| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185095 | A. BUILDING _____ B. WING _____ | R 06/18/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **HILLCREEK REHAB AND CARE, LLC** | **3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 000} | INITIAL COMMENTS<br><br>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. | {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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185095 | A. BUILDING _____ B. WING _____ | 05/14/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HILLCREEK REHAB AND CARE, LLC | 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>An Abbreviated 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 at the highest Scope and Severity of a "D". 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. | F 000 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>Observation on 05/11/2020 and 05/12/2020 revealed an unsecured portable Oxygen canister | F 689 | 1. The Director of Nursing removed the oxygen cylinder noted during the survey from the room on 5/12/2020.<br>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. | 06/19/20 |

RECEIVED
JUN 17 2020
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Interim NHA — (X6) DATE: 06/17/20

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185095 | A. BUILDING _____ B. WING _____ | 05/14/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HILLCREEK REHAB AND CARE, LLC | 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 |
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| F 689 | Continued From page 1<br>in Resident #2's room.<br><br>The findings include:<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br>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, | 06/09/20 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185085 | A. BUILDING _____ B. WING _____ | 05/14/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HILLCREEK REHAB AND CARE, LLC | 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 689 | Continued From page 2 | F 689 | | |

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

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.

06/09/20

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185095 | A. BUILDING _____ B. WING _____ | 05/14/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HILLCREEK REHAB AND CARE, LLC | 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220 |

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| F 689 | Continued From page 3<br>interview, she expected the facility policy and standards of practice to be maintained related to Oxygen Storage. Additionally, Oxygen tanks should not be sitting in the floor because of its combustibility. Further, it was important to ensure Oxygen was stored correctly to decrease the risk of accident hazards and maintain resident safety.<br><br>Interview with the Administrator, on 05/14/2020 at 2:00 PM, revealed he expected the facility policy to be maintained related to Oxygen Storage. Further, it was important for Oxygen to be stored securely and safely to prevent accident hazards and ensure resident safety. | F 689 | | |

PRINTED: 05/26/2020
FORM APPROVED

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 100212 | A. BUILDING _____ B. WING _____ | 05/14/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HILLCREEK REHAB AND CARE, LLC | 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) COMPLETE DATE |
|---|---|---|---|---|
| N 000 | Initial Comments<br><br>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. | N 000 | | |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

RN HSA — 06/03/20

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

PRINTED: 05/26/2020
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HILLCREEK REHAB AND CARE, LLC | 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220 |

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| F 000 | INITIAL COMMENTS<br><br>An Abbreviated 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 at the highest Scope and Severity of a "D". 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. | F 000 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>Observation on 05/11/2020 and 05/12/2020 revealed an unsecured portable Oxygen canister | F 689 | 1. The Director of Nursing removed the oxygen cylinder noted during the survey from the room on 5/12/2020.<br>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. | 06/19/20 |

RECEIVED
JUN 17 2020
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Interim NHA | (X6) DATE: 06/17/20

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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| | 185095 | A. BUILDING _____ B. WING _____ | 05/14/2020 |

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| HILLCREEK REHAB AND CARE, LLC | 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220 |

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| F 689 | Continued From page 1 in Resident #2's room.<br><br>The findings include:<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br>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, | 06/09/20 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 185095 | A. BUILDING _____ B. WING _____ | 05/14/2020 |

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| HILLCREEK REHAB AND CARE, LLC | 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220 |

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| F 689 | Continued From page 2 | F 689 | | |

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

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.

06/09/20

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 689 | Continued From page 3<br>interview, she expected the facility policy and standards of practice to be maintained related to Oxygen Storage. Additionally, Oxygen tanks should not be sitting in the floor because of its combustibility. Further, it was important to ensure Oxygen was stored correctly to decrease the risk of accident hazards and maintain resident safety.<br><br>Interview with the Administrator, on 05/14/2020 at 2:00 PM, revealed he expected the facility policy to be maintained related to Oxygen Storage. Further, it was important for Oxygen to be stored securely and safely to prevent accident hazards and ensure resident safety. | F 689 | | |

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| E 000 | Initial Comments<br><br>A COVID-19 Focused Emergency Preparedness Survey was initiated on 05/11/2020 and concluded on 05/14/2020. It was determined there were no concerns with 42 CFR §483.73 related to E-0024 (b)(6). | E 000 | | |

RECEIVED
JUN - 3 2020
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 06/03/20

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.

Office of Inspector General

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 100212 | A. BUILDING: _____ B. WING _____ | R 06/18/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **HILLCREEK REHAB AND CARE, LLC** | **3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220** |

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|---|---|---|---|---|
| {N 000} | Initial Comments<br><br>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. | {N 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE