

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: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(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 45</p> <p>08/12/15 at 5:20 PM, revealed she was responsible for the monitoring and auditing of the Tell A Nurse program. She stated she reviewed the Tell A Nurse communication sheet in the daily clinical start up meeting and completed audits to ensure care plans and CNA care sheets were updated as needed.</p> <p>Interview with the Medical Director, on 08/12/15 at 1:45 PM, revealed he met weekly with the facility QA committee members to discuss the information brought to the committee by its members. He stated the Tell A Nurse form and communication process was discussed and actions were developed at the meeting. He stated the 1:1 supervision process was also discussed along with audit findings.</p> <p>Review of the QAPI sign in sheets, revealed QAPI meetings were held on 07/23/15, 07/29/15, 08/05/15, and 08/06/15. Review of the QAPI documentation, dated 07/23/15, revealed process and progress of audit systems were discussed.</p>	F 323			

