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

PRINTED: 06/18/2020 FORM APPROVED OMB NO 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) D/	ATE SURVEY OMPLETED	
		185095	B. WING			R	
	PROVIDER OR SUPPLIER	110	B. WING	STREET ADDRESS, CITY, STATE, 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		06/18/2020 CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMEN	тѕ	{F 00	00}			
	Plan of Correction	mentation of the acceptable (POC) received 06/17/2020, med to be in compliance on ged.					
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6		ER/SUPPLIER REPRESENTATIVE'S SIC				2.	

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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DEPARTMENT OF HEALTH AND HUMAN SERVICES  CENTERS FOR MEDICARE & MEDICAID SERVICES				PRINTED: 05/26/20	
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		185095	B. WING		25144/2222
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	05/14/2020 CODE
HILLCR	REEK REHAB AND CAI	<u> </u>		3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 000	INITIAL COMMENT	S	FO	00	
F 689 SS=D	KY#00031659 and a Infection Control Su 05/11/2020 and con Complaint KY#0003 with unrelated defici Scope and Severity the facility had imple Centers for Disease (CDC) recommende COVID-19. Total cer	zards/Supervision/Devices	F 68	Вγ:	CEIVE) JN 17 2020
	§483.25(d) Accident The facility must ens §483.25(d)(1) The re as free of accident h	s. Sure that - Sesident environment remains azards as is possible; and		noted during t	oxygen cylinder the survey from
	§483.25(d)(2)Each resupervision and assi	esident receives adequate stance devices to prevent		the room on 5 2. Central Supply	

This REQUIREMENT is not met as evidenced

Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible.

Observation on 05/11/2020 and 05/12/2020 revealed an unsecured portable Oxygen canister 2. Central Supply Technician conducted a facility wide observation audit on 6/1/2020 on 6/2/2020 to observe for any additional oxygen cylinders not properly stored. No issues were identified during the course of this observation audit.

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

TITLE

(X6) DATE

An descency 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.

accidents.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE .

PRINTED: 05/26/2020

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STATEMENT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MILLTIGLE CONSTRUCTION  (X2) MILLTIGLE CONSTRUCTION  (X3) MILLTIGLE CONSTRUCTION  (X4) PROVIDER/SUPPLIER/CLIA	000
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DENTIFICATION NUMBER: (X3) DATE SURV	EY
COMPLETE	,
185095 B. WING	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE	20
HILLCREEK REHAB AND CARE, LLC 3116 BRECKINRIDGE LANE	
LOUISVILLE KY 40220	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID PROVIDER'S PLAN OF CORREC	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY  (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE DATE DATE DATE DATE DATE DATE DATE DAT	ÉTION

F 689 Continued From page 1 in Resident #2's room.

The findings include:

Review of the facility's Policy, titled "Oxygen Tank Storage", dated 05/17/2016, revealed the facility must ensure that the resident environment remains as free of accident hazards as was possible. Continued review revealed all pressurized Oxygen canisters will be secured in a rack or fastened to a wheeled carrier. This includes full, partial full, empty canisters and canisters that are located in the Oxygen storage location or in use in a resident's room. Further review revealed Oxygen units will be stored in a room that is vented to the outside when not in use or in a secured storage area outside the facility. Additional review revealed the day shift charge nurse will be responsible for monitoring proper and safe storage of Oxygen canisters.

Record review revealed the facility admitted Resident #2 on 05/06/2020 with diagnoses including Pneumonia, Dyspnea, Acute Respiratory Failure, Chronic Systolic Heart Failure, and Chronic Obstructive Pulmonary Disease Exacerbation.

Review of Resident #2's Physician Orders revealed an order, dated 05/07/2020, for Oxygen to be administered at three (3) liters per nasal cannula every shift.

Observation during initial tour, on 05/11/2020 at 12:40 PM, revealed an E tank (portable type cylinder tank) of Oxygen sitting on the floor, unsecured in Resident #2's room. Continued observation revealed the Oxygen tank was sitting approximately two (2) foot from the wall in the line F 689

- 3. Facilty Department manager, consisting of Administrator, Director of Nursing, Assistant Director of Nursing, Nurse Managers, Dietary Director, and Plant Operations, conducted education with staff across departments (including any agency or contracted staff) on the policy for Accidents and Supervision as it relates to Oxygen Storage. This education was completed by 6/8/2020. The education has also been added to the orientation material for any new staff.
- 4. Facility Department managers, consisting of Administrator, **Director of Nursing, Assistant** Director of Nursing, Nurse Managers, Dietary Director, Central Supply Technician, and Plant Operations will conduct facility observation audits to ensure all oxygen cylinders are stored according to the policy to monitor ongoing compliance. These audits will be conducted three times weekly for 4 weeks,

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENT	ERS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROV
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	CMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
NAME OF	F PROVIDER OR SUPPLIER	185095	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	05/14/2020
HILLCREEK REHAB AND CARE, LLC				3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	I mae
; ;	of foot traffic. Furth Oxygen tank was not tubing connected. A 05/12/2020 at 11:39 oxygen canister sittin #2's room.  Interview with Reside 12:40 PM, revealed but did not know who been sitting in the flow Interview, on 05/11/2 Registered Nursing A was assigned to Resworked in the facility interview, she did not was in Resident #2's tanks should be secun wheelchair holder wheelchair holder when sure resident safet revealed the tanks should be secun wheelchair holder when sure resident safet revealed the tanks shunsecured on the floof further stated, if the tanks ard to the same constant with Register 05/12/2020 at 11:42 Peworked at the facility fand was the Unit Man 05/03/2020. Per interview in the same constant was the Unit Man 05/03/2020. Per interview of the same constant was the Unit Man 05/03/2020. Per interview of the same constant was the Unit Man 05/03/2020. Per interview of the same constant was the Unit Man 05/03/2020. Per interview with resident was the Unit Man 05/03/2020. Per interview of the same constant was the Unit Man 05/03/2020. Per interview of the same constant was the Unit Man 05/03/2020. Per interview with resident was the Unit Man 05/03/2020. Per interview with resident was the Unit Man 05/03/2020.	er observation revealed the obtain use, with no Oxygen additional observation, on AM, revealed an unsecureding on the floor in Resident ent #2, on 05/11/2020 at he/she had seen the tank, o had left it or how long it had or.  020 at 12:55 PM, with State assistance (SRNA) #1 who ident #2, revealed she had for three (3) years. Per know why the Oxygen tank room; however, Oxygen ared in a cart or on the en in a resident's room to y. Continued interview sould never be left sitting or of a resident's room. She ank fell, it could be	F 68	then weekly for 3 months. The Administrator will review the results of the audit and take those results to the Quality Assurance and Performance Improvement committee (which meets monthly and consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Social Services, Activities, Therapy, Dietary, and Plant Operations,) for recommendations.	0410910

the risk for accidents.

interview revealed Oxygen tanks were to be secured when in a resident care area to decrease

Interview with the Director of Nursing (DON), on 05/13/2020 at 11:00 AM, revealed she had

