

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

PRINTED: 08/31/2015  
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		
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F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey was initiated on 07/07/15 with an Extended Survey initiated on 08/05/15 and concluded on 08/12/15 to investigate complaints KY23483 and KY23560. The Division of Health Care substantiated complaint KY 23560. The investigation determined the allegation had occurred; however, the facility was in a period of non-compliance at the time of the incident and the deficient practice related to the allegation was determined to be corrected on 07/14/15 as alleged. The Division of Health Care substantiated complaint KY23483 with Immediate Jeopardy identified at 42 CFR 483.20 Resident Assessment (F282) at a scope and severity of a "J" and 42 CFR 483.25 Quality of Care (F323) at a scope and severity of a "J" on 07/21/15 and determined to exist on 06/08/15. The facility was notified of the Immediate Jeopardy and Substandard Quality of Care on 07/21/15.</p> <p>Resident #1 had a history of falls, unsteady gait, and walking with eyes closed. The resident was assessed to need staff assistance with transfers and walking. On 06/08/15, at 12:14 PM Physical Therapy assessed the resident to need the maximum assistance of two (2) persons for ambulation. However, Therapy staff failed to communicate the resident's need for maximum assist to nursing staff. On 06/08/15, at 5:10 PM, Resident #1 fell while walking in the hallway without any assistance of staff. Resident #1 sustained bilateral subdural hematomas to the forehead and a skull fracture to the back of the head and expired sixteen (16) hours later at the hospital.</p> <p>The facility provided an acceptable Allegation of</p>	F 000			

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

*Michael Sheehart RA*

TITLE

*X DNS*

(X6) DATE

*X 9/11/15*

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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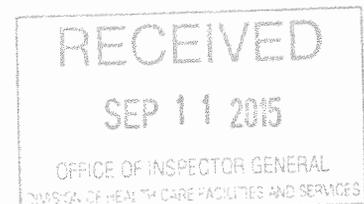
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F 000	Continued From page 1 Compliance (AOC) on 08/05/15 which alleged removal of the Immediate Jeopardy on 08/01/15. The State Survey Agency verified Immediate Jeopardy was removed on 08/01/15 as alleged, on 08/12/15 prior to exit. The Scope and Severity was lowered to a "D" at 42 CFR 483.20 (F282) and 42 CFR 483.25 (F323) while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance.	F 000			
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to follow resident care plan interventions to prevent falls by ensuring assistance with ambulation, a seat belt alarm was turned on at all times and assistance with toileting for three (3) of fifteen (15) sampled residents. (Residents #1, #8, and #10)  Resident #1 had a history of falls, unsteady gait, and walking with eyes closed. The resident was care planned to need staff assistance with walking due to unsteady gait. On 06/08/15 at 12:14 PM, Physical Therapy assessed the resident to need the maximum assistance of two (2) persons for ambulation; however, this was not communicated to nursing. On 06/08/15 at 5:10	F 282  F282	1. Resident #1 was transferred to the hospital on 6-8-2015. Resident #8 was re-assessed for restorative services by the MDS Nurses and Restorative Nurse on 8-31-15. It was determined Resident #8 should be toileted before each smoke break to prevent self-transfers. Resident #10 was re-assessed for the use of a seat belt alarm on 8-31-2015. It was determined Resident #10 should have a seat belt alarm to prevent falls.		

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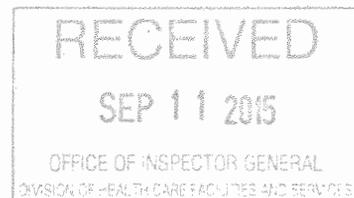
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F 282	<p>Continued From page 2</p> <p>PM, Resident #1 fell while walking in the hallway without staff assistance. Resident #1 sustained bilateral subdural hematomas to the forehead and a skull fracture to the back of the head and expired sixteen (16) hours later at the hospital.</p> <p>In addition, on 08/10/15 at 9:00 AM, revealed Resident #8 had not received the restorative services that was care planned. Resident #8 experienced a fall on 08/08/15 trying to transfer to the toilet. Interview with the ADON revealed the staff had not implemented the toileting and restorative care plan interventions, as per their policy. She stated if the staff had provided toileting assistance to the resident the fall would have been prevented.</p> <p>The facility's failure to have an effective system in place, to ensure care plans were followed has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was determined to exist on 06/08/15.</p> <p>An acceptable Allegation of Compliance was received on 08/05/15 alleging removal of the Immediate Jeopardy on 08/01/15. The State Survey Agency (SSA) validated the removal of Immediate Jeopardy on 08/01/15 as alleged prior to exit on 08/12/15. The scope and severity was lowered to a "D" while the facility monitors the systemic changes and the Quality Assurance monitors the effectiveness of the plan of correction.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Falls Management Guidelines, dated 06/25/15, revealed the interdisciplinary team would evaluate</p>	F 282	<p>2. All residents were assessed by the Director of Nursing Services (DNS), Restorative Nurse, Nurse Consultant and/or MDS Nurses for the need of restorative services by 8-31-2015. It was determined 92 residents are appropriate for restorative services. Twenty-five residents are on a toileting program. The DNS, Restorative Nurse, Nurse Consultant and/or MDS Nurses revised MD orders, Care Plans and CNA Care sheets as needed.</p> <p>All resident with a seat belt alarm in use were assessed by the DNS, Restorative Nurse, Nurse Consultant/or MDS Nurses for use of an appropriate intervention to prevent falls on 8-31-2015. Ten residents have a seat belt alarm in use. The DNS, Restorative Nurse, Nurse Consultant and/or MDS Nurses revised MD orders, Care Plans and CNA Care sheets as needed.</p> <p>A Fall Care Plan Intervention Audit was completed by Charge Nurse on 8-31-2015 for each resident with a Fall Care Plan who has had more than one fall in the last 180 days. This included 33 residents. Charge nurse will communicate those interventions to be followed to the assigned CNA each day.</p>		



