/10/13 and ranged from 104 degrees (F) to 110 degrees (F). On 02/17/13, the records revealed water temperatures ranged from 125 degrees (F) to 133 degrees (F) on the 400 Unit. The next water temperature log was completed on 03/17/13 and revealed water temperatures ranged from 117 degrees (F) to 133 degrees (F). Room 100 was 120 degrees (F), room 141 was 118 degrees (F), the 100 shower room was 117 degrees (F), room 201 was 124 degrees (F), room 239 was 121 degrees (F), room 400 was 126 degrees (F) and the 400 shower room was 125 degrees (F).</p> <p>Interview with the current Administrator in Training, on 06/11/13 at 12:45 PM, revealed he was employed as the Staffing Coordinator in February 2013 and was required to function as a weekend manager. He stated the weekend managers were instructed to take random water temperatures in resident care areas and to notify the Maintenance Director if water temperatures exceeded 110 degrees (F). He stated he worked as a weekend manager on 02/17/13 and found water temperatures on the 400 Unit ranged, after reviewing the log, from 125 degrees (F) to 133 degrees (F). He stated he telephoned the Administrator and the Maintenance Director and relayed that the water temperatures were elevated on the 400 Unit. He stated the reports of the findings were given to the Administrator in Training on Monday mornings. He stated he was not given any instructions on what to do to protect the residents in rooms where the water temperatures exceeded 110 degrees (F). He</p>	F 323	<p>followed to ensure residents safety.</p> <p>June 13, 2013</p> <p>1. Water temperatures continued to be checked every 4 hours throughout the night and start of new day with notification to administrator and assistant administrator and temperatures were adjusted on the twin hot water tanks mixing valve that services 100, 200 and 300 units, as needed some time was allowed to pass and temperatures were rechecked for 110F compliance. During this time the staff and resident of that room was notified to not use the sink/shower room. Once recheck was completed and 110 F compliance was meet, resident and staff were notified they could use the sink/shower rooms.</p> <p>2. A QAPI meeting was held with Medical Director, Dr. Hilgeford and QAPI team consisting of Administrator, DON, assistant administrator, maintenance, unit managers, dietician, dietary manager,</p>		



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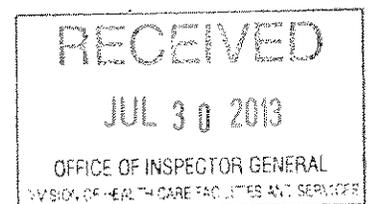
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F 323	<p>Continued From page 40</p> <p>stated he could not remember any action taken by the Administrator or the Maintenance Director. He stated the weekend managers were told by administration that they no longer needed to check water temperatures in resident care areas sometime in early April 2013.</p> <p>Interview with the Registered Dietician, on 06/11/13 at 5:10 PM, revealed she worked as a weekend manager on 03/17/13. She stated she was advised to take random water temperatures in resident care areas while she functioned as the weekend manager. She stated, after reviewing the log, that temperatures on the 100 Unit ranged from 117 degrees (F) to 120 degrees (F), the 200 Unit ranged from 121 degrees (F) to 124 degrees (F), and the 400 Unit ranged from 125 degrees (F) to 133 degrees (F). She stated she notified the Administrator and the Maintenance Director; however, she could not remember if the facility took any action to protect the affected residents from injuries related to the water temperatures exceeding 110 degrees (F). She stated she felt concerned; however, she was not instructed to take any action.</p> <p>Observation of the water temperatures in the resident care areas on 06/11/13 at 5:10 PM, revealed the water temperature in the resident/staff bathroom in physical therapy was 118 degrees (F) and room 208 was 118 degrees (F).</p> <p>Interview with the Administrator, on 06/11/13 at 5:20 PM, revealed she was not aware water temperatures were elevated in the facility. She stated the facility would begin taking random water temperatures in resident care areas every</p>	F 323	<p>housekeeping manager and social services to cover the immediate jeopardy abatement plan, cause of immediate jeopardy and resolution.</p> <p>3. This hot water temperature plan will continue until the new mixing valve is placed on the twin tanks and temperatures are monitored for 48 hours afterward to determine if hot water temperatures are at or below 110F.</p> <p>4. Grievances were reviewed back to March 23, 2013 by Jenny Potts, SSW, to look for any past grievances on hot water temperatures and none were found.</p> <p>5. Accident and Incident reports were reviewed by the Director of Nursing back to January 1, 2013 for any possible identifiable injuries related to hot water temperatures, no injuries noted related to any type of hot water burns.</p> <p>6. Nursing staff to include RNs, LPNs and CNAs were in-serviced starting June 13, 2013 on what to do with a suspected</p>	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
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F 323	<p>Continued From page 41</p> <p>four (4) hours to ensure resident safety. She stated water temperatures would be adjusted and staff would monitor residents in rooms where water temperatures exceeded 110 degrees (F). She stated this would continue until repairs were completed to the heater controlling the 400 Unit and the heater controlling the 100 and 200 Units were repaired. She stated the water temperatures on the 300 Unit would also be monitored even though no out of range temperatures were identified on that unit. She stated the Maintenance Director had admitted to her that the water temperatures in the resident care areas that he obtained on 4/30/13, 05/14/13, 05/20/13 and 06/08/13 were not physically taken but were made-up and he did not monitor the temperatures of the water. She stated he was suspended pending termination. She stated she had not checked the water temperature logs for resident care areas maintained by the Maintenance Director in the thirty (30) days she had been the Administrator.</p> <p>Continued Interview with the Administrator, on 06/12/13 at 8:05 AM, revealed she had not located any other water temperature logs for the resident care areas after 03/23/13. She stated water temperatures in resident care areas were elevated above 110 degrees (F), on 06/11/13 at 7:45 PM, on the 200 Unit in room 208 at 118 degrees (F), room 201 at 118 degrees (F), room 233 at 120 degrees (F), room 239 at 118 degrees (F) and the 200 Unit shower room at 119 degrees (F). She stated the water heater was adjusted downward and there were no elevated water temperatures the rest of the night. She stated plumbers were in the facility and the parts for the repair of the water heaters on 100 and 200 Units</p>	F 323	<p>hot water burn, to include immediate treatment, nurse notification, physician and administrator or Director of Nursing notification and to turn off water at sink. In-servicing completed by Jeanne Viers, Director of Education. Any staff not working before end of day June 13, 2013 will not be allowed to work until in-service completed.</p> <p>7. The number of staff who received the in-service on hot water temperature plan and what to do with a hot water burn is 99/149 employees, all others have not worked yet because of scheduled, on vacation, leave or PRN.</p> <p>8. Alleged date of abatement of immediate jeopardy is June 14, 2013.</p>	



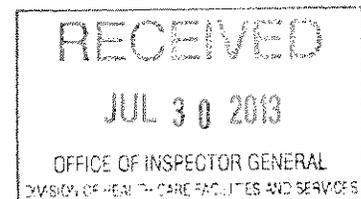
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F 323	<p>Continued From page 42</p> <p>were ordered and the water temperature monitoring would continue. She stated the water heater for the 400 Unit would be repaired that day.</p> <p>Observation of the water temperatures in resident care areas on 06/12/13 at 8:30 AM revealed the following: room 201 was 106 degrees (F), room 214 was 108 degrees (F), room 220 was 106 degrees (F) and room 223 was 104 degrees (F).</p> <p>Interview with the plumber, on 06/12/13 at 8:40 AM, revealed the mixing valve on the water heater supplying hot water to resident care areas on the 400 Unit was stuck in the open position and a new valve needed to be installed. He stated he had submitted a bid to replumb the water heaters supplying hot water to the 100 and 200 Units, two or three months ago, to the former Administrator; however, he had heard nothing back. He stated he had repaired the plumbing problems in the facility for years.</p> <p>Interview with the Director of Nursing, on 06/12/13 at 9:00 AM, revealed twenty-five (25) residents on the 100 and 200 Units plus the five (5) residents on the 400 Unit, on 06/11/13, were mobile and had access to the water faucets in their rooms.</p> <p>Interview with the Director of Nursing, on 06/13/13 at 5:00 PM, revealed all residents were observed for any injury to their skin or tissues and no injuries were found. She stated all incident reports were reviewed and there was no indication of injuries caused by hot water.</p> <p>Review of the AOC revealed the facility</p>	F 323	<p>On June 13, 2013 at approximately 3:30 pm the administrator (Cindi Simpson) of the center became aware that the automatic fire alarm system had been put on "test mode" at 9am that morning while the Simplex-Grinnell technician (referred to SG-technician) had been replacing sprinkler heads on one of the units in the center. The SG-technician had told the administrator in training, Mark Bowman, that he would be doing this, unfortunately this was not communicated to the administrator and Mark did not understand the terminology of "test mode" (meaning he was draining the sprinkler system and notifying the alarm monitoring company that work was being done, so they will not think something was wrong and contacting fire department) and so after the 4 hour time frame that the automatic fire system had been turned off, the center did not do a fire watch for the remaining down time of the system from 12:30pm to 3:30pm</p>	



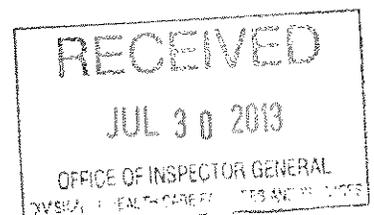
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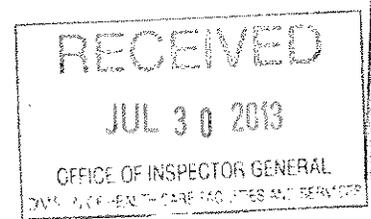
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F 323	Continued From page 43 implemented the following measures 06/12/13 - 06/15/13. The immediate actions taken were: 1. The water on the 400 Unit was turned off on 06/11/13 and the mixing valve on the 400 Unit was replaced (the unit remains closed) on 06/12/13. 2. The five (5) residents on the 400 Unit were relocated to the 300 Unit on 06/11/13. 3. Selected management staff was in-serviced, on 06/11/13, on taking water temperatures on a daily basis in resident care areas until a new Maintenance Director could be hired. 4. An in-service, on 06/11/13, included how to take water temperatures; how to contact the Administrator and Assistant Administrator if water temperatures exceed 110 degrees (F); how to adjust the temperature on the hot water tank; how to provide one to one monitoring if the water temperatures were elevated and the residents in the room were confused; how to post a sign stating the water temperatures are too high in that room and the sink and shower are not to be used; how to recheck water temperatures after the hot water tank has been adjusted; temperatures would be monitored every four (4) hours until repairs are completed on the tanks providing hot water to the 100, 200, and 300 Units and for forty-eight (48) hours after the repairs are completed; and no staff would be allowed to work until they attended this in-service. 5. The Maintenance Director was suspended pending termination on 06/11/13.	F 323	which could have potentially impacted the entire center and all residents. 1. On June 13, 2013 at 3:30pm the administrator verified with the SG-technician at that the automatic fire alarm system was completely back on line and the center's residents were safe. 2. On June 13, 2013 at 4:30pm the administrator in-serviced Mark Bowman on the importance of communicating to her when any maintenance vendors are in the center and what "test mode" meant and the requirement to do a watch fire after the system has been down over 4 hours from a planned event or in an emergency situation and is to continue until the automatic fire alarm system is completely back on line. 3. On June 13, 2013 at 7:30pm the administrator in-serviced the Department Heads to include the DON, ADON, Unit Managers, Business Office Manager, Activities Director, Social Services Director, Dietary Director, Housekeeping Director,	



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F 323	<p>Continued From page 44</p> <p>6. The Administrator would monitor all water temperature logs to ensure resident safety on 06/11/13.</p> <p>7. The parts were ordered to repair the hot water tanks for 100, 200 and 300 Units on 06/12/13.</p> <p>8. Water temperatures were monitored and the water heaters for the 100, 200 and 300 Units were adjusted when needed on 06/11/13.</p> <p>9. A QAPI meeting was held with the Medical Director on 06/13/13.</p> <p>10. Grievance records were reviewed, on 06/13/13, back to March 23, 2013 and there were no grievances related to hot water.</p> <p>11. Nursing staff was in-serviced on the treatment of hot water injuries which included notification of the Administrator, staff will not be allowed to work until they have attended the in-service on 06/13/13.</p> <p>12. On 06/13/13 all Incident and Accident reports were reviewed back to 01/01/13, and no injuries were noted.</p> <p>The State Agency validated the AOC on 06/15/13 prior to exit as follows:</p> <p>* The hot water on the 400 Unit did not come on when the sink handle was turned on 06/11/13 at 12:15 PM.</p> <p>* Review of the water temperature logs for 06/11/13 and 06/12/13, revealed water temperatures were within the range of 100</p>	F 323	<p>MDS Director, Dietician, Admissions Director, Therapy Directors, Director of Clinical Education, Discharge Director, 7-3/3-11/11-7 shift supervisors, along with support staff to include the supply clerk, medical records, payroll clerk, this is 17% of our staff and on the requirement to do a fire watch any time the automatic fire alarm system is down and notification to the administrator if they are made aware the system is or may be down and how to do a fire watch and each given copy of the fire watch policy specifically covering H-M. See attached policy. We will continue to in-service nursing to include RNs, LPNs, CNAs, dietary, housekeeping/laundry and therapy staff, we have completed 35% of this staff and those not in-serviced will not be able to work until they receive the in-service.</p> <p>4. Because Hillcreek always has a shift supervisor 7 days a week and our manager on duty department head on weekends as</p>		



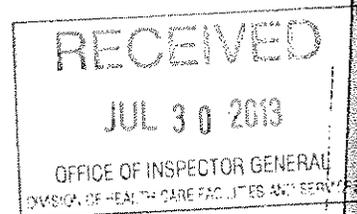
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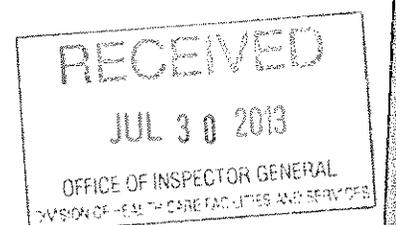
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F 323	<p>Continued From page 45</p> <p>degrees (F) to 110 degrees (F). Interview with the Administrator, on 6/13/13 at 10:00 AM, revealed she had knowledge of the water temperatures over the last several days.</p> <ul style="list-style-type: none"> * Review of the work orders for the vendor (Advanced), on 06/12/13 revealed the parts for the repair of the two water heaters supplying the 100, 200 and 300 Units were ordered. * Review of the water temperature logs on 06/15/13 revealed the facility continued to monitor the water temperatures every (4) hours. Water temperatures obtained by the state agency on 06/15/13 at 2:10 PM revealed water temperatures within the 100 degrees (F) to 110 degrees (F) range. * In-service records were reviewed for content and attendance and ninety-nine (99) of one-hundred forty-nine (149) employees were in-serviced and employees may not return to work until in-services are attended. * Follow-up water temperatures were obtained on the 400 Unit, on 06/15/13 at 2:10 PM, and were within 100 degrees (F) to 110 degrees (F) after repairs were completed. * Interview with the Administrator, on 06/12/13 at 8:30 AM, verified the Maintenance Director was terminated. * Review of the signature sheet revealed the Medical Director attended the QAPI meeting regarding the immediate jeopardy on 06/13/13. * Written statements were obtained from the 	F 323	<p>additional support, one of these staff members would be the one to initiate and direct a fire watch upon either an emergency situation or planned situation. This provides for there to always be someone to take charge of any emergency situation.</p> <p>5. Administrator and SG-technician meet June 14, 2013 at 8am and since he was continuing his sprinkler head replacement work, the automatic fire alarm system would be down starting at 8:15am and he would inform me when work completed and system completely back on line.</p> <p>6. June 14, 2013 at 12:15pm, the center began a fire watch. The 100 (Dana Waters) 200 (Regina Mudd), 300 (Jennifer Moran and Ashley Stover) resident's units were covered by the unit managers and were checked in 15 minute increments. The 400 unit resident area which includes therapy and laundry was covered by the DON (Donna Fountain) and also checked in 15 minute increments. The administrator covered the dining</p>	



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F 323	<p>Continued From page 46</p> <p>Social Worker and the Director of Nursing, on 06/14/13, that grievances and incident reports were reviewed for complaints of hot water being too hot, none noted, and injuries from hot water, none noted. In addition, record review, on 06/14/13, revealed the facility completed skin checks on residents, on 06/13/13, and no resident injuries were found.</p> <p>* Six (6) Licensed Practical Nurses, six (6) Certified Nurse Aides, two (2) Housekeepers, one (1) Nursing Supervisor, one (1) Physical Therapist and the Director of Nursing were interviewed, on 06/15/13, regarding in-services held on 06/11/13 and 06/13/13. The staff was able to verbalize understanding the potential danger of water that was too hot injuring residents, that they should report to the Maintenance Department and the Supervisor when they felt the water was too hot, that residents are to be protected by moving away from the room where the water is too hot or turning the water off, or placing a sign in the room warning of hot water.</p> <p>2. Review of the facility's policy regarding Fire Protection System Impairments, not dated, revealed impairments can result from either planned or emergency shut down of these systems. A lack of prior planning in shut-down or impairment of these systems can result in serious consequences in the event of a fire. The facility will require strict compliance with the basic fire safety precautions outlined in the policy. The fire watch procedures outlined will be implemented immediately for all impairments, regardless of duration. If the facility fire protection system will be shut down or is impaired for four (4) or more</p>	F 323	<p>rooms, offices, resident's smoking areas, activity area, maintenance areas and kitchen in 15 minute increments. All staff were notified we were in a fire watch. During the 15 minute increments the above assigned staff were monitoring for signs of fire and smoke and to call 911 to report if any fire or smoke found and to pull the fire alarm manually.</p> <p>7. On June 14, 2013 at 3:30 the SG-technician notified administrator that the fire alarm system was completely back on line and the fire watch was terminated with successful completion and all resident's were kept safe.</p> <p>8. There was no change made to fire watch policy after administrator review.</p> <p>9. On June 14, 2013 at 4:45 pm the center was notified of the immediate jeopardy due to incident on June 13, 2013, mentioned above in number 1, therefore the purpose of this allegation of compliance.</p>		



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F 323	Continued From page 47 hours in a twenty-four (24) hour period all of the following procedures will be implemented. The facility will maintain a Fire Protection Impairment Kit at all times. The facility's Impairment Coordinator will contact the consultant prior to any impairment. Supervisors in the affected areas, the local fire department, the State Fire Marshal and the Fire Alarm Central Station Monitoring Company shall also be notified of the impairment. Telephone numbers for notification of local and state agencies are (no telephone numbers were listed). The Impairment Coordinator shall make sure that all materials needed to make the repair are ready at the job site before any valve or device is closed or fire protection system is disabled. The appropriate tags shall be attached to all affected areas. Any hot work will be discontinued. A fire watch will be conducted for all affected areas of the facility until the fire protection system is operational again. Fire watch rounds shall be conducted at a minimum of thirty (30) minute intervals for all affected areas of the building. Fire watches shall be provided continuously until the work is completed and the fire protection system is completely functional, including through coffee breaks and lunch breaks. Fire watch personnel shall receive training on recognition of fire hazards and use/location of appropriate portable fire extinguishers as well as the procedure for alerting staff while the fire alarm system is out of service. Review of the facility's policy regarding Smoking, not dated, revealed residents, associates, family members, visitors, vendors and all others may smoke in the designated areas that are identified for each category: residents may smoke in the	F 323	10. On June 14, 2013 at 6:30pm a QAPI meeting was held and in attendance was the DON, AIT, Unit managers, Dieticians, Dietary manger, social services, admissions, activities, MDS Director, supply clerk, medical records, business office manager, director of clinical education, discharge director, to review immediate jeopardy notification and the abatement of the jeopardy notification. Also reviewed was a past incident on 4/30/13 when center had been notified of issue with automatic fire alarm system and had began and completed a successful documented fire watch from 1pm to 4pm and obviously knew what to do when information of potential fire risk were communicated. 11. On June 14, 2013 at 7pm, Medical Director, Dr. Hilgeford, spoken to by phone by administrator to review QAPI and although previously had discussed incident of June 13, 2013, he was made aware of the immediate jeopardy, the fire		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ D. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2013
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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 323 Continued From page 48
smoking solarium; and the courtyard by the 400 Unit. Residents deemed able to smoke alone may do so in the designated smoking areas. Residents deem unable to smoke alone must have a staff person in attendance. Family and visitors are only permitted to smoke in the 400 Unit courtyard. Associates may not smoke on the property. All cigarettes and lighters of residents are kept at the nursing station and the residents may get those when needed. No matches are permitted in the building at any time.