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/26/2020

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NAME OF	PROVIDER OR SUPPLIER		1			05/14/2020
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	interview, she expersional standards of practic Oxygen Storage. A should not be sitting combustibility. Furti Oxygen was stored of accident hazards Interview with the Ad 2:00 PM, revealed hit to be maintained relativither, it was important to the standard of the standar	cted the facility policy and e to be maintained related to dditionally, Oxygen tanks in the floor because of its ner, it was important to ensure correctly to decrease the risk and maintain resident safety.  Iministrator, on 05/14/2020 at a expected the facility policy ated to Oxygen Storage.  Itant for Oxygen to be stored or prevent accident hazards.	F 68			
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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY  3116 BRECKINRIDG LOUISVILLE, KY 40  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A Complaint Survey investigating Complaint KY#00031659 and a COVID-19 Focused Infection Control Survey was initiated on 05/11/2020 and concluded on 05/14/2020. Complaint KY#00031659 was unsubstantiated with unrelated deficiencies cited. It was determined the facility had implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 137.	Y, STATE, ZIP CODE	
HILLCREEK REHAB AND CARE, LLC  3116 BRECKINRIDG LOUISVILLE, KY 40  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  N 000 Initial Comments  N 000  A Complaint Survey investigating Complaint KY#00031659 and a COVID-19 Focused Infection Control Survey was initiated on 05/11/2020 and concluded on 05/14/2020. Complaint KY#00031659 was unsubstantiated with unrelated deficiencies cited. It was determined the facility had implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to propose for	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVE	DN (X DBE COMP
A Complaint Survey investigating Complaint KY#00031659 and a COVID-19 Focused Infection Control Survey was initiated on 05/11/2020 and concluded on 05/14/2020. Complaint KY#00031659 was unsubstantiated with unrelated deficiencies cited. It was determined the facility had implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to propose for	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVE	D BE COMP
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  N 000 Initial Comments  A Complaint Survey investigating Complaint KY#00031659 and a COVID-19 Focused Infection Control Survey was initiated on 05/11/2020 and concluded on 05/14/2020. Complaint KY#00031659 was unsubstantiated with unrelated deficiencies cited. It was determined the facility had implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to propose for	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVE	D BE COMP
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		405005	A. BUILDING	——————————————————————————————————————	MPLETED	
NAME OF	PROVIDER OR SUPPLIER	185095	B. WING	06	J74/2020	
	EEK REHAB AND CA	RE, LLC	3	TREET ADDRESS, CITY, STATE, ZIP COOS 116 BRECKINRIDGE LANE OUISVILLE, KY 40220	1/22/8	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING 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 689 SS=D	KY#00031659 and a Infection Control Su 05/11/2020 and con Complaint KY#0003 with unrelated deficing Scope and Severity the facility had impless (CDC) recommendes (CDC) recomm	zards/Supervision/Devices )(2) s. ure that - sident environment remains azards as is possible; and esident receives adequate stance devices to prevent  is not met as evidenced n, interview, record review, lity's policy, it was r failed to ensure the remained as free of	F 689	<ol> <li>The Director of Nursing removed the oxygen cylinder noted during the survey from the room on 5/12/2020.</li> <li>Central Supply Technician conducted a facility wide observation audit on 6/1/2020 on 6/2/2020 to observe for an additional oxygen cylinders no properly stored. No issues were identified during the course of this observation audit.</li> </ol>		
O re	bservation on 05/11/ evealed an unsecure	/2020 and 05/12/2020 d portable Oxygen canister				

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

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(X6) DATE

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAL

PRINTED: 05/26/2020

STATEL		& MEDICAID SERVICES		_	FORM APPROVE
AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	A CE COUSTRUCTION	MB NO. 0938-039 (X3) DATE SURVEY COMPLETED
NAME OF D	2014020 02	185095	B. WING		7.5
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	05/14/2020
HILLCREI	EK REHAB AND CAR	RE, LLC		3116 BRECKINRIDGE LANE	
(X4) ID	SHAMADY STAT			LOUISVILLE, KY 40220	
PREFIX TAG	LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X3)

F 689 Continued From page 1 in Resident #2's room.

F 689

The findings include:

Review of the facility's Policy, titled "Oxygen Tank Storage", dated 05/17/2016, revealed the facility must ensure that the resident environment remains as free of accident hazards as was possible. Continued review revealed all pressurized Oxygen canisters will be secured in a rack or fastened to a wheeled carrier. This includes full, partial full, empty canisters and canisters that are located in the Oxygen storage location or in use in a resident's room. Further review revealed Oxygen units will be stored in a room that is vented to the outside when not in use or in a secured storage area outside the facility. Additional review revealed the day shift charge nurse will be responsible for monitoring proper and safe storage of Oxygen canisters.

Record review revealed the facility admitted Resident #2 on 05/06/2020 with diagnoses including Pneumonia, Dyspnea, Acute Respiratory Failure, Chronic Systolic Heart Failure, and Chronic Obstructive Pulmonary Disease Exacerbation

Review of Resident #2's Physician Orders revealed an order, dated 05/07/2020, for Oxygen to be administered at three (3) liters per nasal cannula every shift.