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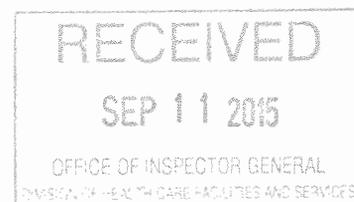
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F 282	<p>Continued From page 3</p> <p>the fall prevention plan of care for residents at risk for falls. Appropriate interventions would be implemented and the care plan updated.</p> <p>Review of the Post Fall Analysis Summary and Guidelines for Completion, dated 11/13/14, revealed the facility would complete the post fall analysis summary after every known resident fall to assess the individuals condition and to identify the reason and/or risk factor for the fall in order to prepare a plan of care to reduce the potential for future falls.</p> <p>1. Review of Resident #1's clinical record revealed the facility admitted the resident on 02/24/15 with diagnoses of Systolic Heart Failure, Hypertension, Atrial Fibrillation, and Dementia with Behavioral Disturbances. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, completed on 04/21/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ten (10) meaning the resident was interviewable.</p> <p>Review of the Comprehensive Care Plan for Resident #1 revealed a plan was developed on 02/25/15 with updated goals and a target date for 06/18/15. The problem stated the resident was at risk for falls due to a history of falls at home and cognitive impairment related to the diagnosis of Dementia. The goal stated the resident would have no falls through next review. The approaches directed the staff to monitor for changes in functional status, environmental and situational hazards daily to ensure a safe environment was provided.</p> <p>Further review of the care plan revealed on</p>	F 282	<p>3. Licensed nursing staff and certified nursing assistants (CNA) received education regarding restorative services, ensuring seat belt alarms are turned on and following fall care plan interventions by the Director of Clinical Education beginning on 9-10-2015. The Charge Nurse will observe interventions daily; beginning 9-11-2015 to ensure the Fall Care Plan is being implemented. The audits will be turned in to the DNS, Nursing Consultant and/or Nursing Supervisor daily for review. Follow up is completed as needed including re-education or if warranted disciplinary action for a nurse or CNA.</p> <p>4. Beginning on 9-3-2015, QAPI meetings will be held weekly for four weeks, then bi-weekly for 1 month, then monthly on going. QAPI committee will review results of staffing and resident participation audits, including trends and compliance. ED is responsible for QAPI meetings.</p> <p>5. Date of Compliance: 9-12-2015</p> <p style="text-align: right;">9/23/15 <i>huz</i></p>	



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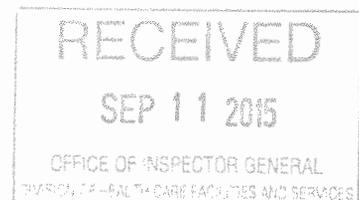
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F 282	<p>Continued From page 4</p> <p>06/08/15, due to a fall that occurred on 06/07/15, the facility noted the resident was to be evaluated by Physical Therapy and staff was to assist with transfers and walking due to an unsteady gait. However on 06/08/15, nursing staff failed to follow the residents' plan of care to assist with ambulation due to an unsteady gait.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/08/15 at 9:25 AM, revealed Resident #1 was very lethargic on the morning of 06/08/15 and was pacing on the unit. She tried to keep the resident as close to her as possible while she completed her daily tasks and so did other staff. She stated later in the day she requested extra staff on the unit in order for Resident #1 to have one to one assistance and monitoring because the resident was at risk for falls; however, she was not provided a rationale for not sending additional staff. Instead she was provided a chair alarm to use. However, the care plan stated to use one staff for ambulation, not a chair alarm. LPN #1 stated a chair alarm was not an appropriate intervention for Resident #1 because the resident would not remain seated for any length of time. Around 5:00 PM she was in the hallway by the nursing station passing medications and Resident #1 was behind her. She stated she turned to give another resident some medications and heard a loud thud. When she turned around she observed Resident #1 laying on the floor on his/her back.</p> <p>Interview, on 07/10/15 at 5:00 PM, with LPN #5, revealed she worked as an aide on 06/08/15 when Resident #1 sustained the fall. The resident was very lethargic and was observed to walk with his/her eyes closed. LPN #5 stated Resident #1 was assessed as a fall risk. She requested extra</p>	F 282			



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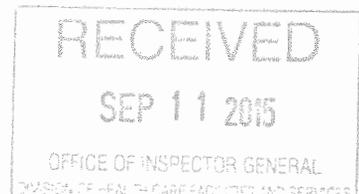
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F 282	<p>Continued From page 5</p> <p>staff for the unit in order for someone to stay one on one with Resident #1 to maintain his/her safety and prevent a fall. However, the request was not granted and instead a chair alarm was provided for use with Resident #1. She did the best she could to watch the resident while trying to take care of her other residents. She stated the chair alarm was not appropriate because the resident would not stay seated and would get up and pace around the unit.</p> <p>Interview with Certified Nursing Assistant (CNA) #4, on 07/14/15 at 8:00 AM, revealed Resident #1 would pace around the unit and at times would walk around with his/her eyes closed. She stated staff was told to keep a closer eye on the resident and assist as needed; however, if she had to tend to another resident she could not be there to provide that close attention. She stated she would put the resident in the chair that reclined in the common area and go tend to another resident. She stated she would come back and the resident would be up walking around without assistance.</p> <p>Interview with the Director of Nursing (DON), on 07/14/15 at 3:40 PM, revealed she was not the DON at the time of Resident #1's fall. She stated after assuming the role of DON and assessing the nursing staff skills related to the care planning process she stated she had concerns with the facility's ability to implement the care plan. She stated she was in the process of developing a plan to fix the issues and the identified concerns. She stated if resident care plans were not followed the appropriate interventions related to the fall, residents were at risk for falls and injuries.</p>	F 282			



