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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 REDACTED]. Review of Resident #2's Physician order [REDACTED]. 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 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 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. 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.

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.