Observation during initial tour, on 05/11/2020 at 12:40 PM, revealed an E tank (portable type cylinder tank) of Oxygen sitting on the floor, unsecured in Resident #2's room. Continued observation revealed the Oxygen tank was sitting approximately two (2) foot from the wall in the line

- 3. Facilty Department manager, consisting of Administrator, Director of Nursing, Assistant Director of Nursing, Nurse Managers, Dietary Director, and Plant Operations, conducted education with staff across departments (including any agency or contracted staff) on the policy for Accidents and Supervision as it relates to Oxygen Storage. This education was completed by 6/8/2020. The education has also been added to the orientation material for any new staff.
- 4. Facility Department managers, consisting of Administrator, Director of Nursing, Assistant Director of Nursing, Nurse Managers, Dietary Director, Central Supply Technician, and Plant Operations will conduct facility observation audits to ensure all oxygen cylinders are stored according to the policy to monitor ongoing compliance. These audits will be conducted three times weekly for 4 weeks,

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
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NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	05/14/2020
HILLCRE	EK REHAB AND CAR	RE, LLC		3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			
PREFIX TAG	CACH DEFICIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	11 D.DC (A2)

#### F 689 Continued From page 2

of foot traffic. Further observation revealed the Oxygen tank was not in use, with no Oxygen tubing connected. Additional observation, on 05/12/2020 at 11:39 AM, revealed an unsecured oxygen canister sitting on the floor in Resident #2's room.

Interview with Resident #2, on 05/11/2020 at 12:40 PM, revealed he/she had seen the tank, but did not know who had left it or how long it had been sitting in the floor.

Interview, on 05/11/2020 at 12:55 PM, with State Registered Nursing Assistance (SRNA) #1 who was assigned to Resident #2, revealed she had worked in the facility for three (3) years. Per interview, she did not know why the Oxygen tank was in Resident #2's room; however, Oxygen tanks should be secured in a cart or on the wheelchair holder when in a resident's room to ensure resident safety. Continued interview revealed the tanks should never be left sitting unsecured on the floor of a resident's room. She further stated, if the tank fell, it could be hazardous.

Interview with Registered Nurse (RN) #1, on 05/12/2020 at 11:42 PM, revealed she has worked at the facility for six (6) and a half years and was the Unit Manager for Resident #2 until 05/03/2020. Per interview, Oxygen tanks should not be sitting in the floor unsecured. Continued interview revealed Oxygen tanks were to be secured when in a resident care area to decrease the risk for accidents.

Interview with the Director of Nursing (DON), on 05/13/2020 at 11:00 AM, revealed she had worked at the facility for two (2) weeks. Per

F 689

then weekly for 3 months. The Administrator will review the results of the audit and take those results to the Quality Assurance and Performance Improvement committee (which meets monthly and consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Social Services, Activities, Therapy, Dietary, and Plant Operations,) for recommendations.

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEME	NT OF DEFICIENCIES	RE & MEDICAID SERVICES					FOR	D: 05/26/2 M APPROV
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO	LTIF	PLE CONSTRUCTION G		(X3) DA	O. 0938-0 TE SURVEY
NAME OF	PROVIDER OR SUPPLIE	185095	B. WING					7,4
	EEK REHAB AND C			;	STREET ADDRESS, CITY, STATE, ZIP COO 3116 BRECKINRIDGE LANE	E	05	14/2020
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	interview, she exp standards of pract Oxygen Storage. should not be sittir combustibility. Fur Oxygen was stored of accident hazard Interview with the A 2:00 PM, revealed to be maintained re Further, it was important of the storage	ected the facility policy and ice to be maintained related to Additionally, Oxygen tanks ag in the floor because of its other, it was important to ensure discorrectly to decrease the risk and maintain resident safety. Administrator, on 05/14/2020 at the expected the facility policy plated to Oxygen to be stored to prevent accident because	F 68	89				
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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		(X3) DATE SURVEY COMPLETED
NAME OF	PROVIDER OR SUPPLIER	185095	B. WING		05144/000
	EEK REHAB AND CA			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE	05/14/2020
(X4) ID				LOUISVILLE, KY 40220	
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E 000	Initial Comments		E 0	00	
	concluded on 05/12	sed Emergency Preparedness d on 05/11/2020 and 1/2020. It was determined erns with 42 CFR §483.73 p)(6).			
				JUN - 3 2020	)
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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

TITLE

PRINTED: 06/18/2020 FORM APPROVED

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_\_ R B. WING 100212 06/18/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE HILLCREEK REHAB AND CARE, LLC LOUISVILLE, KY 40220 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE TAG DEFICIENCY) {N 000} Initial Comments {N 000} Based upon implementation of the acceptable Plan of Correction (POC) received 06/17/2020, the facility was deemed to be in compliance on 06/09/2020, as alleged.

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

TITLE

(X6) DATE