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F 282	<p>Continued From page 6</p> <p>Attempted interview with the previous Director of Nursing, on duty at the time of Resident #1's fall, on 07/16/15 at 4:10 PM, 07/17/15 at 8:17 PM and 3:00 PM, revealed no contact was made and no return call was received.</p> <p>Interview with the Administrator, on 07/10/15 at 3:30 PM, revealed the nursing care plan for Resident #1 was not meaningful to ensure another fall would not occur. She stated the facility had recently recognized the nursing staff needed additional training in the care planning process and they were still in the process of improving the skills of their nursing staff.</p> <p>2. Review of Resident #8's clinical record revealed the facility admitted the resident on 12/21/11 with diagnoses of Human Immunodeficiency Virus, Aphasia, and Cerebral Vascular Accident with Hemiplegia.</p> <p>Review of Resident #8's Quarterly Minimum Data Set (MDS) assessment, completed on 07/17/15, revealed a Brief Interview for Mental Status (BIMS) examination was conducted and the facility assessed the resident with a score of ninety-nine (99) meaning the resident was unable to complete the interview. The MDS assessment stated the resident was currently on a toileting program and occasionally incontinent of urine and always continent of bowel.</p> <p>On 08/05/15 at 11:25 AM, an interview with Licensed Practical Nurse (LPN) #9, revealed Resident #8 needed the assistance of two (2) to toilet. She stated the resident was able to make his/her needs known to staff and would yell out instead of using the call light for assistance to use the bathroom and staff would respond. She</p>	F 282			



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F 282	<p>Continued From page 7</p> <p>stated if staff was not within range they would not hear the resident yelling.</p> <p>Review of the Post Fall Analysis/Plan, dated 07/27/15, revealed Resident #8 had a history of falls and experienced a fall, on 07/27/15 at 11:00 PM, while trying to transfer to the toilet unassisted after returning from a smoke break; no injuries were noted on the form. Recommendations made from the interdisciplinary team review were to immediately reassess the resident; reassess the resident's toileting program needs; refer the resident to therapy for screening or evaluation; for restorative to see as ordered; monitor for changes for three (3) days; and, report to the physician any change in the resident's condition.</p> <p>Review of the Comprehensive Care Plan for Resident #8 revealed a plan was developed on 08/05/15, with updated goals and a target date for 11/13/15. The problem stated the resident had functional incontinence related to the inability to recognize bladder cues secondary to poor mobility and dementia. The goal stated the resident would be accepting to toileting cues and staff would maintain dignity with odor/soiled free clothing. The approaches directed staff to monitor the resident's response with the toileting program; offer assistance to toilet before and after supper; at bedtime; every three (3) hours during the night; and, as necessary.</p> <p>Review of the Post Fall Analysis/Plan, dated 08/08/15, revealed Resident #8 experienced a fall, on 08/08/15 at 10:00 AM, when the resident attempted to transfer self to the toilet.</p> <p>Review of the resident's Restorative Program revealed the resident had only received twelve</p>	F 282			

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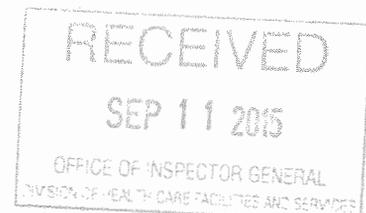
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F 282	<p>Continued From page 8</p> <p>(12) of twenty-eight (28) sessions; and, from 07/27/15 to 08/07/15 the resident had only received two (2) fifteen (15) minute sessions.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 08/10/15 at 9:00 AM, revealed Resident #8 had not received the daily restorative care per the the resident's was care plan. Continued interview with the ADON, revealed Resident #8 experienced another fall on 08/08/15 trying to transfer to the toilet again. The ADON stated the staff had not implemented the toileting and restorative care plan interventions, as per their policy. She stated if the staff had provided toileting assistance to the resident the fall would have been prevented.</p> <p>Interview with the Director of Nursing, on 08/12/15 at 5:20 PM, revealed she did not remember speaking about Resident #8's falls or care plan interventions related to toileting or the restorative programs during the morning meetings. She stated care plans needed to be current and the facility needed to ensure care plan interventions were implemented by the staff to prevent another occurrence as per the facility's policy.</p> <p>Interview with the Administrator, on 08/12/15 at 5:50 PM, revealed she made rounds daily, had an open door policy and insisted staff call her when there were falls or other concerns. She stated she had identified the facility staff still needed additional education and supervision to ensure the resident's care plans were followed and the resident's needs were met. She stated the facility should have followed their care plan policy to ensure Resident #8 received the necessary toileting assistance and restorative services per</p>	F 282			

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F 282	<p>Continued From page 9 his/her plan of care.</p> <p>3. Review of Resident #10's clinical record revealed the facility admitted the resident on 01/07/14 with diagnoses of Dementia with Behavioral Disturbances, Spinal Stenosis, Depression and Macular Degeneration.</p> <p>Review of Resident #10's Annual Minimum Data Set (MDS) assessment, completed on 06/11/15, revealed a Brief Interview for Mental Status (BIMS) examination was conducted and the facility assessed the resident with a score of three (3) meaning the resident was not interviewable.</p> <p>Review of the Comprehensive Care Plan for Resident #10 revealed a plan was developed on 01/08/14, with updated goals and a target date for 10/01/15. The problem stated the resident was at risk for falls due to a history of falls related to unsteady balance, attempts to get up unassisted and anxious behavior. The goal stated the resident would not receive any injuries from falls through the next review. The approaches directed staff to ensure the bed and seat belt alarm to wheelchair was in place at all times and offer diversional activities such as snacks, music or pictures and toilet as scheduled.</p> <p>Observation of Resident #10, on 08/06/15 at 2:00 PM, revealed the resident was in bed in the low position with eyes closed. Observation on 08/10/15 at 11:50 AM, revealed Resident #10 was in the common area seated in a wheelchair with a self releasing seat belt.</p> <p>Review of the Post Fall Analysis/Plan forms, dated 07/10/15, 08/01/15 and 08/03/15, revealed Resident #10 experienced non-injury falls from</p>	F 282			