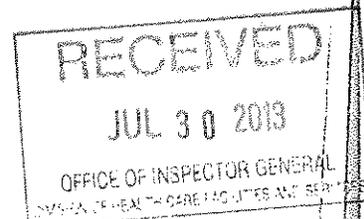
Observation, on 06/13/13 at 2:30 PM, revealed the fire alarm sounded. The designated smoking area connected to the main dining room was filled with smoke as was the dining room. The door to the smoking area was closed at this time. The top of the cigarette can was off of the base and sitting next to the wall. The base was half filled with ash and it had two plastic cups in the base. The Administrator and the AIT were in the room with a fire extinguisher.

Observation, on 06/13/13 at 2:50 PM, revealed the front desk receptionist telling the Administrator she did not know where the fire department was and that no one had called to see what was going on at the facility.

Observation, on 06/13/13 at 3:00 PM, revealed the fire department in the facility. Interview at this time with the AIT revealed he did not see what was in the base; however, housekeeping empties the ashes one (1) to two (2) times a week.

Interview with the front desk Receptionist, on 06/13/13 at 3:40 PM, revealed the contractor was here to work on the sprinkler system and they

F 323
watch completed earlier in the day successfully and this allegation of compliance.
12. Date of Compliance June 15, 2013
AFTER ABATMENT
1. The five residents effected by the hot water temperatures 35, 36, 37, 38 and 39 were moved from 400 unit to 300 unit. All had skin checks completed with no signs of any type of blisters or burns. There were no identified residents involved in the lack of fire watch policy. The QAPI meetings held 6/21/13, 6/25/13, 7/1/13 and 7/8/13 reviewed water temperatures and fire watch logs and discussed any issues or problems that had arose and a plan to correct. The Administrator and DON were in-serviced on 7/26/13 by Area Vice President of Operations for Goldenliving on the responsibility to monitor the day to day functions of the center to ensure compliance and effective use of resources. See attached.



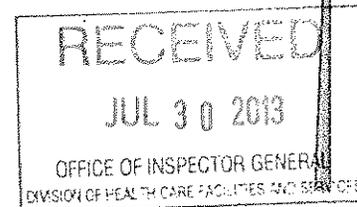
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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F 323	<p>Continued From page 49</p> <p>thought that was why the system did not notify the fire department.</p> <p>Interview with LPN #11, 3-11 Supervisor for the whole facility, on 06/13/13 at 2:40 PM, revealed when the smokers are in the designated smoking area, there is usually a staff member there also. There are few independent smokers. LPN #11 stated the fire was fully extinguished. She further stated it was the responsibility of all staff to check the solarium as they passed by.</p> <p>Interview, on 06/13/13 at 3:45 PM, with the AIT revealed he did not know if the call system would be out, the contractor never told him that. He stated the contractor was working on the 2012 mandate for sprinklers that was arranged by the corporate office.</p> <p>Interview with the Administrator and AIT, on 06/13/13 at 4:10 PM, revealed the automatic dial system for fire alarm was down. They were not aware and the alarm was manually pulled. The contractor had the alarm system in test mode. The AIT stated the contractor told him he was going to drain the line and he did not relay the information to the Administrator. The Administrator stated the AIT did not tell her or she would have known it meant the system was down.</p> <p>Interview, on 06/14/13 at 2:00 PM, with the Administrator revealed a sprinkler company had been contracted by the Corporate Office to replace sprinkler heads within various areas of the facility. The contractor arrived on site at 8:15 AM and discussed his scope of work with the Administrator-in Training. The Administrator-in</p>	F 323	<p>2. All residents at potential risk of being affected if water temperatures exceed the 110 degree and or the fire watch policy is not followed. The QAPI committee failed to monitor maintenance preventative program and staff required fire and safety education, mostly due to administrator and DON turnover. The administrator during survey had been in the center only 31 days and had not yet had time to review all areas of the center.</p> <p>3. The mixing valve on the twin hot water tanks was replaced on 6/18/13. On 300 unit 3 hot and cold check valves were placed to help regulate water temperatures to rooms 332, 334 and 336. We continued to check water temperatures every 4 hours up to 6/25/13 when a QAPI meeting was held to review temperatures and it was determined the temperatures had remained between the 100-110 degrees. Water temperatures checks were changed to every 6 hours starting 6/25. On 7/1/13 a QAPI meeting</p>	



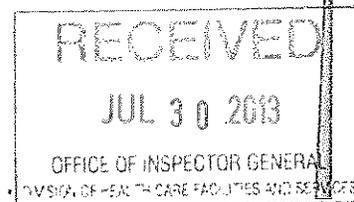
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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F 323	<p>Continued From page 50</p> <p>Training was advised by the sprinkler contractor that both of the sprinkler risers would need to be in the test mode, meaning the sprinkler valves were turned in the off position and the alarm company monitoring the facility should have been notified the automatic dialers were turned off to do the contract work. The Administrator-in-Training failed to contact the Administrator about the sprinkler contractor being on site and that the system would be down for over a four (4) hour period of time. The system was shutdown at 8:30 AM, leaving the facility without the protection of an automatic sprinkler system. The fire watch policy had not been implemented after the shutdown. At approximately 2:20 PM, smoke was discovered coming out of an ashtray located in the indoor, designated smoking area. A Physical Therapist had discovered the fire and notified the Director of Nursing, who pulled the Fire Alarm and alerted the Receptionist to call 911 upon realizing the automatic sprinkler system had been turned off. The Administrator-in-Training extinguished the smoldering ashes with a fire extinguisher. The residents were evacuated to the adjacent smoke compartment during the time of the emergency. The Fire Department arrived on site at 2:62 PM and gave the clear signal to reenter the smoke compartment at 3:11 PM.</p> <p>Interview with the Director of Nursing, on 06/14/13 at 4:10 PM, revealed she pulled the fire alarm and then went to the receptionist area to see the fire panel and the location of the fire and instructed the receptionist to announce, over the intercom, a Code Red in the smoking room. She stated she then returned to the smoking room to assist the Administrator. She stated she failed to</p>	F 323	<p>was held and water temperatures reviewed and the decision was made that the maintenance department would take over the water checks Monday through Friday and the weekend manager on duty would check Saturdays and Sundays. All water temperature checks would be reviewed by administrator, Monday through Friday when daily copy of temperatures turned in by maintenance staff and on Mondays will review copy of Saturday/Sunday water temperature log. Re-in-service maintenance assistant and manager on duty staff to the importance of reporting all temperatures above 110. to administrator and or DON immediately on 7/8/13. Any of the employees who had not received the in-services on the hot water temperature plan, what to do with a resident with a hot water burn or fire watch policy were in-serviced by the director of clinical education before they were or are able to work, this to include new employees will be</p>	



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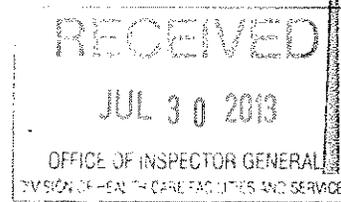
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F 323	<p>Continued From page 51</p> <p>hear the sirens within a few minutes so she returned to the reception area and instructed the receptionist to call 911. She indicated the Fire Department always responded quickly and the absence of the sirens caused her concern. She stated she was not aware that the fire alarm system was down; however, she felt something was wrong.</p> <p>Interview, on 06/14/13 at 2:36 PM, with the Administrator-in-Training (AIT) revealed he had been informed of the system being put in the test mode by the sprinkler contractor at 8:30 AM after the contractor discussed what they would be doing. He stated he was told the sprinkler risers would need to be in the test mode. He was not aware of the implications of being in the test mode or the requirements for implementing the fire watch policy and did not notify the Administrator. He did not implement the fire watch policy when he was told the sprinkler system would be shut down. At approximately 2:20 PM, the Physical Therapist found smoke coming out of an ashtray located in the designated smoking area. The Director of Nursing, pulled the Fire Alarm and the Receptionist called 911. The Administrator-in-Training stated he extinguished the fire with a fire extinguisher. The residents were moved to the other smoke compartment. The Fire Department arrived at 2:52 PM and gave the all clear to take the residents back to their rooms at 3:11 PM. The AIT expressed no knowledge of the policy and procedure for the Fire Watch; however, he was responsible for the fire drills and had conducted and documented the last fire drill during the second shift on 05/30/13 at 7:30 PM. Although the fire drill was conducted in</p>	F 323	<p>completed by 7/24/13. See competency test for all staff. Sprinkler head replacement and repair work continued on the following dates; 6/17/13, 6/18/13, 6/19/13, 6/20/13, 6/21/13, 7/1/13 and 7/2/13 with the center initiating a fire watch once the fire protection system had been down for 4 hours with no issues notes. For each of the fire watches listed above there is documented fire watch logs dated and signed by the staff assigned. Administrator is made aware of any and all maintenance vendors in center to work, examples to include Sprinkler repair/checks, electrical repairs, lift repairs, elevator repair, ac/heat repairs, alarm company repair/checks, in center at all times, by the front office staff and or maintenance staff or AIT. No new maintenance director hired at this time. All employees not receiving the fire watch policy in-service were in-serviced by the director of clinical education before they were or are able to work, this to include new</p>	
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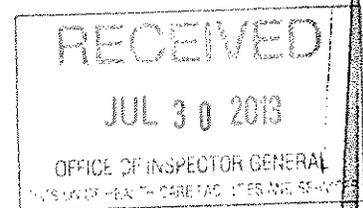
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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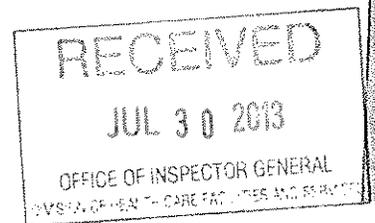
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F 323	<p>Continued From page 62 a satisfactory manner, it did not include the fire watch procedure.</p> <p>Interview, on 06/14/13 at 3:15 PM, with the sprinkler contractor revealed he had informed the Administrator-in-Training of his arriving at the facility to begin the contract work to replace sprinkler heads within the facility. He assumed the Administrator-in-Training was knowledgeable of the procedures when the sprinkler system was put in the test mode.</p> <p>Interview via telephone, on 06/15/13 at 11:15 AM, with the Assistant Fire Chief responding to the 911 call, revealed the Fire Department received the call at 2:47 PM, arrived at the facility at 2:51 PM, he described the situation as a smoke scare, and gave the all-clear signal at 3:11 PM, and departed the facility at 3:11 PM. He voiced a concern about the fire watch policy not being implemented by the facility, as the facility was not protected by the coverage of an automatic sprinkler system and was concerned for the residents.</p> <p>Review of the AOC revealed the facility implemented the following measures: 06/13/12-06/16/13. These immediate actions taken were:</p> <ol style="list-style-type: none"> 1. On 06/13/13 at 3:30 PM, the Administrator verified with the Simplex-Grinnell (S-G) Technician that the automatic fire alarm system was completely back on line. 2. On 06/13/13 at 4:30 PM, the Administrator 	F 323	<p>employees and to be completed by 7/24/13. Administrator and Director of Nursing re-signed their job descriptions on 7/21/2013 and sent to corporate office as to their responsibilities of the day to day function of the center and to ensure compliance and safety of residents. The hot water temperature plan will be put into place anytime water temperatures are above 110 F and a fire watch will be implemented when emergency fire alarm systems are impaired, failure by any staff to do so will result in disciplinary actions up to termination. The medical director has reviewed and given suggestions in the plan of correction and a QAPI meeting will be held 7/24/13 for final discussions with medical director on compliance. The Area Director of Operations and or the Area Director of Clinical Services for Goldenliving will monitor the plan of correction for compliance every two weeks for three months and</p>	



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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 323	<p>Continued From page 53</p> <p>inserviced the AIT on the importance of communicating to her when any maintenance vendors were in the center; the meaning of "test mode"; the requirement to do a fire watch after the system has been down over four (4) hours from a planned event or in an emergency situation; and, to continue the fire watch until the automatic fire alarm system is completely back on line.</p> <p>3. On 06/13/13 at 7:30 PM, the Administrator inserviced the Department Heads which included the DON, ADON, Unit Managers, Business Office Manager, Activities Director, Social Services Director, Dietary Director, Housekeeping Director, MDS Director, Dietician, Admissions Director, Therapy Directors, Director of Clinical Education, Discharge Director the 7-3, 3-11 and 11-7 shift supervisors, along with support staff to include the supply clerk, medical records, and the payroll clerk, (this represents 17% of the staff) on the requirement to do a fire watch any time the automatic fire alarm system was down and notification to the Administrator if they were made aware the system was or may be down and how to do a fire watch and each were given a copy of the fire watch policy specifically covering H-M. The nursing staff will continue inservices to include RNs, LPNs, CNAs, dietary, housekeeping/laundry and therapy staff. thirty-five (35) % of the staff and those not inserviced will not be able to work until they receive the inservice.</p> <p>4. The facility has a shift supervisor 7 days a week and the manager on duty department head on weekends as additional support. One of these staff members will initiate and direct a fire watch</p>	F 323	<p>once a month for next 3 months.</p> <p>4. All maintenance water temperature checks will be reviewed by administrator Monday through Friday and on Mondays will review copy of Saturday/Sunday water temperature log. Also, any emergency calls will be addressed immediately by Administrator. Administrator will review monthly maintenance work invoices that might have had the need for a fire watch, such as any needed or emergency shut down of fire alarm system to make sure fire watch policy and procedures were followed for 6 months. The Administrator will report to QAPI team water temperature reviews and fire watch monitoring to stay in compliance with plan of correction. The QAPI team will continue to monitor hot water temperatures and fire watch compliance by review of Administrator's report,</p>		



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F 323	<p>Continued From page 54</p> <p>upon either an emergency situation or planned situation. This provides for there to always be someone to take charge of any emergency situation.</p> <p>5. The Administrator and S-G Technician met 08/14/13 at 8:00 AM, and since he was continuing his sprinklerhead replacement work, the automatic fire alarm system would be down starting at 8:15 AM and he would inform the Administrator when work was completed and the system completely back on line.</p> <p>6. On 08/14/13 at 12:15 PM, the facility began a fire watch. The 100, 200, 300 resident units were covered by the unit managers and were checked in 15 minute increments. The 400 unit resident area which includes therapy and laundry was covered by the DON and also checked every 15 minutes. The Administrator covered the dining rooms, offices, resident's smoking areas, activity area, maintenance areas and kitchen in 15 minute intervals. All staff were notified they were in fire watch. During the 15 minute checks the above assigned staff were monitoring for signs of fire and smoke and to call 911 to report if any fire or smoke was found and to pull the fire alarm manually.</p> <p>7. On 08/14/13 at 3:30 PM the S-G Technician notified the Administrator that the fire alarm system was completely back on line and the fire watch was terminated.</p> <p>8. There was no change made to the fire watch</p>	F 323	<p>grievances summary log and resident council minutes monthly for 6 months. Any concerns or issues will be addressed immediately and a plan put into place to protect the resident's safety. It is ultimately the administrator's job to validate that all parts of the POC are implemented and compliance is achieved and continues.</p> <p>5. Date of compliance 7/27/13</p>	

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F 323	<p>Continued From page 54</p> <p>upon either an emergency situation or planned situation. This provides for there to always be someone to take charge of any emergency situation.</p> <p>5. The Administrator and S-G Technician met 06/14/13 at 8:00 AM, and since he was continuing his sprinklerhead replacement work, the automatic fire alarm system would be down starting at 8:15 AM and he would inform the Administrator when work was completed and the system completely back on line.</p> <p>6. On 06/14/13 at 12:15 PM, the facility began a fire watch. The 100, 200, 300 resident units were covered by the unit managers and were checked in 15 minute increments. The 400 unit resident area which includes therapy and laundry was covered by the DON and also checked every 15 minutes. The Administrator covered the dining rooms, offices, resident's smoking areas, activity area, maintenance areas and kitchen in 15 minute intervals. All staff were notified they were in fire watch. During the 15 minute checks the above assigned staff were monitoring for signs of fire and smoke and to call 911 to report if any fire or smoke was found and to pull the fire alarm manually.</p> <p>7. On 06/14/13 at 3:30 PM the S-G Technician notified the Administrator that the fire alarm system was completely back on line and the fire watch was terminated.</p> <p>8. There was no change made to the fire watch</p>	F 323	<p>grievances summary log and resident council minutes monthly for 6 months. Any concerns or issues will be addressed immediately and a plan put into place to protect the resident's safety. It is ultimately the administrator's job to validate that all parts of the POC are implemented and compliance is achieved and continues.</p> <p>5. Date of compliance 7/25/13</p>		

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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 06/15/2013
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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 323	<p>Continued From page 55 policy after administrative review on 06/14/13.</p> <p>9. On 06/14/13 at 4:45 PM, the facility was notified of the Immediate Jeopardy due to an incident on 06/13/13, mentioned above in number 1, therefore the purpose of this allegation is compliance.</p> <p>10. On 06/14/13 at 6:30 PM, a QAPI meeting was held to review the Immediate Jeopardy notification and the abatement of the jeopardy.</p> <p>11. On 06/14/13 at 7:00 PM, the Medical Director, was notified on the Immediate Jeopardy and reviewed the QAPI meeting. The Medical Director was already aware of the incident, Immediate Jeopardy, and the fire watch.</p> <p>The state agency validated the AOC on 06/15/13 prior to exit as follows:</p> <p>* Interview, on 06/14/13 at 2:10 PM, with the Simplex-Grinnell (S-G) Technician, the sprinkler contractor, confirmed the automatic Fire Alarm System was put back on line and the sprinkler system was fully functional at 3:30 PM.</p> <p>* Interview, on 06/14/13 at 2:00 PM, with the Administrator in Training confirmed the inservice meeting with the Administrator emphasizing the importance of communication, understanding the terminology of the automatic sprinkler system being put into the test mode, and implementing</p>	F 323		
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JUL 30 2013
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2013
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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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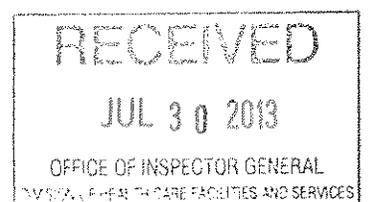
F 323	<p>Continued From page 56 the facility's Fire Watch policy.</p> <p>* Interviews on 06/15/13 between 2:45 PM and 4:15 PM, with the facility department heads and the support staff were conducted to confirm the inservices meeting with the Administrator, emphasizing the importance of communication with the Administrator and procedures for implementing the facility's Fire Watch policy. The inserviced personnel was given a copy of the facility's policy.</p> <p>* As part of the interviewing process on 06/15/13 between 2:45 PM and 4:15 PM, shift supervisors voiced their understanding of the facility's Fire Watch policy and their responsibility to initiate and direct the Fire Watch.</p> <p>* Interview on 06/14/13 at 3:30 PM, with the S-G Technician confirmed the automatic sprinkler system would be turned back on and the system would be fully functional when he left the facility.</p> <p>* On 06/14/13 the Administrator presented a completed copy of the Fire Watch policy in effect from 12:15 PM to 3:30 PM. The sprinkler system was shut down at 8:15 AM and the Fire Watch policy went into effect at 12:15 PM. The facility's personnel was assigned to watch all areas of the facility with supporting documentation.</p> <p>* On 06/14/13 at 3:30 PM, the S-G Technician confirmed he advised the Administrator, that the fire alarm was completely back on line and the facility was protected by the automatic sprinkler system.</p> <p>* A copy of the undated Golden Living Fire Watch</p>	F 323		
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NATIONAL HEALTH CARE PROGRAM