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F 282	<p>Continued From page 10</p> <p>the wheelchair on each of these dates. Continued review of the document revealed each time the resident was found on the floor the seat belt alarm was not sounding and found to be in turned on the off position. Review of the recommended care plan interventions developed after each fall revealed they were the same on each document. Interventions included to immediately assess the resident and monitor for three (3) days; ensure the proper working order of the seat belt alarm; staff to make sure, each shift, the alarm was turned on; and, to provide supervision and offer diversional activities of the resident's choice. However, the facility was unable to provide documented evidence they were following the care plan intervention, per the facility policy, to ensure the seat belt alarm was checked each shift for proper working order.</p> <p>On 08/10/15 at 3:50 PM, an interview with the East Unit Nursing Supervisor, revealed nursing did not document that residents' alarms were checked daily or per shift for functionality. She stated there were no orders to do so for any resident with an alarm. However, it was the nursing staff's responsibility to ensure Resident #10's plan of care intervention regarding making sure his/her alarm was on and functioning properly was actually implemented as per the care plan policy.</p> <p>On 08/10/15 at 1:00 PM, an interview with the Director of Nursing, revealed the facility did not document if the residents' bed/chair/seat belt alarms were checked for functionality. That would have to be put in as a Physician's Order for it to transfer over to the medication or treatment record for the nursing staff to provide documentation that they were checked for proper</p>	F 282			

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F 282	<p>Continued From page 11</p> <p>functioning. The DON stated documenting those types of checks had not been a routine practice for the facility. She stated she had identified the staff was not providing the necessary supervision or diversional activities to prevent the resident from trying to get up from the wheelchair unassisted, as per their facility's care plan policy for implementing care plan interventions.</p> <p>On 08/11/15 at 1:45 PM, an interview with the Administrator, revealed the Director of Nursing and Assistant Director of Nursing brought it to her attention that the staff was not following the care plan policy related to the seat belt alarm intervention to ensure it was on while Resident #10 was in the wheelchair. She stated she was responsible for making sure the staff followed the care plan policy.</p> <p>The facility took the following actions to remove the Immediate Jeopardy on 08/01/15 as follows:</p> <ol style="list-style-type: none"> <li>1. On 06/08/15 Resident #1 was assessed by RN #2 the Nursing Supervisor and immediately sent to the hospital.</li> <li>2. On 07/16/15, the Director of Rehabilitation and Executive Director (ED) reviewed the Therapy Evaluation policy and agreed the policy was followed and that communication would be enhanced by updating to include "Tell a Nurse" for the evaluation process. This was also discussed on the phone with Kentucky Area Vice President of Golden Living on 07/16/15. The previous policy did not include communication upon evaluation. This was completed on 07/16/15.</li> <li>3. On 06/09/15 the facility started training supervisors on one to one (1:1) supervision</li> </ol>	F 282			

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F 282	<p>Continued From page 12</p> <p>staffing by the Administrator and Director of Nursing (DNS); seventy-seven (77) staff had been trained. Training completed 07/31/15. Any staff that had not been trained will not work until training had been completed. Starting on 06/09/15 Nurses and CNAs received training on the meaning of 1:1 by DNS. Seventy-seven (77) nurses and CNAs have received training as of 07/31/15. Attendance is checked by DNS, ADNS and Nursing Supervisors. If a CNA or Nurse was on leave or vacation, they were scheduled to have the education prior to shift upon return. Golden Living Camelot does not utilize Agency staffing.</p> <p>4. One on one competency audit interviews for the one on one (1:1) supervision training follow-up started 07/29/15 with Certified Nursing Assistant (CNA) and nursing staff, Registered Nurse (RN), and Licensed Practical Nurse (LPN). This was completed by Nursing Consultant, ED, and Nursing Supervisors. Forty-eight (48) interviews had been done. Going forward five (5) interviews would be done on varied shifts each day for two (2) weeks and then five (5) times per week for one month. Any deficits were retrained at the time of the interview with the CNA or Nurse.</p> <p>5. Rehabilitation Manager identified residents that had been evaluated by therapy in the last three (3) months or on therapy caseload as of 07/23/15 without any issues noted. Thirty-seven (37) residents had been evaluated. Thirty-seven (37) care plans were revised by nursing and therapy to include gait and transfer information. Those care plans had been reviewed and revised as indicated. On 07/17/15 CNA care cards were revised to assure consistent language was used</p>	F 282			

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F 282	<p>Continued From page 13 throughout the building for CNA care.</p> <p>6. Training on Tell a Nurse program was done with ten (10) therapists starting 07/16/15 by the Director of Rehabilitation. Training with therapists was completed on 07/24/15. Starting on 07/16/15, DNS trained forty-three (43) of forty-four (44) nurses on the Tell a Nurse program. Training for nurses was completed on 07/30/15. The one remaining nurse would be trained prior to working a shift by the DNS, Assistant Director of Nursing Services (ADNS), or Nursing Supervisor.</p> <p>7. Checked the Tell A Nurse binders on each nursing unit for communication sheet, check care plan and care sheet to assure any changes were added to the care plan and the CNA care sheet. Audits were completed on 07/15/15 through 08/04/15 by DNS, ADNS, ED, Nursing Supervisor or Nurse Consultant subsequent to Tell A Nurse form to observe service and confirm it was consistent with Tell A Nurse information. On 07/23/15 the Nurse Consultant completed an audit of the Tell a Nurse process. Each binder was reviewed to assure communication sheets were in place, and care plans and care sheets were reviewed to assure accuracy. Three (3) care plans were updated or changed by the Nurse Consultant. Follow up was completed with the nurse. The modifications included more specific information to a care plan regarding transfers, and supervision to licensed nurse to assure update of CNA care sheet. On the two other cases it was assured that the care plan and CNA care sheets matched and both were updated.</p> <p>8. Starting 07/30/15 when a 1:1 was done, the Unit Manager brought the 1:1 supervision documentation to the clinical start up for a check</p>	F 282			

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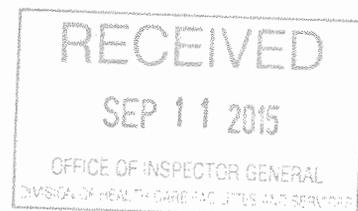
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F 282	<p>Continued From page 14 of the documentation. The Administrator, DNS, or Nursing Supervisor would complete an audit of 1:1's at varied times daily to assure one to one supervision was being done according to protocol.</p> <p>9. Starting on 07/23/15 the DNS, ADNS, or Nurse Supervisor continue to check that changes were made to the care plans from therapy evaluations at the daily clinical start up. The nurse brought the binder to clinical start up, when a Tell a Nurse form had been completed. Therapy, Nursing Consultant/ DNS or ADNS checked the Tell A Nurse form and assured care plan updates and care sheet updates were completed using the Tell A Nurse Audit Form.</p> <p>10. An Ad Hoc Quality Assurance Process Improvement (QAPI) meeting was held on 07/23/15 to discuss and validate that the results of the therapy evaluations were updated to the care plans and the CNA care cards. This was conducted by the Administrator, DNS, ADNS, Social Worker, Therapist, and Medical Director and will continue weekly times four (4) weeks, then bi-weekly times four (4) weeks, then monthly thereafter. The monitoring and auditing of the Tell A Nurse program would be done by the DNS, ADNS, or Nurse Supervisor. Additional Ad Hoc QAPI held on 07/29/15 to update system of checks and validate current systems. Ad Hoc QAPI for entire system held on 07/29/15 including Competency Interview system.</p> <p>The State Survey Agency validated the removal of Immediate Jeopardy on 08/12/15 as follows:</p> <p>1. Review of Resident #1 nurses note, dated 06/08/15, revealed Resident #1 was assessed by</p>	F 282			

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F 282	Continued From page 15 RN #2 the Nursing Supervisor and sent to emergency department post fall on 06/08/15 at 5:17 PM.  2. Review of "Evaluation-Plan of Care policy, undated, and "Tell A Nurse" form, undated, on 08/10/15, revealed the Therapy Evaluation policy and procedure was reviewed and updated to include the Tell A Nurse form by the Director of Rehabilitation, ED, and the Kentucky Area Vice President of Golden Living. Interview with the Rehabilitation Director, on 08/10/15 at 11:00 AM, and Administrator, on 08/10/15 at 8:45 AM, revealed the policy was reviewed and procedure updated to include the Tell A Nurse communication form and completed on 07/16/15.  3. Review of in-service records, dated 06/09/15, revealed seventy-seven (77) staff had been trained by the Administrator and Director of Nursing on one to one staffing. Training included the definition of 1:1 staffing, steps to provide 1:1 supervision, and the required documentation for 1:1 supervision. Interview with Nursing Supervisor #2, on 08/10/15 at 3:50 PM and Licensed Practical Charge Nurse #3 revealed they had received training on 1:1 resident care and could correctly define 1:1 and knew what to document regarding 1:1 supervision.  4. Review of one on one (1:1) Competency Interview audits and Daily Assignment Sheets, revealed forty eight (48) staff, including CNAs, RNs, and LPNs, on varied shifts had been interviewed regarding 1:1 supervision. Interviews began on 07/29/15 and were completed daily until 08/09/15 by Nursing Consultant, Administrator, and Nursing Supervisors. Interview with Administrator, on 08/10/15 at 8:45 AM, revealed	F 282			



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F 282	<p>Continued From page 16</p> <p>she conducted 1:1 Competency interviews, and had done more than the required five each day during the first 2 weeks. She stated any staff person requiring retraining was done at the time of the interview. Interview with Certified Nursing Assistant #10, on 08/10/15 at 3:10 PM, revealed she received training on 1:1 supervision and had been interviewed after training to determine if she could recite what she was required to do. Interview with Licensed Practical Nurse #7, on 08/11/15 at 1:55 PM, stated she had received training regarding 1:1 supervision and had been interviewed afterwards to check if she knew her responsibility regarding 1:1 supervision. She stated she was to ensure the CNA's documented their 1:1 observations and that staff could not leave the resident unless provided relief. Interview with Registered Nurse #2, on 08/10/15 at 11:00 AM, revealed she had received training on 1:1 supervision and had been interviewed after the training to determine her knowledge of the 1:1 process. She stated her responsibility was to ensure documentation was completed by the CNA and that staff was not to leave the resident unless another staff member relieved them.</p> <p>5. Review of the facility's document titled Level of Assist from 05/01/15 to current, revealed thirty-seven (37) residents had been evaluated by therapy during that time. Record review of those thirty seven (37) resident care plans and CNA care cards, revealed gait and transfer information was included on the care plans and CNA care cards. Interview with Rehabilitation Manager, on 08/10/15 at 11:00 AM, revealed she identified 37 residents had been evaluated by therapy in the last 3 months, and resident care plans were updated to include gait and transfer information. Interview with Director of Nursing, on 08/10/15 at</p>	F 282			

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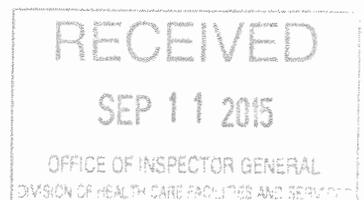
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F 282	<p>Continued From page 17</p> <p>10:40 AM, revealed CNA care cards were revised on 07/17/15 to assure consistent language was used throughout the building.</p> <p>6. Review of in-service records, dated 07/16/15, revealed ten (10) therapists had been trained on Tell a Nurse program by the Director of Rehabilitation. Interview with the Director of Rehabilitation, on 08/10/15 at 11:00 AM, revealed she had trained 10 therapists on the Tell A Nurse program. Interview with the Occupational Therapist, on 08/10/15 at 11:10 AM, revealed she had received training by the Director of Rehabilitation regarding the Tell A Nurse program which included filling out the form and verbally providing a report to nursing staff of their assessment findings.</p> <p>Additional review of in-service record, dated 07/16/15, revealed forty-three (43) nurses had attended training on the Tell A Nurse program by the DNS. Interview with Licensed Practical Nurse #7, on 08/11/15 at 1:55 PM, revealed he/she had been trained on the Tell A Nurse program, including the location and purpose of the Tell a Nurse binder, and the process for updating care plans and CNA care sheet after therapy evaluation.</p> <p>7. Review completed on 08/10/15, of the Tell A Nurse Binder communication sheets, resident care plans, and CNA care sheets, revealed changes and updates from the Tell A Nurse form were updated on the resident care plan and CNA care sheets.</p> <p>Interview with the Administrator, on 08/10/15 at 8:45 AM, and Director of Nursing, on 08/10/15 at 10:40 AM, revealed they had conducted audits of</p>	F 282			