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/16/2013
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 57 policy was reviewed on 06/14/13 with no changes noted. * On 06/15/13 at 4:45 PM, a copy of the QAPI meeting summary and documented attendance was given to the State Agency. The meeting was held on 06/14/13 at 6:30 PM. * The QAPI meeting held on 06/14/13 at 6:30 PM had documented the Medical Director had been notified by phone of the Immediate Jeopardy.	F 323			
F 490 SS=L	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined that Administration failed to ensure safe water temperatures were maintained in resident care areas. The facility failed to ensure staff was trained and knowledgeable regarding water temperatures being maintained between 100-110 degrees Fahrenheit (F). The facility failed to develop and implement policies and procedures to ensure staff identified, reported, monitored and took necessary corrective action when water temperatures were not maintained within safe parameters to ensure the safety of all residents	F 490	F490 Upon notification of the temperatures in excess of 110 F on June 11, 2013. The center completed the following: 1. Individual therapist were assigned to each of the five resident's rooms on the 400 hall and monitored to make sure the resident did not use the sink. 2. The nurse supervisor on the 400 unit gave each of the 5 residents hand sanitizer to use. 3. Maintenance Director turned off the water on 400 hall. 4. The 5 residents on 400 hall were moved to the 300 unit. Effected rooms 401,406,409,415,416) 5. Vendor, Chris with Advanced Mechanic came to center to determine the problem and find the issue to be the "out mixing valve", temperature could not be adjusted and a new mixing valve was ordered to be delivered overnight. 6. In-servicing to the department heads, nursing department (RNs, LPNs, CNAs and shift		



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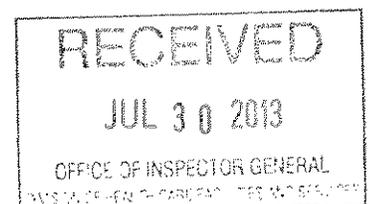
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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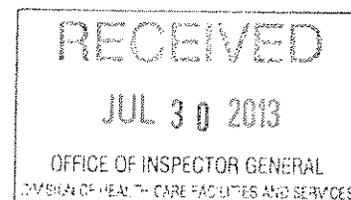
F 490	<p>Continued From page 58</p> <p>within the facility. The facility's water temperature logs, dated 02/17/13 and 3/17/13, detailed water temperatures above 110 degrees (F) in resident care areas on three (3) of four (4) units within the facility. The facility failed to identify these unsafe water temperatures as a concern for resident safety and could provide no evidence that action was taken to reduce the water temperatures in resident care areas. The facility failed to provide water temperature logs for the time period from April 1, 2013 until June 11, 2013 when the water temperatures in resident care areas exceeded 110 degrees (F). The facility failed to ensure water temperatures in resident care areas were monitored during this period.</p> <p>(Refer F323) The facility failed to ensure a safe environment as it related to maintaining safe water temperatures in resident care areas. The facility failed to ensure the facility's hot water system was maintained at a temperature to ensure water temperatures in resident care areas did not exceed regulatory requirements. The facility failed to identify, adjust and/or repair the hot water system when monitored hot water temperatures were above 110 degrees Fahrenheit on three (3) of four (4) units in the facility. The facility failed to ensure hot water temperatures were routinely monitored in resident care areas from 03/23/13 until 06/11/13. This failure placed all residents on the three (3) of four (4) units at risk for potential injury to the skin or body tissues.</p> <p>The facility's failure to administer the facility effectively and efficiently, to provide adequate supervision of water temperatures and failure to</p>	F 490	<p>supervisors), therapy department and any support staff (business office, supply clerk and medical records) that are involved in the manager on duty program and daily monitoring of temperatures until a new full-time maintenance director can be found was completed by the Dietician, Jessica Sullivan and Director of Clinical Education, Jeanne Viers. (The only staff doing hot water temperature checks is Curtis Dykes (Supply Clerk), Mark Bowman (assistant administrator), Jessica Sullivan (Dietician), Jeanne Viers (Director of Clinical Education), Cindi Simpson (Administrator), Cathy Tucker (3-11pm shift supervisor), Tamisha Stokes (11-7pm shift supervisor), Sherry Wallace (3-11pm supervisor), Robin Coder (11-7pm supervisor). The in-service of the hot water temperature plan included how to use the thermometers, how to calibrate the thermometer before each temperature is recorded and to contact administrator and</p>	
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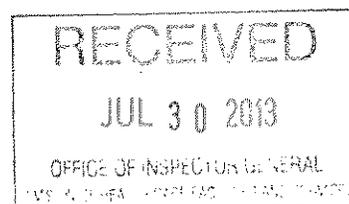
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 490	<p>Continued From page 59</p> <p>implement policy and procedures placed residents at risk in a situation that was likely to cause serious injury, harm, impairment or death. The Immediate Jeopardy was Identified on 06/12/13 and was found to exist on 06/11/13. The facility was notified of the Immediate Jeopardy on 06/12/13.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 06/14/13 and the State Agency validated the Immediate Jeopardy was removed on 06/15/13 as alleged, prior to exit on 06/15/13. The scope and severity was lowered to an "E" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>In addition, it was determined the Administrator failed to implement the facility's policy regarding the Fire Protection System Impairments falling to initiate a fire watch, in accordance with NFPA standards, after the automatic sprinkler system had been shutdown longer than four (4) hours. This failure had the potential to affect each of the eleven (11) smoke compartments, residents, staff and visitors.</p> <p>On 06/13/13 at 8:15 AM the sprinkler contractor began contract work to replace sprinkler heads in various locations throughout the facility. The contractor informed the Administrator in Training that he would be putting the system in the test mode, shutting down the sprinkler system at 8:30 AM to do the remedial work. The Administrator in Training failed to Inform the Administrator of the sprinkler system being shut down and the need to</p>	F 490	<p>assistant administrator if temperatures above 110F,(who then will adjust temperature on the twin hot water tanks mixing valve that services 100, 200 and 300 units), to inform staff and residents (residents with dementia or lack understanding would be removed from room, water turned off or placed on one on one monitoring) that the sink or shower room could not be used and to post a sign above that sink or shower room that it is not to be used until temperature re-checks are done and determined to be at or below 110F, temperatures will be checked every four hours by one of the above in-serviced staff members. None of the above staff will be allowed to work after June 13, 2013 if they have not received the above in-service.</p> <p>7. Temperature checks were began 6-11-13 at 7pm and continued every 4 hours throughout the night. Any temperatures recorded over 110 F, were immediately called to the administrator and assistant</p>		



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F 490	<p>Continued From page 60</p> <p>begin the fire watch. Subsequently a fire was discovered at 2:20 PM in an ashtray in the resident smoking area. The automatic sprinkler system had been shut down from 8:30 AM until 3:52 PM, approximately 7.5 hours. The facility identified the sprinkler shutdown at 2:20 PM at the time of the fire.</p> <p>The facility failed to alert staff of the facility's vulnerability during the test mode of the sprinkler system and failed to ensure a fire watch was initiated during this time which placed the residents at risk and caused or was likely to cause the residents serious injury, harm, impairment or death. Immediate Jeopardy was identified on 06/14/13 and determined to exist on 06/13/13. A deficiency was cited at 483.75 Administration, F490 Administration at a scope and severity of an "L".</p> <p>An acceptable Allegation of Compliance was received on 06/15/13 and the State Agency validated the Immediate Jeopardy was removed on 06/15/13 prior to exit on 06/15/13 with remaining non-compliance at 483.75 Administration, F490 Administration with a scope and severity of an "F" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>1. On 06/11/13 at 11:20 AM, water temperatures were observed in resident care areas, on the 400 unit, ranging from 125 degrees (F) to 138 degrees (F). These water temperatures were</p>	F 490	<p>administrator. Temperatures were adjusted on the twin hot water tanks mixing valve that services 100, 200 and 300 units, some time was allowed to pass and temperatures were rechecked for 110F compliance. During this time the staff and resident of that room was notified to not use the sink/shower room. Once recheck was completed and 110 F compliance was met, resident and staff were notified they could use the sink/shower rooms.</p> <p>8. Maintenance Director suspended pending termination.</p> <p>9. Administrator reviewed all hot water temperatures logged to verify that this plan continues to be followed, some temperatures still above 110F, but plan followed to ensure residents safety.</p> <p>10. There have been no changes to our hot water temperature test policy and this was reviewed by administrator. Please see attached policy.</p> <p>1. June 12, 2013 continued to do random hot water temperatures every 4 hours throughout the</p>	



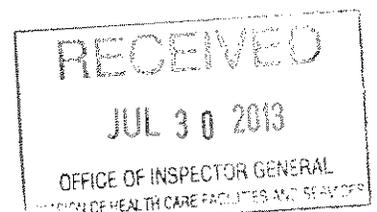
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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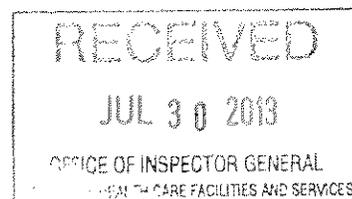
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F 490	<p>Continued From page 61</p> <p>verified by the Maintenance Director. He stated the temperatures were above the 100 degrees (F) to 110 degrees (F) regulatory limits.</p> <p>Review of the facility's water temperature log, dated 06/11/13 at 7:00 PM, revealed water temperatures in resident care areas on the 100 unit and the 200 Unit ranged from 117 degrees (F) to 120 degrees (F).</p> <p>The facility was unable to provide documented evidence that a policy and procedure had been developed and implemented to ensure safe water temperatures were maintained in resident care areas for clinical use. On 06/11/13 interview with the Maintenance Director revealed he sporadically monitored water temperatures in the facility's resident care areas. Interview with the Administrator on 06/11/13 revealed a policy for how to take water temperatures existed; however, there were no policies or procedures for what staff was to do if water temperatures exceeded the regulatory range and how residents were to be protected when water temperatures impacted their safety.</p> <p>The facility was unable to provide documented evidence that monitoring of water temperatures in resident care areas were conducted for the period from 03/23/13 until 06/11/13 when water temperatures were found to be above 110 degrees (F). In addition, review of water temperature logs from 02/17/13 and 03/17/13 revealed the water temperatures in resident care areas ranged from 117 degrees (F) to 133 degrees (F). On 06/11/13, interview with the Maintenance Director revealed he sporadically monitored water temperatures in the facility's</p>	F 490	<p>center. Adjustments made to twin hot water tanks mixing valve as needed. Staff and residents notified to discontinue the use of sink/shower room until notified water temperatures were at or under 110 F. Signs placed above the sink/shower rooms as a reminder.</p> <p>2. Advanced mechanic put new mixing valve on 400 unit hot water tank, monitored water temperatures until 110 F compliance was met. The center continued to monitor the 400 unit water temperatures.</p> <p>3. Advanced Mechanic also examined the 2 twin hot water tanks that service 100, 200 and 300 unit and determined the mixing valve was not adequate size to temper the water sufficiently and a larger mixing valve was ordered to be delivered as soon as possible, tentatively delivery and installations June 17, 2012.</p> <p>4. Water temperatures continued to be checked every 4 hours throughout the night, with notification to administrator and</p>	



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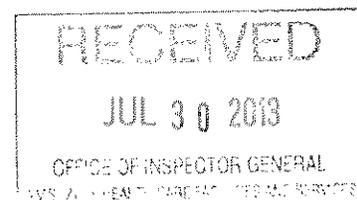
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 490	<p>Continued From page 62</p> <p>resident care areas. Review of this log revealed water temperatures were consistently 109 degrees (F) in all resident care areas. On 06/12/13, interview with the Administrator revealed the water temperature logs kept by the Maintenance Director were fabricated and no actual water temperatures were obtained or monitored.</p> <p>Furthermore, the facility was unable to provide documented evidence that they had provided training to staff regarding the regulations to ensure safe water temperatures were maintained between 100 degrees (F) and 110 degrees (F) for resident care areas. Interview with the Administrator on 06/11/13, revealed the Maintenance Director had been the assistant for approximately six (6) months and was trained by the former Maintenance Director. Review of the personnel file for the Maintenance Director did not provide specific information regarding training on water temperature regulations.</p> <p>Additionally, the Administrator revealed, through interview, that she did not review the water temperature logs for safe temperatures. By not reviewing the water temperatures logs for safety, the Administrator did not identify that the facility water temperatures in resident care areas were not being monitored to ensure compliance with hot water regulations therefore, the hot water temperatures were not referred to the facility's Quality Assurance Committee for action to correct the problem. Further interview with the Administrator revealed hot water temperatures were dangerous for the residents.</p> <p>Review of the AOC revealed the facility</p>	F 490	<p>assistant administrator and temperatures were adjusted to the twin hot water tanks mixing valve that services 100, 200 and 300 units. Time was allowed to pass and temperatures were rechecked for 110F compliance. During this time the staff and resident of that room was notified to not use the sink/shower room. Once recheck was completed and 110 F compliance was meet, resident and staff were notified they could use the sink/shower rooms.</p> <p>5. Called retired 20 year past maintenance director for his historical input on hot water tanks, he suggested the call to "Schardein Mechanical," a prior vendor who had worked in the center for many years for additional suggestions. Scheduled to come to center 6/13/13. No new suggestions.</p> <p>6. Administrator reviewed all hot water temperatures logged to verify that this plan continues to be followed, some temperatures still above 110F, but plan</p>		



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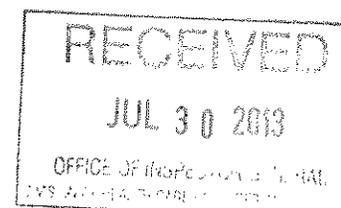
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 490	Continued From page 83 Implemented the following measures 06/12/13 - 08/15/13. The immediate actions taken were: 1. The water on the 400 Unit was turned off on 06/11/13 and the mixing valve on the 400 Unit was replaced (the unit remains closed) on 06/12/13. 2. The five (5) residents on the 400 Unit were relocated to the 300 Unit on 08/11/13. 3. Selected management staff was in-serviced, on 06/11/13, regarding taking water temperatures on a daily basis in resident care areas until a new Maintenance Director could be hired. 4. An In-service, on 08/11/13, included how to take water temperatures; how to contact the Administrator and Assistant Administrator if water temperatures exceed 110 degrees (F); how to adjust the temperature on the hot water tank; how to provide one (1) to one (1) monitoring if the water temperatures were elevated and the residents in the room were confused; how to post a sign stating the water temperatures are too high in that room and the sink and shower are not to be used; how to recheck water temperatures after the hot water tank has been adjusted; temperatures would be monitored every four (4) hours until repairs are completed on the tanks providing hot water to the 100, 200, and 300 Units and for forty-eight (48) hours after the repairs are completed; and no staff would be allowed to work until they attended this In-service. 5. The Maintenance Director was suspended pending termination on 08/11/13.	F 490	followed to ensure residents safety. June 13, 2013 1. Water temperatures continued to be checked every 4 hours throughout the night and start of new day with notification to administrator and assistant administrator and temperatures were adjusted on the twin hot water tanks mixing valve that services 100, 200 and 300 units, as needed some time was allowed to pass and temperatures were rechecked for 110F compliance. During this time the staff and resident of that room was notified to not use the sink/shower room. Once recheck was completed and 110 F compliance was meet, resident and staff were notified they could use the sink/shower rooms. 2. A QAPI meeting was held with Medical Director, Dr. Hilgford and QAPI team consisting of Administrator, DON, assistant administrator, maintenance, unit managers, dietician, dietary manager, housekeeping manager and social		



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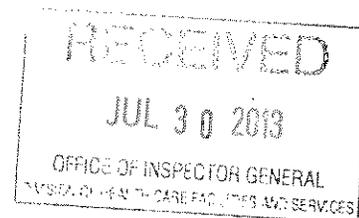
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP 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 490	<p>Continued From page 64</p> <p>6. The Administrator would monitor all water temperature logs to ensure resident safety on 06/11/13.</p> <p>7. The parts were ordered to repair the hot water tanks for 100, 200 and 300 Units on 06/12/13.</p> <p>8. Water temperatures were monitored and the water heaters for the 100, 200 and 300 Unit were adjusted when needed on 06/11/13.</p> <p>9. A QAPI meeting was held with the Medical Director on 06/13/13.</p> <p>10. On 06/13/13 grievance records were reviewed, back to March 23, 2013 and there were no grievances related to hot water, accident and incident reports were also reviewed back to January 1, 2013 and no injuries were noted.</p> <p>11. Nursing staff was in-serviced on the treatment of hot water injuries which included notification of the Administrator, and staff will not be allowed to work until they have attended the in-service and receive the information provided on 06/13/13.</p> <p>12. On 06/13/13 Incident and Accident reports were reviewed back to 01/01/13, and no injuries were noted.</p> <p>The State Agency validated the AOC on 06/15/13 prior to exit as follows:</p> <p>* The hot water on the 400 Unit did not come on when the sink handle was turned on, on 06/11/13 at 12:15 PM.</p> <p>* Review of the water temperature logs for</p>	F 490	<p>services to cover the immediate jeopardy abatement plan, cause of immediate jeopardy and resolution.</p> <p>3. This hot water temperature plan will continue until the new mixing valve is placed on the twin tanks and temperatures are monitored for 48 hours afterward to determine if hot water temperatures are at or below 110F.</p> <p>4. Grievances were reviewed back to March 23, 2013 by Jenny Potts, SSW, to look for any past grievances on hot water temperatures and none were found.</p> <p>5. Accident and Incident reports were reviewed by the Director of Nursing back to January 1, 2013 for any possible identifiable injuries related to hot water temperatures, no injuries noted related to any type of hot water burns.</p> <p>6. Nursing staff to include RNs, LPNs and CNAs were in-serviced starting June 13, 2013 on what to do with a suspected hot water burn, to include</p>	



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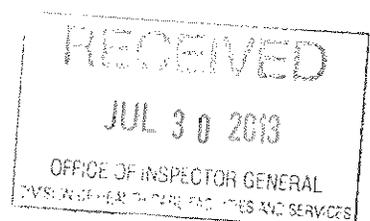
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP 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 490	<p>Continued From page 65</p> <p>06/11/13 and 06/12/13, revealed water temperatures were within the range of 100 degrees (F) to 110 degrees (F). Interview with the Administrator, on 6/13/13 at 10:00 AM, revealed she had knowledge of the water temperatures over the last several days.</p> <ul style="list-style-type: none"> * Review of the work orders for the vendor (Advanced), on 06/12/13, revealed the parts for the repair of the two water heaters supplying the 100, 200 and 300 Units were ordered. * On 06/15/13, review of the water temperature logs revealed the facility continued to monitor the water temperatures every four (4) hours. Water temperatures obtained by the state agency, on 06/15/13 at 2:10 PM, revealed water temperatures within the 100 degrees (F) to 110 degrees (F) range. * In-service records were reviewed for content and attendance and ninety-nine (99) of the one hundred forty-nine (149) employees were in-serviced and employees may not return to work until in-services are attended. * Follow-up water temperatures were obtained on the 400 Unit, on 06/15/13 at 2:10 PM, and were within 100 degrees (F) to 110 degrees (F) after repairs were completed. * Interview with the Administrator, on 06/12/13 at 8:30 AM, verified the Maintenance Director was terminated. * Review of the signature sheet revealed the Medical Director attended the QAPI meeting regarding the immediate jeopardy on 06/13/13. 	F 490	<p>immediate treatment, nurse notification, physician and administrator or Director of Nursing notification and to turn off water at sink. In-servicing completed by Jeanne Viers, Director of Education. Any staff not working before end of day June 13, 2013 will not be allowed to work until in-service completed.</p> <p>7. The number of staff who received the in-service on hot water temperature plan and what to do with a hot water burn is 99/149 employees, all others have not worked yet because of scheduled, on vacation, leave or PRN.</p> <p>8. Alleged date of abatement of immediate jeopardy is 6/14/13.</p> <p>On June 13, 2013 at approximately 3:30 pm the administrator (Cindi Simpson) of the center became aware that the automatic fire alarm system had been put on "test mode" at 9am that morning while the Simplex-Grinnell technician (referred to SG-technician) had been</p>		



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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 490	<p>Continued From page 66</p> <p>* Written statements were obtained from the Social Worker and the Director of Nursing, on 06/14/13, that grievances and incident reports were reviewed for complaints of hot water being too hot, none noted, and injuries from hot water, none noted. In addition, record review, on 06/14/13, revealed the facility completed skin checks on residents, and on 06/13/13, with no resident injuries found.</p> <p>* Six (6) Licensed Practical Nurses, six (6) Certified Nurse Aides, two (2) Housekeepers, one (1) Nursing Supervisor, one (1) Physical Therapist and the Director of Nursing were interviewed, on 06/15/13, regarding in-services held on 06/11/13 and 06/13/13. Staff was able to verbalize understanding the potential danger of water that was too hot injuring residents, that they should report to the Maintenance Department and the supervisor when they feel the water was too hot, that residents are to be protected by moving away from the room where the water is too hot or turning the water off, or placing a sign in the room warning of hot water.</p> <p>2. Review of the facility's policy regarding Fire Protection System Impairments, not dated, revealed impairments can result from either planned or emergency shut down of these systems. A lack of prior planning in shut-down or impairment of these systems can result in serious consequences in the event of a fire. The facility will require strict compliance with the basic fire safety precautions outlined in the policy. The fire watch procedures outlined will be implemented immediately for all impairments, regardless of duration. If the facility fire protection system will</p>	F 490	<p>replacing sprinkler heads on one of the units in the center. The SG-technician had told the administrator in training, Mark Bowman, that he would be doing this, unfortunately this was not communicated to the administrator and Mark did not understand the terminology of "test mode" (meaning he was draining the sprinkler system and notifying the alarm monitoring company that work was being done, so they will not think something was wrong and contacting fire department) and so after the 4 hour time frame that the automatic fire system had been turned off, the center did not do a fire watch for the remaining down time of the system from 12:30pm to 3:30pm which could have potentially impacted the entire center and all residents.</p> <p>1. On June 13, 2013 at 3:30pm the administrator verified with the SG-technician at that the automatic fire alarm system was completely back on line and the center's residents were safe.</p>		



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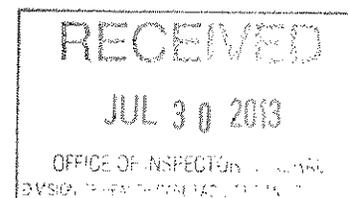
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
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F 490	Continued From page 67 be shut down or is impaired for four (4) or more hours in a twenty-four (24) hour period all of the following procedures will be implemented. The facility will maintain a Fire Protection Impairment Kit at all times. The facility's Impairment Coordinator will contact the consultant prior to any impairment. Supervisors in the affected area, the local fire department, the State Fire Marshal and the Fire Alarm Central Station Monitoring Company shall also be notified of the impairment. Telephone numbers for notification of local and state agencies are (blank). The Impairment Coordinator shall make sure that all materials needed to make the repairs are ready at the job site before any valve or device is closed or fire protection system is disabled. The appropriate tags shall be attached to all affected areas. Any hot work will be discontinued. A fire watch will be conducted for all affected areas of the facility until the fire protection system is operational again. Fire watch rounds shall be conducted at a minimum of thirty (30) minute intervals for all affected areas of the building. Fire watches shall be provided continuously until the work is completed and the fire protection system is completely functional, including through coffee breaks and lunch breaks. Fire watch personnel shall receive training on recognition of fire hazards and use/location of appropriate portable fire extinguishers as well as the the procedure for alerting staff while the fire alarm system is out of service. Observation and record review of the facility's Policies and Procedures, on 06/14/13 between 1:45 PM and 5:30 PM, with the Administrator and the Administrator in Training revealed the facility failed to implement a fire watch policy after the	F 490	2. On June 13, 2013 at 4:30pm the administrator in-serviced Mark Bowman on the importance of communicating to her when any maintenance vendors are in the center and what "test mode" meant and the requirement to do a watch fire after the system has been down over 4 hours from a planned event or in an emergency situation and is to continue until the automatic fire alarm system is completely back on line. 3. On June 13, 2013 at 7:30pm the administrator in-serviced the Department Heads to include the DON, ADON, Unit Managers, Business Office Manager, Activities Director, Social Services Director, Dietary Director, Housekeeping Director, MDS Director, Dietician, Admissions Director, Therapy Directors, Director of Clinical Education, Discharge Director, 7-3/3-11/11-7 shift supervisors, along with support staff to include the supply clerk, medical records, payroll clerk, this is 17% of our staff and on the	

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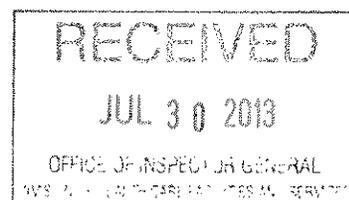
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 490	Continued From page 68 automatic sprinkler system had been shut down from 8:30 AM until 3:52 PM, approximately 7.5 hours. Interview, on 06/14/13 at 2:00 PM, with the Administrator revealed a sprinkler company had been contracted by the Corporate Office to replace sprinkler heads within various areas of the facility. The contractor arrived on site at 8:15 AM and discussed his scope of work with the Administrator In Training. The Administrator In Training was advised by the sprinkler contractor that both of the sprinkler risers would need to be in the test mode, meaning the sprinkler valves were turned in the off position and the alarm company monitoring the facility should have been notified the automatic dialers were turned off to do the contract work. The Administrator In Training failed to contact the Administrator about the sprinkler contractor being on site and the system would be down for over a four (4) hour period of time. The system was shutdown at 8:30 AM, leaving the facility without the protection of an automatic sprinkler system. The fire watch policy had not been implemented after the shutdown. At approximately 2:20 PM, smoke was discovered coming out of an ashtray located in the indoor, designated smoking area. A Physical Therapist had discovered the fire and notified the Director of Nursing, who pulled the Fire Alarm and alerted the Receptionist to call 911 upon realizing the automatic sprinkler system had been turned off. The Administrator-in-Training extinguished the smoldering ashes with a fire extinguisher. The residents were evacuated to the adjacent smoke compartment during the time of the emergency. The Fire Department arrived on site at 2:52 PM and gave the clear signal to	F 490	requirement to do a fire watch any time the automatic fire alarm system is down and notification to the administrator if they are made aware the system is or may be down and how to do a fire watch and each given copy of the fire watch policy specifically covering H-M. See attached policy. We will continue to in-service nursing to include RNs, LPNs, CNAs, dietary, housekeeping/laundry and therapy staff, we have completed 35% of this staff and those not in-serviced will not be able to work until they receive the in-service. 4. Because Hillcreek always has a shift supervisor 7 days a week and our manager on duty department head on weekends as additional support, one of these staff members would be the one to initiate and direct a fire watch upon either an emergency situation or planned situation. This provides for there to always be someone to take charge of any emergency situation.		



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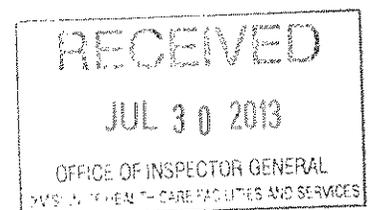
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 490	<p>Continued From page 69 reenter the smoke compartment at 3:11 PM.</p> <p>Interview with the Director of Nursing, on 06/14/13 at 4:10 PM, revealed she pulled the fire alarm and then went to the receptionist area to see the fire panel and the location of the fire and instructed the receptionist to announce, over the intercom, a Code Red in the smoking room. She stated she then returned to the smoking room to assist the Administrator. She stated she failed to hear the sirens within a few minutes so she returned to the reception area and instructed the receptionist to call 911. She indicated the fire department always responded quickly and the absence of the sirens caused her concern. She stated she was not aware that the fire alarm system was down; however, she felt something was wrong.</p> <p>Interview with the Receptionist, on 06/14/13 at 4:20 PM, revealed she called 911 at the instruction of the Director of Nursing. She stated she normally did not make this call and was not aware that the fire alarm system was down.</p> <p>Interview, on 06/14/13 at 2:35 PM, with the Administrator in Training revealed he had been informed of the system being put in the test mode by the sprinkler contractor at 8:30 AM after the contractor discussed what they would be doing. He stated he was told the sprinkler risers would need to be in the test mode. He was not aware of the implications of being in the test mode or the requirements for implementing the fire watch policy and did not notify the Administrator. He did not implement the fire watch policy when he was told the sprinkler system would be shut down. At approximately 2:20 PM, the Physical Therapist</p>	F 490	<p>5. Administrator and SG-technician meet June 14, 2013 at 8am and since he was continuing his sprinkler head replacement work, the automatic fire alarm system would be down starting at 8:15am and he would inform me when work completed and system completely back on line.</p> <p>6. June 14, 2013 at 12:15pm, the center began a fire watch. The 100 (Dana Waters) 200 (Regina Mudd), 300 (Jennifer Moran and Ashley Stover) resident's units were covered by the unit managers and were checked in 15 minute increments. The 400 unit resident area which includes therapy and laundry was covered by the DON (Donna Fountain) and also checked in 15 minute increments. The administrator covered the dining rooms, offices, resident's smoking areas, activity area, maintenance areas and kitchen in 15 minute increments. All staff were notified we were in a fire watch. During the 15 minute increments the above assigned staff were monitoring for signs of</p>		



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F 490	<p>Continued From page 70</p> <p>found smoke coming out of an ashtray located in the designated smoking area. The Director of Nursing, pulled the Fire Alarm and the Receptionist called 911. The Administrator in Training stated he extinguished the fire with a fire extinguisher. The residents were moved to the other smoke compartment. The Fire Department arrived at 2:52 PM and gave the all clear to take the residents back to their rooms at 3:11 PM. The Administrator in Training expressed no knowledge of the policy and procedure for the Fire Watch; however, he was responsible for the fire drills and had conducted and documented the last fire drill during the second shift on 05/30/13 at 7:30 PM. Although the fire drill was conducted in a satisfactory manner, it did not include the fire watch procedure.</p> <p>Interview, on 06/14/13 at 3:15 PM, with the sprinkler contractor revealed he had informed the Administrator In Training of his arriving at the facility to begin the contract work to replace sprinkler heads within the facility. He assumed the Administrator in Training was knowledgeable of the procedures when the sprinkler system was put in the test mode.</p> <p>Interview via telephone, on 06/15/13 at 11:15 AM, with the Assistant Fire Chief responding to the 911 call, revealed the Fire Department received the call at 2:47 PM, arrived at the facility at 2:51 PM, described the situation as a smoke scare, gave the all-clear signal at 3:11 PM, and departed the facility at 3:11 PM. He voiced a concern about the fire watch policy not being implemented by the facility, as it was not protected by the coverage of an automatic sprinkler system and was concerned for the residents.</p>	F 490	<p>fire and smoke and to call 911 to report if any fire or smoke found and to pull the fire alarm manually.</p> <p>7. On June 14, 2013 at 3:30 the SG-technician notified administrator that the fire alarm system was completely back on line and the fire watch was terminated with successful completion and all resident's were kept safe.</p> <p>8. There was no change made to fire watch policy after administrator review.</p> <p>9. On June 14, 2013 at 4:45 pm the center was notified of the immediate jeopardy due to incident on June 13, 2013, mentioned above in number 1, therefore the purpose of this allegation of compliance.</p> <p>10. On June 14, 2013 at 6:30pm a QAPI meeting was held and in attendance was the DON, AIT, Unit managers, Dieticians, Dietary manger, social services, admissions, activities, MDS Director, supply clerk, medical records, business office manager, director of clinical education,</p>		



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F 490	Continued From page 71 Review of the AOC revealed the facility implemented the following measures: 06/13/12-06/15/13. The immediate actions taken were: 1. On 06/13/13 at 3:30 PM, the Administrator verified with the Simplex-Grinnell (S-G) Technician that the automatic fire alarm system was completely back on line. 2. On 06/13/13 at 4:30 PM, the Administrator inserviced the Administrator in Training on the importance of communicating to her when any maintenance vendors are in the center and what "test mode" meant and the requirement to do a fire watch after the system has been down over (4) hours from a planned event or in an emergency situation and is to continue until the automatic fire alarm system is completely back on line. 3. On 06/13/13 at 7:30 PM, the Administrator inserviced the Department Heads to include the DON, ADON, Unit Managers, Business Office Manager, Activities Director, Social Services Director, Dietary Director, Housekeeping Director, MDS Director, Dietician, Admissions Director, Therapy Directors, Director of Clinical Education, Discharge Director 7-3/3-11/11-7 shift supervisors, along with support staff to include the supply clerk, medical records, and the payroll clerk, (this represented seventeen (17) % of the staff) on the requirement to do a fire watch any time the automatic fire alarm system is down and notification to the Administrator if they are made	F 490	discharge director, to review immediate jeopardy notification and the abatement of the jeopardy notification. Also reviewed was a past incident on 4/30/13 when center had been notified of issue with automatic fire alarm system and had began and completed a successful documented fire watch from 1pm to 4pm and obviously knew what to do when information of potential fire risk were communicated. 11. On June 14, 2013 at 7pm, Medical Director, Dr. Hilgford, spoken to by phone by administrator to review QAPI and although previously had discussed incident of June 13, 2013, he was made aware of the immediate jeopardy, the fire watch completed earlier in the day successfully and this allegation of compliance. 12. Date of Compliance June 15, 2013 <u>AFTER ABATMENT</u> 1. The five residents effected by the hot water temperatures 35, 36, 37, 38 and 39 were moved		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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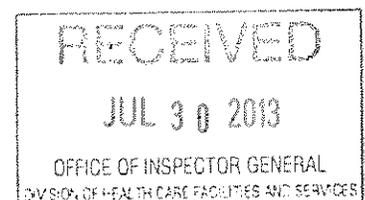
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F 490	<p>Continued From page 72</p> <p>aware the system is or may be down and how to do a fire watch and each were given a copy of the fire watch policy specifically covering H-M. The nursing staff will continue inservices to include RNs, LPNs, CNAs, dietary, housekeeping/laundry and therapy staff. Thirty-five (35) % of the staff and those not inserviced will not be able to work until they receive the inservice.</p> <p>4. Facility has a shift supervisor assigned seven (7) days a week and the manager on duty department head on weekends as additional support. One of these staff members would initiate and direct a fire watch upon either an emergency situation or planned situation. This provided for there to always be someone to take charge of an emergency situation.</p> <p>5. The Administrator and S-G Technician met, on 06/14/13 at 8:00 AM, and since he was continuing his sprinkler head replacement work, the automatic fire alarm system would be down starting at 8:15 AM and he would inform the Administrator when work was completed and the system completely back on line.</p> <p>6. On 06/14/13 at 12:15 PM, the facility began a fire watch. The 100, 200, 300 resident Units were covered by the Unit Managers and were checked in fifteen (15) minute increments. The 400 Unit resident area which included therapy and laundry were covered by the DON and also checked every fifteen (15) minutes. The Administrator covered the dining rooms, offices, resident's smoking areas, activity area, maintenance areas and kitchen in fifteen (15) minute intervals. All staff was notified they were in a fire watch. During</p>	F 490	<p>from 400 unit to 300 unit. All had skin checks completed with no signs of any type of blisters or burns. There were no identified residents involved in the lack of fire watch policy. The QAPI meetings held 6/21/13, 6/25/13, 7/1/13 and 7/8/13 reviewed water temperatures and fire watch logs and discussed any issues or problems that had arose and a plan to correct. The Administrator and DON were in-serviced on 7/26/13 by Area Vice President of Operations for Goldenliving on the responsibility to monitor the day to day functions of the center to ensure compliance and effective use of resources. See attached.</p> <p>2. All residents at potential risk of being affected if water temperatures exceed the 110 degree and or the fire watch policy is not followed. The QAPI committee failed to monitor maintenance preventative program and staff required fire and safety education, mostly due to administrator and DON</p>	
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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 06/15/2013
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 490	<p>Continued From page 73</p> <p>the fifteen (15) minute checks the above assigned staff were monitoring for signs of fire and smoke and to call 911 to report if any fire or smoke was found and to pull the fire alarm manually.</p> <p>7. On 06/14/13 at 3:30 PM the S-G Technician notified the Administrator that the fire alarm system was completely back on line and the fire watch was terminated.</p> <p>8. There was no change made to the fire watch policy after administrative review on 06/14/13.</p> <p>9. On 06/14/13 at 6:30 PM, a QAPI meeting was held to review the Immediate Jeopardy notification and the abatement of the jeopardy.</p> <p>10. On 06/14/13 at 7:00 PM, the Medical Director was notified on the Immediate Jeopardy and reviewed the QAPI meeting. The Medical Director was already aware of the incident, Immediate Jeopardy, and the fire watch. The signature page of the QAPI attendance sheet revealed the Medical Director's signature.</p> <p>The state agency validated the AOC on 06/15/13 prior to exit as follows:</p> <p>* Interview, on 06/14/13 at 2:10 PM, with the S-G Technician, the sprinkler contractor, confirmed the automatic Fire Alarm System was put back on</p>	F 490	<p>turnover. The administrator during survey had been in the center only 31 days and had not yet had time to review all areas of the center.</p> <p>3. The mixing valve on the twin hot water tanks was replaced on 6/18/13. On 300 unit 3 hot and cold check valves were placed to help regulate water temperatures to rooms 332, 334 and 336. We continued to check water temperatures every 4 hours up to 6/25/13 when a QAPI meeting was held to review temperatures and it was determined the temperatures had remained between the 100-110 degrees. Water temperatures checks were changed to every 6 hours starting 6/25. On 7/1/13 a QAPI meeting was held and water temperatures reviewed and the decision was made that the maintenance department would take over the water checks Monday through Friday and the weekend manager on duty would check Saturdays and Sundays. All water temperature checks would be reviewed by administrator,</p>	



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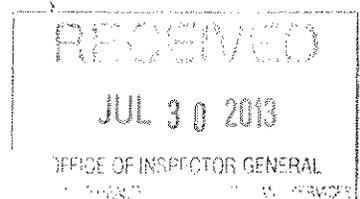
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F 490	<p>Continued From page 74 line and the sprinkler system was fully functional at 3:30 PM.</p> <p>* Interview, on 06/14/13 at 2:00 PM, with the Administrator in Training confirmed the inservice meeting with the Administrator emphasizing the importance of communication, understanding the terminology of the automatic sprinkler system being put into the test mode, and implementing the facility's Fire Watch policy.</p> <p>* Interviews on 06/15/13 between 2:45 PM and 4:15 PM, with the facility department heads and the support staff were conducted to confirm the inservices meeting with the Administrator, emphasizing the importance of communication with the Administrator and procedures for implementing the facility's Fire Watch policy. The inserviced personnel was given a copy of the facility's policy.</p> <p>* As part of the interviewing process on 06/15/13 between 2:45 PM and 4:15 PM, shift supervisors voiced their understanding of the facility's Fire Watch policy and their responsibility to initiate and direct the Fire Watch.</p> <p>* Interview, on 06/14/13 at 3:30 PM, with the S-G Technician confirmed the automatic sprinkler system would be turned back on and the system would be fully functional when he left the facility.</p> <p>* On 06/14/13 the Administrator presented a completed copy of the Fire Watch policy in effect from 12:15 PM to 3:30 PM. The sprinkler system was shut down at 8:16 AM and the Fire Watch policy went into effect at 12:15 PM. The facility's personnel was assigned to watch all areas of the</p>	F 490	<p>Monday through Friday when daily copy of temperatures turned in by maintenance staff and on Mondays will review copy of Saturday/Sunday water temperature log. Re-in-service maintenance assistant and manager on duty staff to the importance of reporting all temperatures above 110. to administrator and or DON immediately on 7/8/13. Any of the employees who had not received the in-services on the hot water temperature plan, what to do with a resident with a hot water burn or fire watch policy were in-serviced by the director of clinical education before they were or are able to work, this to include new employees will be completed by 7/24/13. See competency test for all staff. Sprinkler head replacement and repair work continued on the following dates; 6/17/13, 6/18/13, 6/19/13, 6/20/13, 6/21/13, 7/1/13 and 7/2/13 with the center initiating a fire watch once the fire protection system had been down for 4 hours with</p>		