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F 282	<p>Continued From page 18</p> <p>the Tell A Nurse communication sheet, resident care plans, and CNA care sheets to confirm that information was consistent on all documents.</p> <p>Interview with Nurse Consultant, on 08/10/15 at 10:45 AM, and Nursing Supervisor #2, on 08/10/15 at 3:50 PM, revealed they completed audits of the Tell A Nurse process on 07/23/15, including reviewing the Tell A Nurse binders to assure communication sheets were in place, and care plans and care sheets were reviewed for accuracy. In addition, they revealed three (3) care plans were updated to include more specific information regarding transfers, and supervision to licensed nurse to assure update of CNA care sheet. Review of the three care plans, revealed care plans and CNA care sheets were updated with therapy's recommendations for assistance with transfers and walking.</p> <p>8. Observation of the clinical start up meeting, on 08/06/15 at 9:00 AM, revealed the Unit Manager of the Alzheimer's Care Unit (ACU) had one resident on 1:1 supervision. The 1:1 documentation was discussed and reviewed by the DON. Review of the 1:1 documentation for the resident, revealed 1:1 documentation was complete, and the ED, DNS, or Nursing Supervisor had completed a daily audit of the documentation. Review of Golden Living Center Camelot E.D. Stand-Up Meeting sheets from 07/31/15-08/05/15, revealed 1:1 documentation was reviewed daily during the clinical start up meeting.</p> <p>9. Observation of the clinical start up meeting, on 08/06/15 at 9:00 AM, revealed the Tell A Nurse binders on each nursing unit were reviewed with no new Tell A Nurse forms completed the</p>	F 282		



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F 282	<p>Continued From page 19</p> <p>previous day. Review of the Tell A Nurse forms from 07/23/15, resident care plans, and CNA care sheets, revealed therapy evaluations from the Tell A Nurse form were updated on the resident care plan and CNA care sheets to reflect therapy recommendations. Interview with the DNS, on 08/12/15 at 5:20 PM, revealed she checked the Tell A Nurse form and assured care plans and CNA care sheets were updated using the Tell A Nurse Audit Form.</p> <p>10. Review of the Ad Hoc Quality Assurance Process Improvement (QAPI) sign in sheets, and agendas dated 07/23/15 and 07/29/15, revealed the Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, Therapist and Medical Director were in attendance. Interview with the Administrator, on 08/12/15 at 5:50 PM, revealed the QAPI team met weekly if not more frequently. In addition, the QAPI team discussed the results of therapy evaluations and ensured care plans and CNA care cards were updated.</p> <p>Interview with the Director of Nursing, on 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</p>	F 282			

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F 282	Continued From page 20 the 1:1 supervision process was also discussed along with audit findings.	F 282			
F 323 SS-J	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. 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: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure residents received supervision to prevent accidents. The facility's analysis of the potential causes of the incidents failed to determine the root cause. In addition, the interventions developed were not evaluated for relevancy or effectiveness in order to prevent recurrence for three (3) of fifteen (15) sampled residents. (Resident's #1, #8, and #10).  Resident #1 had a history of falls, unsteady gait, and walking with eyes closed. The resident was assessed to need staff assistance with transfers and walking. On 06/08/15, at 12:14 PM Physical	F 323	F323  1. Resident #1 was transferred to the hospital on 6-8-2015. Resident #8 was re-assessed for restorative services by the MDS Nurses and Restorative Nurse on 8-31-15. It was determined Resident #8 should be toileted before each smoke break to prevent self-transfers. Resident #10 was re-assessed for the use of a seat belt alarm on 8-31-2015. It was determined Resident #10 should have a seat belt alarm to prevent falls.		



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F 323	<p>Continued From page 21</p> <p>Therapy assessed the resident to need the maximum assistance of two (2) persons for ambulation. However, Therapy staff failed to communicate the resident's need for maximum assist to nursing staff. On 06/08/15, at 5:10 PM, Resident #1 fell while walking in the hallway without any assistance of staff. Resident #1 sustained bilateral subdural hematomas to the forehead and a skull fracture to the back of the head and expired sixteen (16) hours later at the hospital.</p> <p>In addition, Resident #8 had a history of falls and experienced a fall, on 07/27/15 at 11:00 PM, while trying to transfer to the toilet unassisted after returning from a smoke break; no injuries were noted. The resident experienced another fall, on 08/08/15 at 10:00 AM, again at the time of the facility's smoking break.</p> <p>On 07/10/15 at 4:22 PM, 08/01/15 at 3:35 PM and 08/03/15 at 9:00 AM, Resident #10 experienced non-injury falls from the wheelchair on each of these dates. All three falls the resident was found on the floor in the common area by the nurses station, and the seat belt alarm was not sounding and was found to be turned off.</p> <p>The facility's failure to have an effective system in place to ensure adequate supervision and monitoring for residents to prevent accidents or incidents has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was determined to exist on 06/08/15.</p> <p>An acceptable Allegation of Compliance was received on 08/05/15 alleging removal of the Immediate Jeopardy on 08/01/15. The State</p>	F 323	<p>2. All residents who previously had a fall are at risk for the deficient practice. A Fall Care Plan Intervention Audit was completed by Charge Nurse on 8-31-2015 for all residents with a Fall Care Plan who has had more than one fall in the last 180 days. This included 33 residents. All interventions were determined to be in place. All residents with a seat belt alarm in use were assessed by the DNS, Restorative Nurse, Nurse Consultant/or MDS Nurses for use of an appropriate intervention to prevent falls on 8-31-2015. Ten residents have a seat belt alarm in use. The DNS, Restorative Nurse, Nurse Consultant and/or MDS Nurses revised MD orders, Care Plans and CNA Care sheets as needed.</p>		