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F 490	Continued From page 75 facility with supporting documentation. * Interview, on 06/14/13 at 3:30 PM, revealed the S-G Technician confirmed he advised the Administrator, that the fire alarm was completely back on line and the facility was protected by the automatic sprinkler system. * A copy of the undated Golden Living Fire Watch policy was reviewed on 06/14/13 with no changes noted. * On 06/15/13 at 4:45 PM, a copy of the QAPI meeting summary and documented attendance was given to the State Agency. The meeting was held on 06/14/13 at 6:30 PM. * The QAPI meeting held, on 06/14/13 at 6:30 PM, had documented the Medical Director had been notified by phone of the Immediate Jeopardy.	F 490	no issues notes. For each of the fire watches listed above there is documented fire watch logs dated and signed by the staff assigned. Administrator is made aware of any and all maintenance vendors in center to work, examples to include Sprinkler repair/checks, electrical repairs, lift repairs, elevator repair, ac/heat repairs, alarm company repair/checks, in center at all times, by the front office staff and or maintenance staff or AIT. No new maintenance director hired at this time. All employees not receiving the fire watch policy in-service were in-serviced by the director of clinical education before they were or are able to work, this to include new employees and to be completed by 7/24/13. Administrator and Director of Nursing re-signed their job descriptions on 7/21/2013 and sent to corporate office as to their responsibilities of the day to day function of the center and to ensure compliance and safety of residents. The hot water temperature plan will be		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514			



F490

put into place anytime water temperatures are above 110 F and a fire watch will be implemented when emergency fire alarm systems are impaired, failure by any staff to do so with result in disciplinary actions up to termination. The medical director has reviewed and given suggestions in the plan of correction and a QAPI meeting will be held 7/24/13 for final discussions with medical director on compliance. **The Area Director of Operations and or the Area Director of Clinical Services for Goldenliving will monitor the plan of correction for compliance every two weeks for three months and once a month for next 3 months.**

4. All maintenance water temperature checks will be reviewed by administrator Monday through Friday and on Mondays will review copy of Saturday/Sunday water temperature log. Also, any emergency calls will be addressed immediately by

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Administrator. Administrator will review monthly maintenance work invoices that might have had the need for a fire watch, such as any needed or emergency shut down of fire alarm system to make sure fire watch policy and procedures were followed for 6 months. The Administrator will report to QAPI team water temperature reviews and fire watch monitoring to stay in compliance with plan of correction. The QAPI team will continue to monitor hot water temperatures and fire watch compliance by review of Administrator's report, grievances summary log and resident council minutes monthly for 6 months. Any concerns or issues will be addressed immediately and a plan put into place to protect the resident's safety. It is ultimately the administrator's job to validate that all parts of the POC are implemented and compliance is achieved and continues.

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5. Date of compliance 7/27/13

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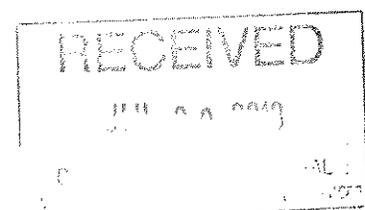
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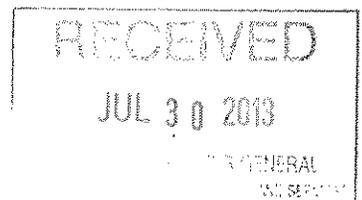
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
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F 514	Continued From page 76 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to maintain medical records with accurate documentation for two (2) of thirty-nine (39) sampled residents (Resident #16 and #31). Resident #16's medical record contained illegible signatures, undated documentation and failed to identify the resident. Resident #31's medical record had physician orders that were not dated or timed. The findings include: 1. The facility provided a document with no title and no date for the requested Medical Records policy. The document had a star marked under Employee Responsibilities highlighting the following statement: Maintain accurate and complete records for all business purposes, and never alter or destroy records in response to an investigation, or when an investigation is anticipated. Review of the facility's policy, Red Line Guideline, revised 09/2007, revealed the supervisor or nurse would check the chart for orders after a physician visits. Orders would be placed in the computer and noted by the nurse. The order would then be placed on the MAR, TAR, Calendar, INR sheets, etc. Appropriate parties would be notified, i.e. Pharmacy, physician's office, dietary, therapy, etc. The nurse would make an entry in the computer progress notes that the physician was in and any new determinations made. When a physician visits the residents in the facility, the nurse would note the visit on the 24 hour report	F 514	F514 1. Resident # 16 and #31 charts were reviewed and dates and printed name of physician and resident were added to the orders on 7/11/13 to 7/18/13. 2. An audit completed 7/12/13 to 7/17/13 of all physician orders back to June 1, 2013 were reviewed for resident's name, room number, date, printed physician name. 3. Medical records updated her physician signature list with each physician, to make sure we have their most up to date signature 7/9/13 to 7/18/13. The administrator will send a letter to the physicians instructing them that all orders and forms must be signed and dated in legible handwriting on 7/19/13. Medical records will set up an audit calendar starting 7/22/13 and will audit 10 charts a day to review orders for legible dates, times, resident's name and signatures for first 30 days, then 10 charts a week for next 30 days and then 5 charts a week for next 30 days,	



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F 514	<p>Continued From page 77 sheet. The Nurse would check assigned charts for potential missed orders that were not picked up and inputted in the computer. The Nurses would check the lab sheets, consults, physician orders, and progress notes. If there are new orders, they would be entered into the computer, and the staff would follow through with implementation, and red line, date and initial after the last order.</p> <p>Review of the medical record for Resident #16 revealed:</p> <ol style="list-style-type: none"> 1. A Clinical Pharmacist Letter to Physician Services, with a date from 06/01/13 to 06/30/13. The letter included a recommendation from the pharmacist to the physician of the resident, which required the physician's signature to acknowledge the physician accepted or rejected the recommendation. The signature on the line for the physician's signature was illegible. It had the appearance of a smooth curved check mark. 2. A printed order sheet dated 06/03/13, with the medications the resident was ordered and other ancillary treatments, had a signature of a physician that was illegible. The adjacent line had a printed physician's name listed. 3. Another order sheet, dated 03/20/13, had the same adjacent line that printed the physician's name. However, the illegible signature on the signature line did not match the illegible signature of the same physician on the previous document, #2 above. 4. An order sheet dated 03/04/13 had the line for 	F 514	<p>the next 90 days in the daily clinical meeting orders will be reviewed. The DON will review medical record audits three times a week and address any issues with nursing staff.</p> <p>4. QAPI team will meet for 6 months and review the results of the medical records audits for compliance. The administrator will review monthly for 6 months with DON the medical record audits for compliance with plan of correction. It is ultimately the administrator's job to validate all parts of the POC are implemented and compliance is achieved and continues.</p> <p>5. Date of compliance 7/27/13</p>		



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F 514	<p>Continued From page 78</p> <p>the physician's signature blank. However, there was an illegible scribble at the bottom of the page followed by a date.</p> <p>5. An order sheet dated 02/04/13 had a curved check mark on the signature line opposite the typed name of the physician. There was no legible signature.</p> <p>6. A Physician's Orders and Signature Form copied from the chart of Resident #16 had no identifying entries. Missing was the name of the resident, the attending physician, the room number and the name of the facility. In addition, the four (4) entries on the document had illegible signatures next to the entries.</p> <p>7. Record review from a Physician's Orders and Signature Form from a chart, had no resident's name, room number or other identifying features on the document. The document was offered as an example by Licensed Practical Nurse (LPN) #17 to identify a signature she had witnessed signed on the document earlier.</p> <p>Interview, on 06/14/13 at 2:30 PM, with LPN #16 revealed from the documents listed above, she did not know who signed on #1, #2 and #3. She revealed clinical records were to be legible. She continued by stating the rationale for legibility was to know who had given the order and who to call with questions related to the order. She revealed if an order was misread, you may not know what to follow and there was the potential for errors if unreadable.</p> <p>Interview, on 06/14/13 at 2:38 PM, with LPN #17 revealed from the documents listed above, she</p>	F 514			

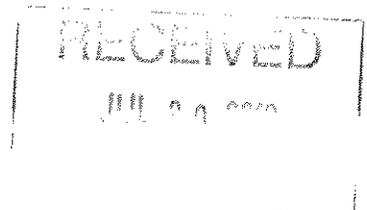
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F 514	<p>Continued From page 79</p> <p>did not know who signed #1 and #3. She stated #2 looked like the Nurse Practitioner's signature. However, the signature was illegible, and it was on the line for the physician to sign, so if it was the nurse practitioner's signature, there was no title listed to indicate it was not the physician that had signed the document. LPN #17 copied an order from the chart of another resident to show the nurse practitioner's signature, which she had witnessed earlier during her shift. The signature did match the signature from the document listed as #2 above. LPN #17 revealed a signature needed to be legible to make the chart accurate and to know who to call if there were questions about the orders that were signed. She stated the potential for harm was that "anything could go wrong".</p> <p>Interview, on 06/14/13 at 2:50 PM, with Medical Records revealed she believed the documents listed above as #1, #2, #3 and #5 were signed by the Nurse Practitioner. However, on the documents, the Physician's printed name was on one line and the Physician's signature was to be on the following line. With the signature illegible and no title behind the name, it was not known who had signed to approve the orders, the Physician, or the Nurse Practitioner on behalf of the Physician. In addition, below the signature on #5 listed above, a nurse had signed off that the orders were reviewed and verified by the Physician (she noted the Physician's name), when the signature had been stated to be that of the Nurse Practitioner, no title behind the signature, and not the Physician. The nurse that signed off on the orders had also not signed her name with her title. The Medical Records person revealed medical records were to be legible so</p>	F 514			



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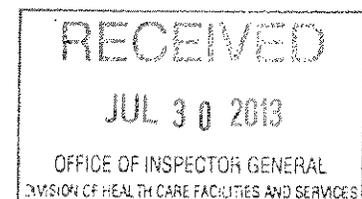
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 514	<p>Continued From page 80</p> <p>the reader would be able to read who wrote the entry or who signed it and to be able to verify the order with the individual who wrote it. She revealed she was responsible for the medical records.</p> <p>2. Review of Resident #31's medical record revealed a physician's order requesting to be called as to why the resident did not have a follow up appointment with the hand surgeon, it was not dated or timed. In addition the orders were not noted as being acknowledged or initiated by the facility. An order dated 05/02, did not have a year, or a time it was written. The order was lined with the Unit Manager's signature, but no date was noted indicating when the order was acknowledge and initiated.</p> <p>Interview with the Unit Manger, on 06/14/13 at 3:25 PM, revealed all orders should be dated and timed. The Unit Manager revealed it was the nurses responsibility to ensure all entries were legible, dated, and timed. The Unit Manager revealed any concerns should be called and clarified with the physician. The Unit Manger stated she was not monitoring to ensure the accuracy of the medical records.</p> <p>Interview with the Director of Nursing Services (DNS), on 06/15/13 at 9:36 AM, revealed all orders should be legible, dated, and timed to ensure records are accurate, and systematically in chronological order. The DNS revealed she was not aware orders were not being dated or timed, and that nurses were not dating their entries when chart checks are completed or orders are acknowledged.</p>	F 514			



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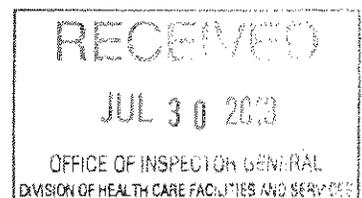
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 520 SS=K	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to report unsafe hot water temperatures, exceeding 110 degrees Fahrenheit, in resident care areas to the Quality Assessment and Assurance (QAA) Committee. The facility failed to ensure</p>	F 520	<p>F520</p> <p>Upon notification of the temperatures in excess of 110 F on June 11, 2013. The center completed the following:</p> <ol style="list-style-type: none"> 1. Individual therapist were assigned to each of the five resident's rooms on the 400 hall and monitored to make sure the resident did not use the sink. 2. The nurse supervisor on the 400 unit gave each of the 5 residents hand sanitizer to use. 3. Maintenance Director turned off the water on 400 hall. 4. The 5 residents on 400 hall were moved to the 300 unit. <p>Effected rooms 401,406,409,415,416)</p> <ol style="list-style-type: none"> 5. Vendor, Chris with Advanced Mechanic came to center to determine the problem and find the issue to be the "out mixing valve", temperature could not be adjusted and a new mixing valve was ordered to be delivered overnight. 6. In-servicing to the department heads, nursing department (RNs, LPNs, CNAs and shift 		



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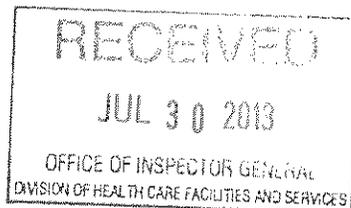
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 520	<p>Continued From page 82</p> <p>non-compliance related to hot water temperatures exceeding 110 degrees Fahrenheit (F) were reported to the QAA committee in order to ensure a corrective action plan was developed for resident safety from burns to skin and body tissues. The facility failed to report the hot water system when monitored hot water temperatures were above 110 degrees Fahrenheit in resident care areas for three (3) of four (4) resident units. This failure placed residents on these units in the facility at risk for potential injury to the body tissues or skin.</p> <p>(Refer to F323) The facility failed to ensure a safe environment as it related to maintaining safe water temperatures in resident care areas. The facility failed to ensure the facility's hot water system was maintained at a temperature to ensure water temperatures in resident care areas did not exceed regulatory requirements. The facility failed to identify the hot water temperatures exceeding 110 degrees (F) as a quality deficiency and failed to develop and implement an action plan to correct the quality deficiency, including monitoring the effect of implemented changes and making needed revisions to the action plan. This failure placed residents on three (3) of four (4) units at risk for potential injuries to the skin or body tissues.</p> <p>The facility's failure to have an effective Quality Assessment and Assurance Program that identified deficiencies and developed action plans and/or revised action plans based on the Quality Assurance review and failure to implement policy and procedures placed residents at risk in a situation that was likely to cause serious injury, harm, impairment or death. The immediate</p>	F 520	<p>supervisors), therapy department and any support staff (business office, supply clerk and medical records) that are involved in the manager on duty program and daily monitoring of temperatures until a new full-time maintenance director can be found was completed by the Dietician, Jessica Sullivan and Director of Clinical Education, Jeanne Viers. (The only staff doing hot water temperature checks is Curtis Dykes (Supply Clerk), Mark Bowman (assistant administrator), Jessica Sullivan (Dietician), Jeanne Viers (Director of Clinical Education), Cindi Simpson (Administrator), Cathy Tucker (3-11pm shift supervisor), Tanisha Stokes (11-7pm shift supervisor), Sherry Wallace (3-11pm supervisor), Robin Coder (11-7pm supervisor). The in-service of the hot water temperature plan included how to use the thermometers, how to calibrate the thermometer before each temperature is recorded and to contact administrator and</p>		



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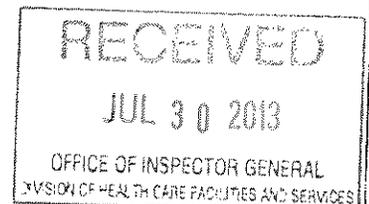
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F 520	<p>Continued From page 83</p> <p>Jeopardy was identified on 06/12/13 and found to exist on 06/11/13. The facility was notified of the Immediate Jeopardy on 06/12/13.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 06/14/13 and the State Agency validated the Immediate Jeopardy was removed on 06/15/13 as alleged, prior to exit on 06/15/13. The scope and severity was lowered to an E while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes and compliance status.</p> <p>The findings include:</p> <p>On 06/11/13 at 11:20 AM, water temperatures were observed in resident care areas, on the 400 Unit, ranging from 126 degrees (F) to 138 degrees (F). These water temperatures were verified by the Maintenance Director. He stated the temperatures were above the 100 degrees (F) to 110 degrees (F) regulatory limits.</p> <p>Review of the facility's water temperature log, dated 06/11/13 at 7:00 PM, revealed water temperatures in resident care areas on the 100 Unit and the 200 Unit ranged from 117 degrees (F) to 120 degrees (F).</p> <p>Review of the facility's water temperature logs, for resident care areas, revealed water temperatures were obtained on 02/17/13 and ranged from 125 degrees (F) to 133 degrees (F) on the 400 Unit. Review of the hot water temperature log completed on 03/17/13 revealed hot water</p>	F 520	<p>assistant administrator if temperatures above 110F,(who then will adjust temperature on the twin hot water tanks mixing valve that services 100, 200 and 300 units), to inform staff and residents (residents with dementia or lack understanding would be removed from room, water turned off or placed on one on one monitoring) that the sink or shower room could not be used and to post a sign above that sink or shower room that it is not to be used until temperature re-checks are done and determined to be at or below 110F, temperatures will be checked every four hours by one of the above in-serviced staff members. None of the above staff will be allowed to work after June 13, 2013 if they have not received the above in-service. 7. Temperature checks were began 6-11-13 at 7pm and continued every 4 hours throughout the night. Any temperatures recorded over 110 F, were immediately called to the administrator and assistant</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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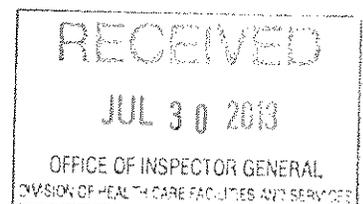
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 520	<p>Continued From page 84</p> <p>temperatures in resident care areas ranged from 117 degrees (F) to 133 degrees (F) on the 100, 200 and 400 Units.</p> <p>The facility was unable to provide any evidence that the hot water temperatures above 110 degrees (F) were reviewed by the QAA Committee and a corrective action plan developed to address the non-compliance with regulatory limits on hot water in resident care areas. Interview with the Director of Nursing, on 06/12/13, revealed she attended the facility's QAA Committee meetings and the non-compliance with regulated hot water temperatures in resident care areas were not reported to the committee nor was an action plan developed to ensure hot water temperatures did not place residents at risk for potential injuries from burns to the skin or body tissues. She stated all department heads, including the Maintenance Director attended the QAA Committee meetings. Interview with the Administrator, on 06/12/13, revealed the hot water temperatures, in resident care areas, placed residents at risk for injury.</p> <p>Review of the AOC revealed the facility implemented the following measures 06/12/13 - 06/15/13. The immediate actions taken were:</p> <ol style="list-style-type: none"> 1. The water on the 400 Unit was turned off on 06/11/13 and the mixing valve on the 400 Unit was replaced (the unit remains closed) on 06/12/13. 2. The five (5) residents on the 400 Unit were relocated to the 300 Unit on 06/11/13. 3. On 06/11/13 selected management staff was 	F 520	<p>administrator. Temperatures were adjusted on the twin hot water tanks mixing valve that services 100, 200 and 300 units, some time was allowed to pass and temperatures were rechecked for 110F compliance. During this time the staff and resident of that room was notified to not use the sink/shower room. Once recheck was completed and 110 F compliance was met, resident and staff were notified they could use the sink/shower rooms.</p> <p>8. Maintenance Director suspended pending termination.</p> <p>9. Administrator reviewed all hot water temperatures logged to verify that this plan continues to be followed, some temperatures still above 110F, but plan followed to ensure residents safety.</p> <p>10. There have been no changes to our hot water temperature test policy and this was reviewed by administrator. Please see attached policy.</p> <p>1. June 12, 2013 continued to do random hot water temperatures every 4 hours throughout the</p>		