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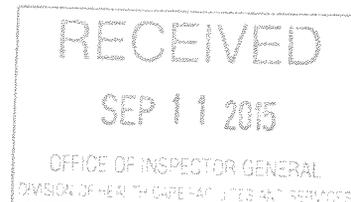
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F 323	<p>Continued From page 22</p> <p>Survey Agency (SSA) validated the removal of Immediate Jeopardy on 08/01/15 as alleged prior to exit on 08/12/15. The scope and severity was lowered to an "D" while the facility monitors the systemic changes and the Quality Assurance monitors the effectiveness of the plan of correction.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Falls Management Guideline, dated 01/22/15 and reviewed 06/26/15, revealed the interdisciplinary team would evaluate the fall prevention plan of care for residents "at risk" for falls. Following a resident's fall the nurse would assess the resident for injuries and provide the necessary care and services, including neurological checks if indicated. Appropriate interventions would be implemented and the care plan updated. Per center practices licensed nurses would complete continued ongoing assessment and documentation.</p> <p>1. Review of Resident #1's clinical record revealed the facility admitted the resident on 02/24/15 with diagnoses of Systolic Heart Failure, Hypertension, Atrial Fibrillation, and Dementia with Behavioral Disturbances.</p> <p>Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, completed on 04/21/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ten (10) meaning the resident was interviewable.</p> <p>Review of the Comprehensive Care Plan for Resident #1 revealed a plan was developed on</p>	F 323	<p>3. Licensed nursing staff and certified nursing assistants (CNA) were educated by the Director of Clinical Education on fall prevention, following fall care plans and ensuring seat belt alarms are turned on beginning on 9-10-2015. Beginning 9-11-2015, the Charge Nurse will observe interventions daily, to ensure the Fall Care Plan is being implemented. The audits will be turned in to the DNS, Nursing Consultant and/or Nursing Supervisor daily for review. Follow up is completed as needed including re-education or if warranted disciplinary action for a nurse or CNA. If a nurse assessment determines a resident should be placed 1:1 supervision, the Executive Director and/or Director of Nursing Services will be notified immediately. All accidents and incidents will be brought to clinical start-up meeting and discussed with the interdisciplinary team (IDT). Root cause analysis will be identified for each fall and appropriate interventions will be based on the root cause analysis.</p>		

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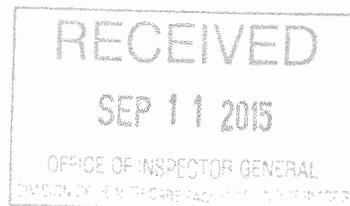
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F 323	<p>Continued From page 23</p> <p>02/25/15 with updated goals and a target date for 06/18/15. The problem stated the resident was at risk for falls due to a history of falls at home and cognitive impairment related to the diagnosis of Dementia. The goal stated the resident would have no falls through next review. The approaches directed the staff to monitor for changes in functional status, environmental and situational hazards daily to ensure a safe environment was provided.</p> <p>Review of Nursing note, dated 06/07/15 and timed 9:50 AM, revealed the staff witnessed Resident #1 stand without assistance in the dining room and then observed the resident to lose their balance and fall to his/her knees.</p> <p>Further review of the resident's care plan revealed on 06/08/15, due to a fall that occurred on 06/07/15, Resident #1's care plan approaches were revised, and the facility noted the resident was to be evaluated by Physical Therapy and staff was to assist with transfers and walking due to an unsteady gait.</p> <p>Review of the Therapy assessment, dated 06/08/15 at 12:14 PM, revealed the reason for referral was due to a fall. The therapist assessed the resident as moderate assistance of two (2) persons for ambulation, the resident required cues redirection on multiple occasions during the evaluation. The resident further scored a one (1) of five (5) on the standing balance and fell asleep twice when ambulating twenty (20) feet.</p> <p>Review of Nursing note, dated 06/08/15 and 5:10 PM, revealed the nurse was standing in the hallway with Resident #1 and turned her back to the resident to provide care to another resident.</p>	F 323	<p>4. Beginning on 9-3-2015, QAPI meetings will be held weekly for four weeks, then bi-weekly for 1 month, then monthly on going. QAPI committee will review results of audits pertaining to accidents and incidents and identification of root cause analysis. This is in addition to the process of monitoring for care plan modifications following each fall. ED is responsible for QAPI meetings.</p> <p>5. Date of Compliance: 9-12-2015</p>		



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F 323	<p>Continued From page 24</p> <p>The nurse heard a loud noise from behind her and turned back toward to the resident to find the resident laying on the floor, flat on his/her back unresponsive.</p> <p>Interview, on 07/16/15 at 8:41 AM, with Physical Therapist #1, revealed she had completed an ordered Physical Therapy evaluation, with the help of the Occupational Therapist, on 06/08/15 at 12:14 PM. The evaluation was to determine Resident #1's gait, transferring and walking ability. The resident required the maximum assistance of two (2) to assist the resident out of a reclining chair, to walk twenty (20) feet and to return to a sitting position. The resident could only provide twenty-five percent of own effort in rising from the chair. While walking the resident would close his/her eyes and also fall asleep, but was easily cued to open the eyes. She did not provide a report to nursing, using the facility's "Tell a Nurse" form regarding her evaluation; however, she stated the nursing staff had access to the report in the medical record. She stated if she had made a report to the nursing staff she would have recommended Resident #1 be a maximum assistance of one (1) to two (2) at all times while walking. She added the problem was the resident had a history of getting up without staff knowledge and falling.</p> <p>Interview, on 07/10/15 at 5:00 PM, with Licensed Practical Nurse (LPN) #5, revealed she worked as an aide on 06/08/15 when Resident #1 sustained the fall. She stated the resident was very lethargic and was observed to walk with his/her eyes closed. LPN #5 stated Resident #1 was assessed as a fall risk. She spoke with the Director of Nursing and requested extra staff for the unit in order for someone to stay one on one</p>	F 323		