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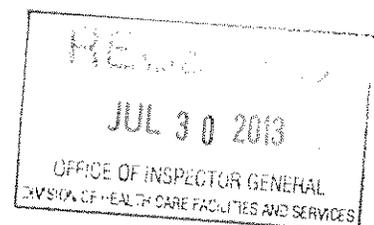
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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F 520	<p>Continued From page 86</p> <p>in-serviced, regarding taking water temperatures on a daily basis in resident care areas until a new Maintenance Director could be hired.</p> <p>4. On 06/11/13 an In-service included how to take water temperatures; how to contact the Administrator and Assistant Administrator if water temperatures exceed 110 degrees (F); how to adjust the temperature on the hot water tank; how to provide one (1) to one (1) monitoring if the water temperatures were elevated and the residents in the room were confused; how to post a sign stating the water temperatures are too high in that room and the sink and shower are not to be used; how to recheck water temperatures after the hot water tank has been adjusted; temperatures would be monitored every four (4) hours until repairs are completed on the tanks providing hot water to the 100, 200, and 300 Units and for forty-eight (48) hours after the repairs are completed; and no staff would be allowed to work until they attended this In-service.</p> <p>5. The Maintenance Director was suspended pending termination on 06/11/13.</p> <p>6. The Administrator would monitor all water temperature logs to ensure resident safety on 06/11/13.</p> <p>7. The parts were ordered to repair the hot water tanks for 100, 200 and 300 Units on 06/12/13.</p> <p>8. Water temperatures were monitored and the water heaters for the 100, 200 and 300 Unit were adjusted when needed on 06/11/13.</p> <p>9. A QAPI meeting was held with the Medical</p>	F 520	<p>center. Adjustments made to twin hot water tanks mixing valve as needed. Staff and residents notified to discontinue the use of sink/shower room until notified water temperatures were at or under 110 F. Signs placed above the sink/shower rooms as a reminder.</p> <p>2. Advanced mechanic put new mixing valve on 400 unit hot water tank, monitored water temperatures until 110 F compliance was met. The center continued to monitor the 400 unit water temperatures.</p> <p>3. Advanced Mechanic also examined the 2 twin hot water tanks that service 100, 200 and 300 unit and determined the mixing valve was not adequate size to temper the water sufficiently and a larger mixing valve was ordered to be delivered as soon as possible, tentatively delivery and installations June 17, 2012.</p> <p>4. Water temperatures continued to be checked every 4 hours throughout the night, with notification to administrator and</p>		



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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
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F 520	<p>Continued From page 86 Director on 06/13/13.</p> <p>10. On 06/13/13 grievance records were reviewed back to March 23, 2013 and there were no grievances related to hot water.</p> <p>11. Nursing staff was in-serviced on the treatment of hot water injuries which included notification of the Administrator, and staff will not be allowed to work until they have attended the in-service on 06/13/13.</p> <p>12. On 06/13/13 Incident and Accident reports were reviewed back to 01/01/13, and no injuries were noted.</p> <p>The State Agency validated the AOC on 06/15/13 prior to exit as follows:</p> <ul style="list-style-type: none"> * The hot water on the 400 Unit did not come on when the sink handle was turned on, on 06/11/13 at 12:15 PM. * Review of the water temperature logs for 06/11/13 and 06/12/13, revealed water temperatures were within the range of 100 degrees (F) to 110 degrees (F). Interview with the Administrator, on 6/13/13 at 10:00 AM, revealed she had knowledge of the water temperatures over the last several days. * On 06/12/13 review of the work orders for the vendor (Advanced), revealed the parts for the repair of the two (2) water heaters supplying the 100, 200 and 300 Units were ordered. * Review of the water temperature logs on 08/15/13 revealed the facility continued to monitor 	F 520	<p>assistant administrator and temperatures were adjusted to the twin hot water tanks mixing valve that services 100, 200 and 300 units. Time was allowed to pass and temperatures were rechecked for 110F compliance. During this time the staff and resident of that room was notified to not use the sink/shower room. Once recheck was completed and 110 F compliance was meet, resident and staff were notified they could use the sink/shower rooms.</p> <p>5. Called retired 20 year past maintenance director for his historical input on hot water tanks, he suggested the call to "Schardein Mechanical," a prior vendor who had worked in the center for many years for additional suggestions. Scheduled to come to center 6/13/13. No new suggestions.</p> <p>6. Administrator reviewed all hot water temperatures logged to verify that this plan continues to be followed, some temperatures still above 110F, but plan</p>	



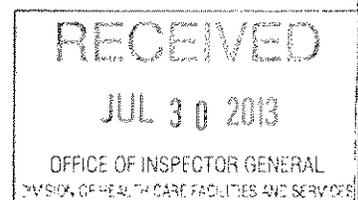
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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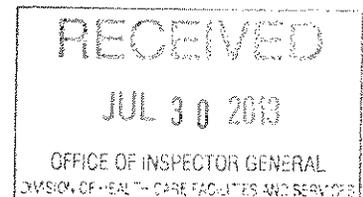
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F 520	<p>Continued From page 87</p> <p>the water temperatures every four (4) hours. Water temperatures obtained by the state agency, on 08/15/13 at 2:10 PM, revealed water temperatures within the 100 degrees (F) to 110 degrees (F) range.</p> <ul style="list-style-type: none"> * In-service records were reviewed for content and attendance and ninety-nine (99) of the one hundred forty-nine (149) employees were in-serviced and employees may not return to work until in-services are attended. * Follow-up water temperatures were obtained on the 400 Unit, on 08/15/13 at 2:10 PM, and were within 100 degrees (F) to 110 degrees (F) after repairs were completed. * Interview with the Administrator, on 06/12/13 at 8:30 AM, verified the Maintenance Director was terminated. * Review of the signature sheet revealed the Medical Director attended the QAPI meeting regarding the immediate jeopardy on 06/13/13. * Written statements were obtained from the Social Worker and the Director of Nursing, on 06/14/13, that grievances and incident reports were reviewed for complaints of hot water being too hot, none were noted, and injuries from hot water were not found. In addition, record review, on 06/14/13, revealed the facility completed skin checks on residents, on 06/13/13, and no resident injuries were found. * Six (6) Licensed Practical Nurses, six (6) Certified Nurse Aides, two (2) Housekeepers, one (1) Nursing Supervisor, one (1) Physical 	F 520	<p>followed to ensure residents safety.</p> <p>June 13, 2013</p> <ol style="list-style-type: none"> 1. Water temperatures continued to be checked every 4 hours throughout the night and start of new day with notification to administrator and assistant administrator and temperatures were adjusted on the twin hot water tanks mixing valve that services 100, 200 and 300 units, as needed some time was allowed to pass and temperatures were rechecked for 110F compliance. During this time the staff and resident of that room was notified to not use the sink/shower room. Once recheck was completed and 110 F compliance was meet, resident and staff were notified they could use the sink/shower rooms. 2. A QAPI meeting was held with Medical Director, Dr. Hilgeford and QAPI team consisting of Administrator, DON, assistant administrator, maintenance, unit managers, dietician, dietary manager, housekeeping manager and social 	



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F 520	Continued From page 88 Therapist and the Director of Nursing were interviewed, on 06/15/13, regarding in-services held on 06/11/13 and 06/13/13. Staff was able to verbalize understanding the potential danger of water that was too hot injuring residents, that they should report to the maintenance department and the supervisor when they feel the water is too hot, that residents are to be protected by moving away from the room where the water is too hot or turning the water off, or placing a sign in the room warning of hot water.	F 520	services to cover the immediate jeopardy abatement plan, cause of immediate jeopardy and resolution. 3. This hot water temperature plan will continue until the new mixing valve is placed on the twin tanks and temperatures are monitored for 48 hours afterward to determine if hot water temperatures are at or below 110F. 4. Grievances were reviewed back to March 23, 2013 by Jenny Potts, SSW, to look for any past grievances on hot water temperatures and none were found. 5. Accident and Incident reports were reviewed by the Director of Nursing back to January 1, 2013 for any possible identifiable injuries related to hot water temperatures, no injuries noted related to any type of hot water burns. 6. Nursing staff to include RNs, LPNs and CNAs were in-serviced starting June 13, 2013 on what to do with a suspected hot water burn, to include		



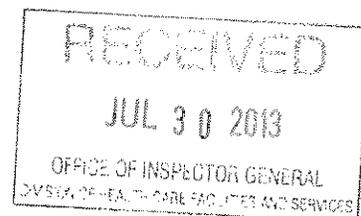
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immediate treatment, nurse notification, physician and administrator or Director of Nursing notification and to turn off water at sink. In-servicing completed by Jeanne Viers, Director of Education. Any staff not working before end of day June 13, 2013 will not be allowed to work until in-service completed.

7. The number of staff who received the in-service on hot water temperature plan and what to do with a hot water burn is 99/149 employees, all others have not worked yet because of scheduled, on vacation, leave or PRN.

8. Alleged date of abatement of immediate jeopardy is 6/14/13.

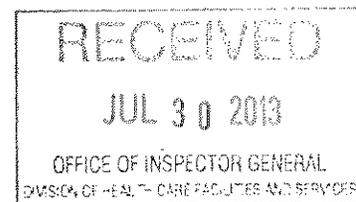
On June 13, 2013 at approximately 3:30 pm the administrator (Cindi Simpson) of the center became aware that the automatic fire alarm system had been put on "test mode" at 9am that morning while the Simplex-Grinnell technician (referred to SG-technician) had been



F520

replacing sprinkler heads on one of the units in the center. The SG-technician had told the administrator in training, Mark Bowman, that he would be doing this, unfortunately this was not communicated to the administrator and Mark did not understand the terminology of "test mode" (meaning he was draining the sprinkler system and notifying the alarm monitoring company that work was being done, so they will not think something was wrong and contacting fire department) and so after the 4 hour time frame that the automatic fire system had been turned off, the center did not do a fire watch for the remaining down time of the system from 12:30pm to 3:30pm which could have potentially impacted the entire center and all residents.

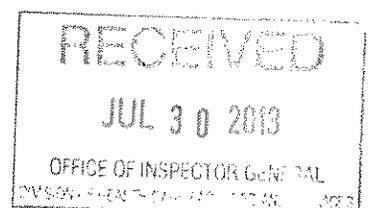
1. On June 13, 2013 at 3:30pm the administrator verified with the SG-technician at that the automatic fire alarm system was completely back on line and the center's residents were safe.



F520

2. On June 13, 2013 at 4:30pm the administrator in-serviced Mark Bowman on the importance of communicating to her when any maintenance vendors are in the center and what "test mode" meant and the requirement to do a watch fire after the system has been down over 4 hours from a planned event or in an emergency situation and is to continue until the automatic fire alarm system is completely back on line.

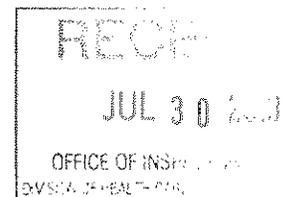
3. On June 13, 2013 at 7:30pm the administrator in-serviced the Department Heads to include the DON, ADON, Unit Managers, Business Office Manager, Activities Director, Social Services Director, Dietary Director, Housekeeping Director, MDS Director, Dietician, Admissions Director, Therapy Directors, Director of Clinical Education, Discharge Director, 7-3/3-11/11-7 shift supervisors, along with support staff to include the supply clerk, medical records, payroll clerk, this is 17% of our staff and on the



F520

requirement to do a fire watch any time the automatic fire alarm system is down and notification to the administrator if they are made aware the system is or may be down and how to do a fire watch and each given copy of the fire watch policy specifically covering H-M. See attached policy. We will continue to in-service nursing to include RNs, LPNs, CNAs, dietary, housekeeping/laundry and therapy staff, we have completed 35% of this staff and those not in-serviced will not be able to work until they receive the in-service.

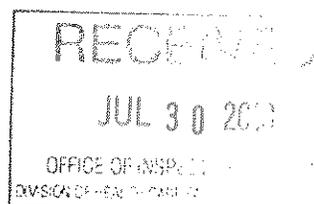
4. Because Hillcreek always has a shift supervisor 7 days a week and our manager on duty department head on weekends as additional support, one of these staff members would be the one to initiate and direct a fire watch upon either an emergency situation or planned situation. This provides for there to always be someone to take charge of any emergency situation.



FS20

5. Administrator and SG-technician meet June 14, 2013 at 8am and since he was continuing his sprinkler head replacement work, the automatic fire alarm system would be down starting at 8:15am and he would inform me when work completed and system completely back on line.

6. June 14, 2013 at 12:15pm, the center began a fire watch. The 100 (Dana Waters) 200 (Regina Mudd), 300 (Jennifer Moran and Ashley Stover) resident's units were covered by the unit managers and were checked in 15 minute increments. The 400 unit resident area which includes therapy and laundry was covered by the DON (Donna Fountain) and also checked in 15 minute increments. The administrator covered the dining rooms, offices, resident's smoking areas, activity area, maintenance areas and kitchen in 15 minute increments. All staff were notified we were in a fire watch. During the 15 minute increments the above assigned staff were monitoring for signs of



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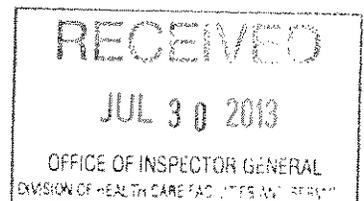
fire and smoke and to call 911 to report if any fire or smoke found and to pull the fire alarm manually.

7. On June 14, 2013 at 3:30 the SG-technician notified administrator that the fire alarm system was completely back on line and the fire watch was terminated with successful completion and all resident's were kept safe.

8. There was no change made to fire watch policy after administrator review.

9. On June 14, 2013 at 4:45 pm the center was notified of the immediate jeopardy due to incident on June 13, 2013, mentioned above in number 1, therefore the purpose of this allegation of compliance.

10. On June 14, 2013 at 6:30pm a QAPI meeting was held and in attendance was the DON, AIT, Unit managers, Dieticians, Dietary manger, social services, admissions, activities, MDS Director, supply clerk, medical records, business office manager, director of clinical education,



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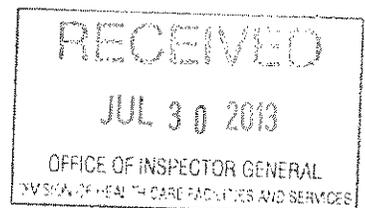
discharge director, to review immediate jeopardy notification and the abatement of the jeopardy notification. Also reviewed was a past incident on 4/30/13 when center had been notified of issue with automatic fire alarm system and had began and completed a successful documented fire watch from 1pm to 4pm and obviously knew what to do when information of potential fire risk were communicated.

11. On June 14, 2013 at 7pm, Medical Director, Dr. Hilgeford, spoken to by phone by administrator to review QAPI and although previously had discussed incident of June 13, 2013, he was made aware of the immediate jeopardy, the fire watch completed earlier in the day successfully and this allegation of compliance.

12. Date of Compliance June 15, 2013

AFTER ABATMENT

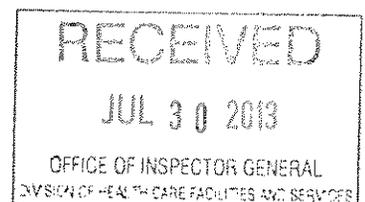
1. The five residents effected by the hot water temperatures 35, 36, 37, 38 and 39 were moved



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from 400 unit to 300 unit. All had skin checks completed with no signs of any type of blisters or burns. There were no identified residents involved in the lack of fire watch policy. The QAPI meetings held 6/21/13, 6/25/13, 7/1/13 and 7/8/13 reviewed water temperatures and fire watch logs and discussed any issues or problems that had arose and a plan to correct. **The Administrator and DON were in-serviced on 7/26/13 by Area Vice President of Operations for Goldenliving on the responsibility to monitor the day to day functions of the center to ensure compliance and effective use of resources. See attached.**

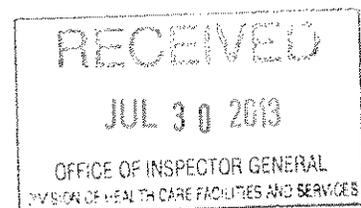
2. All residents at potential risk of being affected if water temperatures exceed the 110 degree and or the fire watch policy is not followed. The QAPI committee failed to monitor maintenance preventative program and staff required fire and safety education, mostly due to administrator and DON



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turnover. The administrator during survey had been in the center only 31 days and had not yet had time to review all areas of the center. The QAPI meetings held 6/21/13, 6/25/13, 7/1/13 and 7/8/13 reviewed water temperatures and fire watch logs and discussed any issues or problems that had arose and a plan to correct.

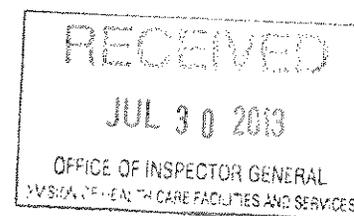
3. The mixing valve on the twin hot water tanks was replaced on 6/18/13. On 300 unit 3 hot and cold check valves were placed to help regulate water temperatures to rooms 332, 334 and 336. We continued to check water temperatures every 4 hours up to 6/25/13 when a QAPI meeting was held to review temperatures and it was determined the temperatures had remained between the 100-110 degrees. Water temperatures checks were changed to every 6 hours starting 6/25. On 7/1/13 a QAPI meeting was held and water temperatures reviewed and the decision was made that the maintenance department would take over the



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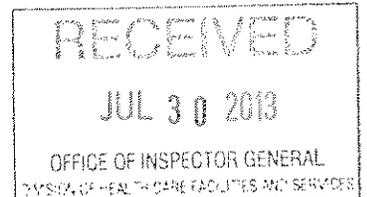
water checks Monday through Friday and the weekend manager on duty would check Saturdays and Sundays. All water temperature checks would be reviewed by administrator, Monday through Friday when daily copy of temperatures turned in by maintenance staff and on Mondays will review copy of Saturday/Sunday water temperature log. Re-in-service maintenance assistant and manager on duty staff to the importance of reporting all temperatures above 110.

to administrator and or DON immediately on 7/8/13. Any of the employees who had not received the in-services on the hot water temperature plan, what to do with a resident with a hot water burn or fire watch policy were in-serviced by the director of clinical education before they were or are able to work, this to include new employees will be completed by 7/24/13. See competency test for all staff. Sprinkler head replacement and repair work continued on the



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following dates; 6/17/13, 6/18/13, 6/19/13, 6/20/13, 6/21/13, 7/1/13 and 7/2/13 with the center initiating a fire watch once the fire protection system had been down for 4 hours with no issues notes. For each of the fire watches listed above there is documented fire watch logs dated and signed by the staff assigned. Administrator is made aware of any and all maintenance vendors in center to work, examples to include Sprinkler repair/checks, electrical repairs, lift repairs, elevator repair, ac/heat repairs, alarm company repair/checks, in center at all times, by the front office staff and or maintenance staff or AIT. No new maintenance director hired at this time. All employees not receiving the fire watch policy in-service were in-serviced by the director of clinical education before they were or are able to work, this to include new employees and to be completed by 7/24/13. Administrator and Director of Nursing re-signed their job descriptions on



F520

7/21/2013 and sent to corporate office as to their responsibilities of the day to day function of the center and to ensure compliance and safety of residents. The hot water temperature plan will be put into place anytime water temperatures are above 110 F and a fire watch will be implemented when emergency fire alarm systems are impaired, failure by any staff to do so will result in disciplinary actions up to termination. The medical director has reviewed and given suggestions in the plan of correction and a QAPI meeting will be held 7/24/13 for final discussions with medical director on compliance. **The Area Director of Operations and or the Area Director of Clinical Services for Goldenliving will monitor the plan of correction for compliance every two weeks for three months and once a month for next 3 months.**

4. All maintenance water temperature checks will be reviewed by administrator

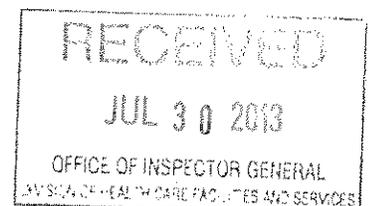
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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

F520

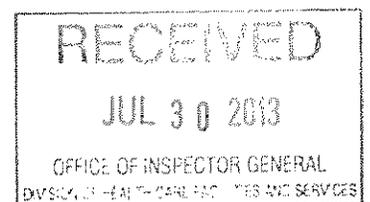
Monday through Friday and on Mondays will review copy of Saturday/Sunday water temperature log. Also, any emergency calls will be addressed immediately by Administrator. Administrator will review monthly maintenance work invoices that might have had the need for a fire watch, such as any needed or emergency shut down of fire alarm system to make sure fire watch policy and procedures were followed for 6 months. The Administrator will report to QAPI team water temperature reviews and fire watch monitoring to stay in compliance with plan of correction. The QAPI team will continue to monitor hot water temperatures and fire watch compliance by review of Administrator's report, grievance summary log and resident council minutes monthly for 6 months. Any concerns or issues will be addressed immediately and a



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plan put into place to protect the resident's safety. It is ultimately the administrator's job to validate that all parts of the POC are implemented and compliance is achieved and continues.

5. Date of compliance 7/27/13



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

PRINTED: 09/06/2013
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 08/21/2013
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)	(X6) COMPLETION DATE	
{F 000}	INITIAL COMMENTS An on-site revisit survey was conducted 08/20 -21/13 and found cited deficiencies corrected for the health survey. Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 07/27/13 as alleged.	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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

PRINTED: 06/28/2013
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GOLDEN LIVING CENTER HILLCREEK B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2013
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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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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 standard Life Safety Code survey was initiated on 06/11/13 and concluded on 06/12/13. Golden Living - Hillcreek was found not in compliance with the Requirements for Participation in Medicare and Medicaid. An extended survey was initiated on 06/13/13 and concluded on 06/15/13.</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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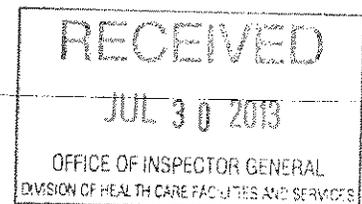
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Cinda [Signature]* TITLE: ADMINISTRATOR (X6) DATE: 7/29/13

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	<p>Continued From page 1</p> <p>Deficiencies were cited with the highest deficiency identified as Immediate Jeopardy at a S/S of an L..</p> <p>On 06/13/13 at 8:15 AM, the sprinkler contractor began contract work to replace sprinkler heads in various locations throughout the facility. The contractor informed the Administrator-in-Training that he would be putting the system in the test mode, shutting down the sprinkler system at 8:30 AM to do the remedial work. The Administrator-in-Training failed to inform the Administrator of the sprinkler system being shut down and the need to begin the fire watch. Subsequently a fire was discovered at 2:20 PM in an ashtray in the resident smoking area. The automatic sprinkler system had been shut down from 8:30 AM until 3:52 PM, approximately 7.5 hours. The facility identified the sprinkler shutdown at 2:20 PM at the time of the fire.</p> <p>The facility failed to alert staff of the facility's vulnerability during the test mode of the sprinkler system and failed to ensure a fire watch was initiated during this time which placed the residents at risk and caused or was likely to cause the residents serious injury, harm, impairment or death. Immediate Jeopardy was identified on 06/14/13 and determined to exist on 06/13/13. The facility was notified of the Immediate Jeopardy on 06/14/13.</p> <p>An acceptable Allegation of Compliance was received on 06/15/13 and the State Agency validated the Immediate Jeopardy was removed on 06/15/13 as alleged prior to exit on 06/15/13. The scope and severity was lowered to an F while</p>	K 000			



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

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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K 000	Continued From page 2	K 000	K018	
K 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors would close and latch, to prevent the passage of smoke in the event of an emergency in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eleven (11) smoke compartments, approximately</p>	K 018	<p>1. Resident room doors 205 and 236 were repaired to close on 7/11/13, room door 236 continues to not close properly and will be repaired or replaced by Schaefer General Contracting Services.</p> <p>2. An audit was completed on 7/10/13 on all other resident's room doors and those that can be repaired by facility maintenance has been done so, but some that cannot be repaired are part of the corporate work project with Schaefer General Contracting Services. See new attached contract.</p> <p>3. Maintenance will do once a month checks on all resident's room doors to make sure they latch, this is part of preventative maintenance (PM) program, see attached PM #10. Administrator will do random checks of 30 doors to monitor for compliance for 6 months.</p> <p>4. QAPI team will meet monthly for 6 months to review results of</p>	

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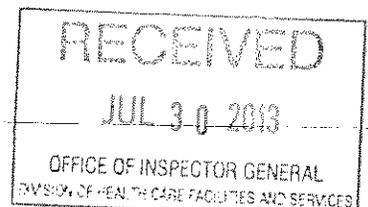
JUL 30 2013

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES

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

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 018	<p>Continued From page 3</p> <p>forty (40) residents, staff and visitors. The facility had one-hundred and seventy-two (172) certified beds; and, the census was one-hundred and forty-three (143) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 06/11/13 between 1:25 PM and 1:40 PM, with the Maintenance Director revealed the doors to resident rooms 205 and 236 did not latch when tested. Corridor doors are required to latch when closed and be smoke tight.</p> <p>Interview, on 06/11/13 at 1:25 PM, with the Maintenance Director revealed he was unaware of the doors not latching and acknowledged they would not resist the passage of smoke in the event of an emergency.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and</p>	K 018	<p>PM door checks/administrator checks to make sure all resident's doors latch completely for resident's safety.</p> <p>5. Date of compliance: July 27, 2013</p>		



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

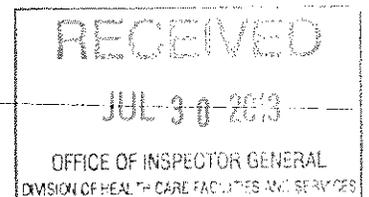
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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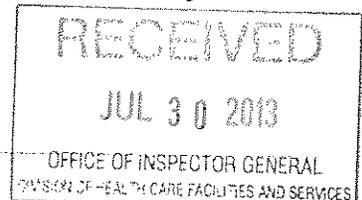
K 018	Continued From page 4 similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least	K 027		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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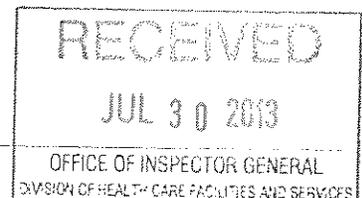
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	<p>Continued From page 5</p> <p>1 ¾-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 NFPA standards. The deficiency had the potential to affect two (2) of seven (11) smoke compartments, approximately forty (40) residents, staff and visitors. The facility had one-hundred and seventy-two (172) certified beds and the census was one-hundred and forty-three (143) on the day of the survey.</p> <p>The findings include:</p> <p>1. Observation, on 06/11/13 at 10:40 AM, with the Maintenance Director revealed the cross-corridor doors located in the Ground Floor vending area would not completely close when tested, leaving a gap of approximately three (3) inches between the pair of doors in the closed position. The pair of doors could not close completely and resist the passage of smoke in the event of an emergency.</p>	K 027	<p>K027</p> <p>1. The cross corridor doors located on ground floor by vending area were repaired on 7/11/13 so they close completely. The cross-corridors doors on 300 were repaired on 7/11/13, but doors continue to not stay aligned and will be repaired by Schaefer General Contracting Services.</p> <p>2. An audit was completed for all cross-corridor doors on 7/10/13 to check for complete closure and no gaps, those found and in need of repair are part of the corporate work project with Schaefer General Contracting Services. See new attached contract.</p> <p>3. Maintenance will do once a month checks of all cross corridor doors to make sure they close completely, administrator will witness this process. The cross corridor doors are also checked during monthly staff fire drill, see attached fire drill form #10 that is filled out during and after fire drill.</p>	



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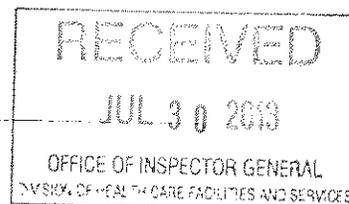
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GOLDEN LIVING CENTER HILLCREEK B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
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K 027	<p>Continued From page 6</p> <p>Interview, on 06/11/13 at 10:40 AM, with the Maintenance Director revealed he was not aware of the pair of doors not completely closing and not being capable of resisting the passage of smoke in the event of an emergency. Further interview with the Director of Maintenance revealed the magnetic hold open devices had malfunctioned when tested and were in need of repair or replacement.</p> <p>2 Observation, on 06/12/13 at 9:45 AM, with the Administrator-in-Training revealed the cross-corridors doors located on the 300 Wing closed completely when tested but were out of alignment and had a gap at the bottom of the doors greater than one-half of an inch.</p> <p>Interview, on 06/12/13 at 9:45 AM, with the Administrator-in-Training revealed he was not aware of the gap between the pair of doors in the closed position and acknowledged the gap was large enough not to contain smoke within the smoke compartment in the event of an emergency.</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 operallon 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</p>	K 027	<p>4. QAPI team will meet monthly for 6 months to review once a month door checks results, frill drill form results to make sure center's cross-corridors doors are closing correctly for resident's safety.</p> <p>5. Date of compliancc 7/27/13</p>		



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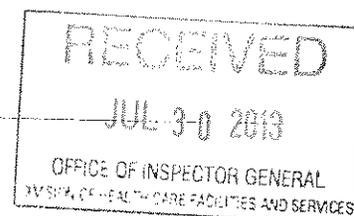
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K 027	Continued From page 7 the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18 mm) for wood doors.	K 027	K029	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eleven (11) smoke compartments, approximately forty (40) residents, staff and visitors. The facility had one-hundred and seventy-two (172) certified beds, and the census was one-hundred and forty-three (143) on the day of the survey. The findings include: Observation, on 06/12/13 at 9:40 AM, with the Administrator-In-Training revealed the door to the	K 029	1. The door 300 hall next to nurses' station had a self closure device installed. 2. An audit of all doors to hazardous areas was completed to make sure there were self closure devices. Any found to not have, had one placed. 3. Maintenance will do a once a month check on all doors to hazardous areas to make sure self closure device is working, administrator will observe. 4. QAPI team will meet monthly for 3 months to review results of self closure device checks for compliance. 5. Date of compliance:7/25/13	



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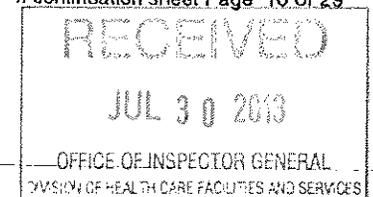
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K 029	<p>Continued From page 8</p> <p>Storage Room located next to the Nurses' Station on the 300 Hall, did not have a self-closing device installed on the door. Interview at that time, revealed the room was used for the storage of the Med Carts and supplies.</p> <p>Interview, on 06/12/13 at 9:40 AM, with the Administrator-in-Training revealed he was not aware of the stored items being categorized as a hazardous storage area and the requirement for the door to be equipped with a self-closing device.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms 	K 029			



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K 029	Continued From page 9 (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029	K038	
K 038 SS=D	Exit access is arranged so that exits are readily accessible at all times in accordance with section 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 the exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eleven (11) smoke compartments, approximately twenty (20) residents, staff, and visitors. The facility had one-hundred seventy-two (172) certified beds and the census was one-hundred and forty-three (143) on the day of the survey.	K 038	1. The 400 exit door is to be repaired or replaced by the corporate capital project by Schaefer General Contracting Services, see attached. 2. An audit was completed on all other exit doors on 7/10/13 and any issues found were repaired by facility maintenance or will be repaired or replaced as part of the Schaefer General Contracting Services corporate contract project, see new attached contract. 3. Maintenance will do once a month checks on all exit doors to make sure they work correctly, administrator will observe the process. 4. QAPI team will meet monthly for 6 months to review exit door checks and that exit doors are working correctly for resident safety. 5. Date of compliance: 7/27/13	



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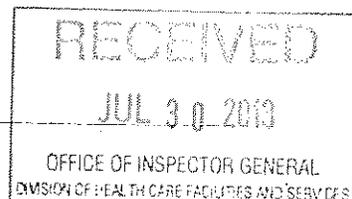
K 038	Continued From page 10	K 038		
	<p>The findings include:</p> <p>Observation, on 06/11/13 at 10:20 AM, with the Maintenance Director revealed the exit door from the Ground Level, 400 Wing opened when the fifteen (15) second delayed egress was checked. However, the bottom of the door drag on the threshold and the self-closing device on the door had been broken.</p> <p>Interview, on 06/11/13 at 10:20 AM, with the Maintenance Director revealed he was not aware of the exit door dragging on the threshold and the self-closing device being broken. He acknowledged the condition of the exit door would make it difficult to exit the facility in an expedient manner, during an emergency.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.</p> <p>7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required</p>			

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K 038	Continued From page 11 width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.	K 038		
K 066 SS=F	Reference: CMS S&C letter 5-38 NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is	K 066		



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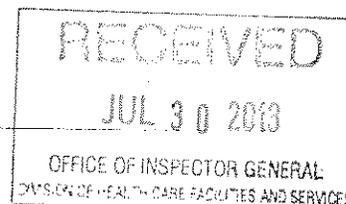
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K 066	Continued From page 12 permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the designated outdoor smoking area was properly equipped for safe smoking, in accordance with NFPA standards. The deficiency had the potential to affect each of the eleven (11) smoke compartments, residents, staff and visitors. The facility had one-hundred and seventy-two certified beds and the census was one-hundred and forty-three (143) on the day of the survey. The findings include: Observation, on 06/11/13 at 11:45 AM, with the Maintenance Director revealed the Lower Level exterior courtyard was used as an outdoor designated smoking area for residents. Further observation revealed the area did not have an approved metal container with a self-closing lid to empty the ash trays, a fire extinguisher, and a fire blanket present. Interview, on 06/11/13 at 11:45 AM, with the Maintenance Director revealed he was not aware of the requirements of the designated, outdoor smoking area to have an approved metal container with a self-closing lid to empty ash trays, a fire extinguisher and a fire blanket readily available for usage. There were two (2) table-top ashtrays available with a metal lid but no	K 066			

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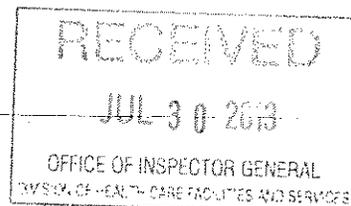
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K 066	Continued From page 13 container with a self-closing lid to empty the table-top ashtrays. Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily	K 066	K066 1. A fire blanket was installed on 7/1/13; a fire extinguisher was placed in the outdoor smoking area on 6/11/13. A self closing metal container to empty ash trays was ordered 7/10/13. 2. The other smoking area was checked on 7/10/13 and a self closing metal container to empty ash trays in was ordered 7/10/13. 3. Maintenance will monitor monthly that both smoking areas have the appropriate safety equipment and administrator will witness. 4. QAPI team will meet monthly for 6 months to review that center is in compliance with required safety equipment in smoking areas. 5. Date of compliance: 7/25/13		



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K 068	Continued From page 14 available to all areas where smoking is permitted.	K 068		
K 069 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the kitchen cooking appliances were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eleven (11) smoke compartments, residents, staff and visitors. The facility had one-hundred and seventy-two (172) certified beds and the census was one-hundred and forty-three (143) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/11/13 at 2:00 PM, with the Maintenance Director revealed the grease fryer was located directly next to the open flame burner of the stove. The stove did not have an eight (8) inch splash guard in place or was located more than sixteen (16) inches from the deep fryer.</p> <p>Interview, on 06/11/13 at 2:00 PM, with the Maintenance Director revealed he was unaware the grease fryer had to have a minimum of sixteen (16) inches clearance between the fryer and the stove unless an eight (8) inch splash guard was installed.</p>	K 069	<p>K069</p> <p>1. A 12 inch splash guard has been ordered, 7/17/13 and installed 7/20/13.</p> <p>2&3 Dietary staff in-serviced to the importance of the splash guard and to alert dietary manager or maintenance director if there are ever any problems with on 7/22/13 and 7/23/13. Maintenance and Dietary Manager will do once a month PM check of kitchen equipment. See attached.</p> <p>4. QAPI team with meet monthly for 6 months to review the PM check of kitchen equipment for safety concerns and compliance.</p> <p>5. Date of compliance: 7/25/13</p>	



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K 069	Continued From page 15 NFPA 96 (1998 Edition)	K 069			
K 147 SS=D	<p>9-1.2.3 All deep fat fryers shall be installed with at least 16-in. (406.4-mm) space between the fryer and surface flames from adjacent cooking equipment. Exception: Where a steel or tempered glass baffle plate is installed at a minimum 8 in. (203 mm) in height between the fryer and surface flames of the adjacent appliance.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards and failed to ensure the staff was knowledgeable of the requirements. The deficiency had the potential to affect two (2) of eleven (11) smoke compartments, approximately fifty (50) residents, staff, and visitors. The facility had one-hundred and seventy-two (172) certified beds and the census was one-hundred and forty-three (143) on the day of the survey.</p> <p>The findings include:</p> <p>1. Observation, on 06/11/13 at 2:05 PM, with the</p>	K 147			

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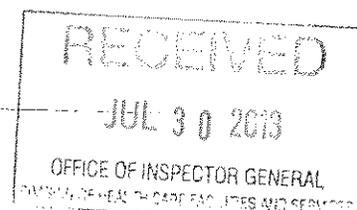
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GOLDEN LIVING CENTER HILLCREEK B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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K 147	Continued From page 16 Maintenance Director revealed a refrigerator and an unattended coffee pot were plugged into a power strip located in the Director of Nursing's Office. Interview, on 06/11/13 at 2:05 PM, with the Maintenance Director revealed he was aware of the requirements for the usage of power strips; however, he was not aware that a refrigerator and coffee pot were plugged into a power strip in the Director of Nursing's Office. 2. Observation, on 06/11/13 at 2:15 PM, with the Maintenance Director revealed a refrigerator and an extension cord were plugged into a power strip located in Resident Room 216. Interview, on 06/11/13 at 2:15 PM, with the Maintenance Director revealed he was aware of the requirement for the usage of power strips; however, he was not aware of a refrigerator and an extension cord being plugged into a power strip located in Resident Room 216. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	K147 1. The power strip in DON office was removed 6/17/13, the power strip in room 216 was removed on 6/17/13. 2. A completed facility audit was completed on 7/10/13 to check for power strips used for any items, but electronics, such as televisions or computers only. Any power strips found were removed. 3. During department head daily room rounds, see attached form used, rooms will be checked for power strips used for anything other than electronic equipment. Administrator will review room rounds daily to make sure no power strips used inappropriately. 4. QAPI team will meet monthly for 6 months to review the room rounds for compliance as to the use of power strips. 5 Date of compliance 7/27/13	
K 154 SS=L	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is	K 154		



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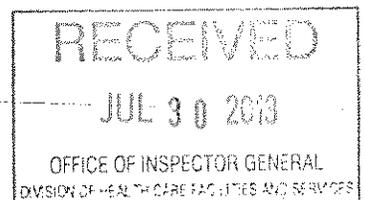
K 154	<p>Continued From page 17</p> <p>out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to follow their policy regarding Fire Protection System Impairments by initiating a fire watch after the automatic sprinkler system had been shutdown in accordance with NFPA standards. The deficiency had the potential to affect each of the eleven (11) smoke compartments, residents, staff, and visitors. The facility had one-hundred and seventy-two (172) certified beds and the census was one-hundred and forty-three (143) on the days of the survey.</p> <p>On 06/13/13 at 8:15 AM, the sprinkler contractor began contract work to replace sprinkler heads in various locations throughout the facility. The contractor informed the Administrator-in-Training that he would be putting the system in the test mode, shutting down the sprinkler system at 8:30 AM to do the remedial work. The Administrator-in-Training failed to inform the Administrator of the sprinkler system being shut down and the need to begin the fire watch. Subsequently a fire was discovered at 2:20 PM in</p>	K 154	<p>On June 13, 2013 at approximately 3:30 pm the administrator (Cindi Simpson) of the center became aware that the automatic fire alarm system had been put on "test mode" at 9am that morning while the Simplex-Grinnell technician (referred to SG-technician) had been replacing sprinkler heads on one of the units in the center. The SG-technician had told the administrator in training, Mark Bowman, that he would be doing this, unfortunately this was not communicated to the administrator and Mark did not understand the terminology of "test mode" (meaning he was draining the sprinkler system and notifying the alarm monitoring company that work was being done, so they will not think something was wrong and contacting fire department) and so after the 4 hour time frame that the automatic fire system had been turned off, the center did not do a fire watch for the remaining down time of the system from 12:30pm to 3:30pm which could have potentially impacted the entire center and all residents.</p> <p>1. On June 13, 2013 at 3:30pm the administrator verified with the SG-technician at that the automatic fire alarm system was completely back on line and the center's residents were safe.</p>	
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K 154	<p>Continued From page 18</p> <p>an ashtray in the resident smoking area. The automatic sprinkler system had been shut down from 8:30 AM until 3:52 PM, approximately 7.5 hours. The facility identified the sprinkler shutdown at 2:20 PM at the time of the fire.</p> <p>The facility failed to alert staff of the facility's vulnerability during the test mode of the sprinkler system and failed to ensure a fire watch was initiated during this time which placed the residents at risk and caused or was likely to cause the residents serious injury, harm, impairment or death. Immediate Jeopardy was identified on 06/14/13 and determined to exist on 06/13/13.</p> <p>An acceptable Allegation of Compliance was received on 06/15/13 and the State Agency validated the Immediate Jeopardy was removed on 06/15/13 as alleged prior to exit on 06/15/13. The scope and severity was lowered to an F while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Fire Protection System Impairments, not dated, revealed impairments can result from either planned or emergency shut down of these systems. A lack of prior planning in shut-down or impairment of these systems can result in serious consequences in the event of a fire. The facility will require strict compliance with the basic fire</p>	K 154	<p>2. On June 13, 2013 at 4:30pm the administrator in-serviced Mark Bowman on the importance of communicating to her when any maintenance vendors are in the center and what "test mode" meant and the requirement to do a watch fire after the system has been down over 4 hours from a planned event or in an emergency situation and is to continue until the automatic fire alarm system is completely back on line.</p> <p>3. On June 13, 2013 at 7:30pm the administrator in-serviced the Department Heads to include the DON, ADON, Unit Managers, Business Office Manager, Activities Director, Social Services Director, Dietary Director, Housekeeping Director, MDS Director, Dietician, Admissions Director, Therapy Directors, Director of Clinical Education, Discharge Director, 7-3/3-11/11-7 shift supervisors, along with support staff to include the supply clerk, medical records, payroll clerk, this is 17% of our staff and on the requirement to do a fire watch any time the automatic fire alarm system is down and notification to the administrator if they are made aware the system is or may be down and how to do a fire watch and each given copy of the fire watch policy specifically</p>		



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K 154 Continued From page 19
safety precautions outlined in the policy. The fire watch procedures outlined will be implemented immediately for all impairments, regardless of duration.

If the facility fire protection system will be shut down or is impaired for four (4) or more hours in a twenty-four (24) hour period all of the following procedures will be implemented. The facility will maintain a Fire Protection Impairment Kit at all times. The facility's Impairment Coordinator will contact the consultant prior to any impairment. Supervisors in the affected areas, the local fire department, the State Fire Marshal and the Fire Alarm Central Station Monitoring Company shall also be notified of the impairment. Telephone numbers for notification of local and state agencies are (no telephone numbers were listed). The Impairment Coordinator shall make sure that all materials needed to make the repair are ready at the job site before any valve or device is closed or fire protection system is disabled. The appropriate tags shall be attached to all affected areas. Any hot work will be discontinued. A fire watch will be conducted for all affected areas of the facility until the fire protection system is operational again. Fire watch rounds shall be conducted at a minimum of thirty (30) minute intervals for all affected areas of the building. Fire watches shall be provided continuously until the work is completed and the fire protection system is completely functional, including through coffee breaks and lunch breaks. Fire watch personnel shall receive training on recognition of fire hazards and use/location of appropriate portable fire extinguishers as well as the the procedure for alerting staff while the fire alarm system is out of service.

K 154 covering H-M. See attached policy.
We will continue to in-service nursing to include RNs, LPNs, CNAs, dietary, housekeeping/laundry and therapy staff, we have completed 35% of this staff and those not in-serviced will not be able to work until they receive the in-service.

4. Because Hillcreek always has a shift supervisor 7 days a week and our manager on duty department head on weekends as additional support, one of these staff members would be the one to initiate and direct a fire watch upon either an emergency situation or planned situation. This provides for there to always be someone to take charge of any emergency situation.

5. Administrator and SG-technician meet June 14, 2013 at 8am and since he was continuing his sprinkler head replacement work, the automatic fire alarm system would be down starting at 8:15am and he would inform me when work completed and system completely back on line.

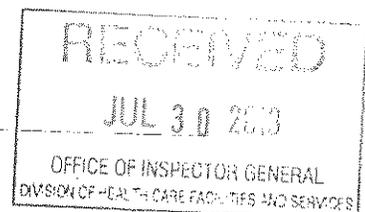
6. June 14, 2013 at 12:15pm, the center began a fire watch. The 100 (Dana Waters) 200 (Regina Mudd), 300 (Jennifer Moran and Ashley Stover) resident's units were covered by the unit managers and were checked in 15 minute increments. The 400 unit resident area which includes therapy and laundry was covered by the DON (Donna Fountain) and also checked in 15 minute increments. The

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K 154	Continued From page 20 Observation and review of the facility's Policies and Procedures, on 06/14/13 between 1:45 PM and 5:30 PM, with the Administrator and the Administrator-in-Training revealed the facility failed to implement a fire watch policy after the automatic sprinkler system had been shut down from 8:30 AM until 3:52 PM, approximately 7.5 hours. Interview, on 06/14/13 at 2:00 PM, with the Administrator revealed a sprinkler company had been contracted by the Corporate Office to replace sprinkler heads within various areas of the facility. The contractor arrived on site at 8:15 AM and discussed his scope of work with the Administrator-in Training. The Administrator-in Training was advised by the sprinkler contractor that both of the sprinkler risers would need to be in the test mode, meaning the sprinkler valves were turned in the off position and the alarm company monitoring the facility should have been notified the automatic dialers were turned off to do the contract work. The Administrator-in-Training failed to contact the Administrator about the sprinkler contractor being on site and that the system would be down for over a four (4) hour period of time. The system was shutdown at 8:30 AM, leaving the facility without the protection of an automatic sprinkler system. The fire watch policy had not been implemented after the shutdown. At approximately 2:20 PM, smoke was discovered coming out of an ashtray located in the indoor, designated smoking area. A Physical Therapist had discovered the fire and notified the Director of Nursing, who pulled the Fire Alarm and alerted the Receptionist to call 911 upon realizing the	K 154	administrator covered the dining rooms, offices, resident's smoking areas, activity area, maintenance areas and kitchen in 15 minute increments. All staff were notified we were in a fire watch. During the 15 minute increments the above assigned staff were monitoring for signs of fire and smoke and to call 911 to report if any fire or smoke found and to pull the fire alarm manually. 7. On June 14, 2013 at 3:30 the SG-technician notified administrator that the fire alarm system was completely back on line and the fire watch was terminated with successful completion and all resident's were kept safe. 8. There was no change made to fire watch policy after administrator review. 9. On June 14, 2013 at 4:45 pm the center was notified of the immediate jeopardy due to incident on June 13, 2013, mentioned above in number 1, therefore the purpose of this allegation of compliance. 10. On June 14, 2013 at 6:30pm a QAPI meeting was held and in attendance was the DON, AIT, Unit managers, Dieticians, Dietary manger, social services, admissions, activities,		



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K 154 Continued From page 21
automatic sprinkler system had been turned off. The Administrator-in-Training extinguished the smoldering ashes with a fire extinguisher. The residents were evacuated to the adjacent smoke compartment during the time of the emergency. The Fire Department arrived on site at 2:52 PM and gave the clear signal to reenter the smoke compartment at 3:11 PM.

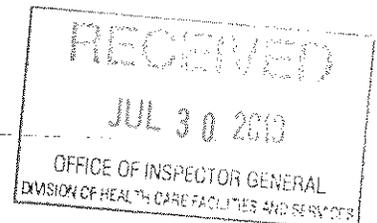
Interview with the Director of Nursing, on 06/14/13 at 4:10 PM, revealed she pulled the fire alarm and then went to the receptionist area to see the fire panel and the location of the fire and instructed the receptionist to announce, over the intercom, a Code Red in the smoking room. She stated she then returned to the smoking room to assist the Administrator. She stated she failed to hear the sirens within a few minutes so she returned to the reception area and instructed the receptionist to call 911. She indicated the Fire Department always responded quickly and the absence of the sirens caused her concern. She stated she was not aware that the fire alarm system was down; however, she felt something was wrong.

Interview, on 06/14/13 at 2:35 PM, with the Administrator-in-Training (AIT) revealed he had been informed of the system being put in the test mode by the sprinkler contractor at 8:30 AM after the contractor discussed what they would be doing. He stated he was told the sprinkler risers would need to be in the test mode. He was not aware of the implications of being in the test mode or the requirements for implementing the fire watch policy and did not notify the Administrator. He did not implement the fire watch policy when he was told the sprinkler

K 154 MDS Director, supply clerk, medical records, business office manager, director of clinical education, discharge director, to review immediate jeopardy notification and the abatement of the jeopardy notification. Also reviewed was a past incident on 4/30/13 when center had been notified of issue with automatic fire alarm system and had began and completed a successful documented fire watch from 1pm to 4pm and obviously knew what to do when information of potential fire risk were communicated.

11. On June 14, 2013 at 7pm, Medical Director, Dr. Hilgefurd, spoken to by phone by administrator to review QAPI and although previously had discussed incident of June 13, 2013, he was made aware of the immediate jeopardy, the fire watch completed earlier in the day successfully and this allegation of compliance.

12. Date of Compliance June 15, 2013
AFTER ABATEMENT
1&2 There have been no other fire watch issues since the annual extended survey.



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K 154 Continued From page 22
system would be shut down. At approximately 2:20 PM, the Physical Therapist found smoke coming out of an ashtray located in the designated smoking area. The Director of Nursing, pulled the Fire Alarm and the Receptionist called 911. The Administrator-in-Training stated he extinguished the fire with a fire extinguisher. The residents were moved to the other smoke compartment. The Fire Department arrived at 2:52 PM and gave the all clear to take the residents back to their rooms at 3:11 PM. The AIT expressed no knowledge of the policy and procedure for the Fire Watch; however, he was responsible for the fire drills and had conducted and documented the last fire drill during the second shift on 05/30/13 at 7:30 PM. Although the fire drill was conducted in a satisfactory manner, it did not include the fire watch procedure.

Interview, on 06/14/13 at 3:15 PM, with the sprinkler contractor revealed he had informed the Administrator-in-Training of his arriving at the facility to begin the contract work to replace sprinkler heads within the facility. He assumed the Administrator-in-Training was knowledgeable of the procedures when the sprinkler system was put in the test mode.

Interview via telephone, on 06/15/13 at 11:15 AM, with the Assistant Fire Chief responding to the 911 call, revealed the Fire Department received the call at 2:47 PM, arrived at the facility at 2:51 PM, he described the situation as a smoke scare, and gave the all-clear signal at 3:11 PM, and departed the facility at 3:11 PM. He voiced a concern about the fire watch policy not being implemented by the facility, as the facility was not

K 154 3. Sprinkler head replacement and repair work continued on the following dates; 6/17/13, 6/18/13, 6/19/13, 6/20/13, 6/21/13, 7/1/13 and 7/2/13 and 7/11/13 with the center initiating a fire watch once the fire protection system had been down for 4 hours with no issues notes. For each of the fire watches listed above there is documented fire watch logs dated and signed by the staff assigned. Administrator is made aware of any and all maintenance vendors, examples to include Sprinkler repair/checks, electrical repairs, lift repairs, elevator repair, ac/heat repairs, alarm company repair/checks, in center at all times, by the front office staff and or maintenance staff or AIT. No new maintenance director hired at this time. All employees not receiving the fire watch policy in-service were in-serviced by the director of clinical education before they were or are able to work, this to include new employees by 7/24/13.

4. QAPI team will review monthly maintenance work invoices that might have had the need for a fire watch, such as any needed or emergency shut down of fire alarm system to make sure fire watch policy and procedures were followed for 6 months. The AIT, ED, DON and the department heads of

center all have a solid understanding of the fire watch policy, when to initiate one and the role this plays in resident's safety.

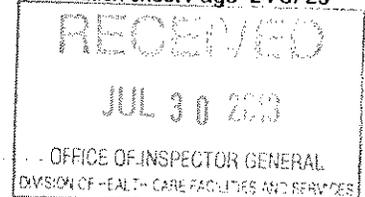
5. Date of compliance July 25, 2013.

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K 154	<p>Continued From page 23 protected by the coverage of an automatic sprinkler system and was concerned for the residents.</p> <p>Review of the AOC revealed the facility implemented the following measures: 06/13/12-06/15/13. These immediate actions taken were:</p> <ol style="list-style-type: none"> 1. On 06/13/13 at 3:30 PM, the Administrator verified with the S-G Technician that the automatic fire alarm system was completely back on line. 2. On 06/13/13 at 4:30 PM, the Administrator inserviced the AIT on the importance of communicating to her when any maintenance vendors were in the center; the meaning of "test mode"; the requirement to do a fire watch after the system has been down over four (4) hours from a planned event or in an emergency situation; and, to continue the fire watch until the automatic fire alarm system is completely back on line. 3. On 06/13/13 at 7:30 PM, the Administrator inserviced the Department Heads which included the DON, ADON, Unit Managers, Business Office Manager, Activities Director, Social Services Director, Dietary Director, Housekeeping Director, MDS Director, Dietician, Admissions Director, Therapy Directors, Director of Clinical Education, Discharge Director the 7-3, 3-11 and 11-7 shift supervisors, along with support staff to include the supply clerk, medical records, and the payroll clerk, (this represents 17% of the staff) on the 	K 154			



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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 01 - GOLDEN LIVING CENTER HILLCREEK B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 154	<p>Continued From page 24</p> <p>requirement to do a fire watch any time the automatic fire alarm system was down and notification to the Administrator if they were made aware the system was or may be down and how to do a fire watch and each were given a copy of the fire watch policy specifically covering H-M. The nursing staff will continue inservices to include RNs, LPNs, CNAs, dietary, housekeeping/laundry and therapy staff. thirty-five (35) % of the staff and those not inserviced will not be able to work until they receive the inservice.</p> <p>4. Because Hillcreek always has a shift supervisor 7 days a week and the manager on duty department head on weekends as additional support, one of these staff members would be the one to initiate and direct a fire watch upon either an emergency situation or planned situation. This provides for there to always be someone to take charge of any emergency situation.</p> <p>5. The Administrator and S-G Technician met 06/14/13 at 8:00 AM, and since he was continuing his sprinkler head replacement work, the automatic fire alarm system would be down starting at 8:15 AM and he would inform the Administrator when work was completed and the system completely back on line.</p> <p>6. On 06/14/13 at 12:15 PM, the facility began a fire watch. The 100, 200, 300 resident units were covered by the unit managers and were checked in 15 minute increments. The 400 unit resident area which includes therapy and laundry was covered by the DON and also checked every 15 minutes. The Administrator covered the dining</p>	K 154			

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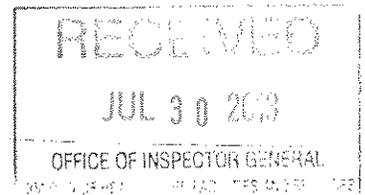
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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K 154	<p>Continued From page 25</p> <p>rooms, offices, resident's smoking areas, activity area, maintenance areas and kitchen in 15 minute intervals. All staff were notified they were in fire watch. During the 15 minute checks the above assigned staff were monitoring for signs of fire and smoke and to call 911 to report if any fire or smoke was found and to pull the fire alarm manually.</p> <p>7. On 06/14/13 at 3:30 PM the S-G Technician notified the Administrator that the fire alarm system was completely back on line and the fire watch was terminated.</p> <p>8. There was no change made to the fire watch policy after administrative review.</p> <p>9. On 06/14/13 at 4:45 PM, the facility was notified of the Immediate Jeopardy due to an incident on 06/13/13, mentioned above in number 1, therefore the purpose of this allegation is compliance.</p> <p>10. On 06/14/13 at 6:30 PM, a QAPI meeting was held to review the Immediate Jeopardy notification and the abatement of the jeopardy.</p> <p>11. On 06/14/13 at 7:00 PM, the Medical Director was notified on the Immediate Jeopardy and reviewed the QAPI meeting. The Medical Director was already aware of the incident, Immediate Jeopardy, and the fire watch.</p>	K 154		
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K 154	<p>Continued From page 26</p> <p>The state agency validated the AOC on 06/15/13 prior to exit as follows:</p> <ul style="list-style-type: none"> * Interview, on 06/14/13 at 2:10 PM, with the Simplex-Grinnell (S-G) Technician, the sprinkler contractor, confirmed the automatic Fire Alarm System was put back on line and the sprinkler system was fully functional at 3:30 PM. * Interview, on 06/14/13 at 2:00 PM, with the Administrator in Training confirmed the inservice meeting with the Administrator emphasizing the importance of communication, understanding the terminology of the automatic sprinkler system being put into the test mode, and implementing the facility's Fire Watch policy. * Interviews on 06/15/13 between 2:45 PM and 4:15 PM, with the facility department heads and the support staff were conducted to confirm the inservices meeting with the Administrator, emphasizing the importance of communication with the Administrator and procedures for implementing the facility's Fire Watch policy. The inserviced personnel was given a copy of the facility's policy. * As part of the interviewing process on 06/15/13 between 2:45 PM and 4:15 PM, shift supervisors voiced their understanding of the facility's Fire Watch policy and their responsibility to initiate and direct the Fire Watch. * Interview on 06/14/13 at 3:30 PM, with the S-G Technician confirmed the automatic sprinkler system would be turned back on and the system 	K 154		
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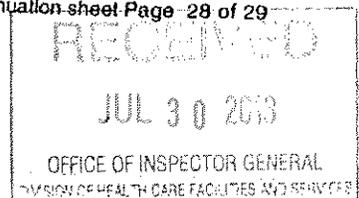
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K 154	<p>Continued From page 27 would be fully functional when he left the facility.</p> <ul style="list-style-type: none"> * On 06/14/13 the Administrator presented a completed copy of the Fire Watch policy in effect from 12:15 PM to 3:30 PM. The sprinkler system was shut down at 8:15 AM and the Fire Watch policy went into effect at 12:15 PM. The facility's personnel was assigned to watch all areas of the facility with supporting documentation. * On 06/14/13 at 3:30 PM, the S-G Technician confirmed he advised the Administrator, that the fire alarm was completely back on line and the facility was protected by the automatic sprinkler system. * A copy of the undated Golden Living Fire Watch policy was reviewed on 06/14/13 with no changes noted. * On 06/15/13 at 4:45 PM, a copy of the QAPI meeting summary and documented attendance was given to the State Agency. The meeting was held on 06/14/13 at 6:30 PM. * The QAPI meeting held on 06/14/13 at 6:30 PM had documented the Medical Director had been notified by phone of the Immediate Jeopardy. <p>Reference; NFPA 101 (2000 edition) 9.7.6* Sprinkler System Shutdown. 9.7.6.1 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour</p>	K 154		



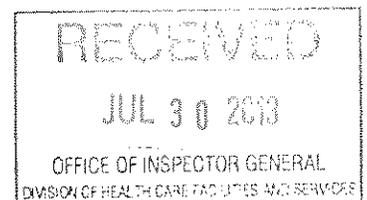
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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K 154	Continued From page 28 period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service.	K 154		



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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 revisit Life Safety Code survey was conducted on 08/21/13 for the standard survey completed on 06/15/13. Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 07/27/13 as alleged.</p>	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.