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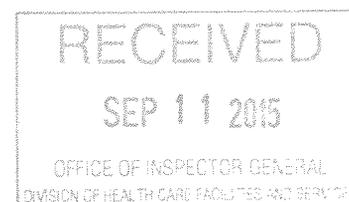
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F 323	<p>Continued From page 25</p> <p>with Resident #1 to maintain his/her safety and prevent a fall. However, the request was denied and instead a chair alarm was provided for use with Resident #1. She did the best she could to watch the resident while trying to take care of her other residents. The chair alarm was not appropriate because the resident would not stay seated and would get up and pace around the unit. She stated she did not know about the Therapy evaluation. She stated the staff knew the evaluation was in the computer; however, did not know the evaluation was completed.</p> <p>Phone calls to the previous Director of Nursing (DON), on duty at the time of Resident #1's fall, were attempted on 07/16/15 at 4:10 PM and on 07/17/15 at 8:17 AM and 3:00 PM, but were unsuccessful and no return calls were received by the DON.</p> <p>Interview, on 07/08/15 at 9:20 AM, with Licensed Practical Nurse (LPN) #1, revealed she had worked on 06/08/15 from 7:00 AM to 11:00 PM. Resident #1 appeared very tired all day and had been experiencing problems with sleeping and staying awake. The resident was unsteady on his/her feet and was a fall risk. Further the resident paced the unit and mumbled constantly about going somewhere. She continued to complete her daily nursing duties while keeping an eye on Resident #1 and trying to keep him/her close to her. She stated a Physical Therapist evaluated the resident on 06/08/15; however, she did not receive a report regarding their evaluation and was not provided any recommendations related to the resident's assessed needs related to walking and she had not reviewed the chart for the evaluation. She was administering medications to another resident while standing in</p>	F 323			

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F 323	<p>Continued From page 26</p> <p>the hallway. She stated Resident #1 was a little ways behind her when she turned her back to Resident #1, in order to administer medication to a resident. She heard a loud thud behind her and when she turned around Resident #1 was on the floor, on his/her back and unresponsive. The resident was unresponsive for a few minutes and sustained swelling to the back of the head, breathing was difficult and pupils were sluggish. An ambulance was called to transport the resident to the hospital. She stated she learned later that the resident had passed away at the hospital from his/her injuries.</p> <p>Interview with the Rehab Director, on 07/16/15 at 8:41 AM, revealed it was not the rehab's policy to use a Tell A Nurse form, or their process to notify nursing of any evaluation results, as it is put in the computer and the nursing staff was aware they can retrieve the information at any time. If staff was aware of the resident's risk for falls and did not report it then the resident would remain at risk and if therapy did not communicate with nursing the resident would still be at risk for falls.</p> <p>Interview, on 07/14/15 at 5:30 PM, with the Administrator revealed she was not aware of the request for extra staffing in order to provide the one to one supervision for Resident #1. If she had known she would have approved the request. The facility could have done a better job at identifying the root cause of Resident #1's falls and in the development of relevant interventions to prevent reoccurrence. She stated the facility had identified educational needs in regards to the root cause analysis and care planning process. Further the facility was still in the process of providing additional education to correct these identified issues. Continued interview with the</p>	F 323		



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F 323	<p>Continued From page 27</p> <p>Administrator, revealed they had not identified an issue with communication between nursing and rehab and the root cause analysis, until after surveyor intervention. She further stated the process was to use the Tell A Nurse form; however, this was not a policy. Per interview, it was at the discretion of therapy whether to use the form or not after an evaluation was completed.</p> <p>2. Review of Resident #8's clinical record revealed the facility admitted the resident on 12/21/11 with diagnoses of Human Immunodeficiency Virus, Aphasia, and Cerebral Vascular Accident with Hemiplegia.</p> <p>Review of Resident #8's Quarterly Minimum Data Set (MDS) assessment, completed on 07/17/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99) meaning the resident was unable to complete the interview. However, the resident was able to use a picture board, and answer "yes" and "no" with a nod of the head. The MDS assessment stated the resident was currently on a toileting program and occasionally incontinent of urine and always continent of bowel.</p> <p>Review of the Post Fall Analysis/Plan, dated 07/27/15, revealed Resident #8 had a history of falls and experienced another fall, on 07/27/15 at 11:00 PM, while trying to transfer to the toilet unassisted after returning from a smoke break; no injuries were noted on the form. The analysis stated the resident was found on the floor on his/her left side with the upper body in the adjoining resident's room. Recommendations made from the interdisciplinary team review were</p>	F 323			

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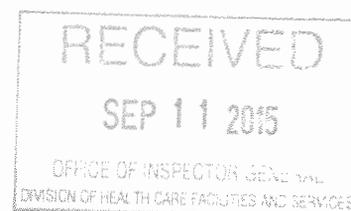
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F 323	<p>Continued From page 28</p> <p>to immediately reassess resident, reassess resident's toileting program needs, refer to therapy for screen or evaluation, and for restorative to see as ordered, monitor for changes for three days and report to physician any change in condition.</p> <p>Interview with Restorative Nursing Assistant (RNA) #2, on 08/11/15 at 11:55 AM, revealed at times the restorative aides were pulled to work as a Certified Nursing Assistant (CNA). RNA #2 stated the facility was short CNA's on 08/08/15 and she was not able to complete the restorative program requirements for Resident #8.</p> <p>Interview with Assistant Director of Nursing (ADON), on 08/10/15 at 9:00 AM, revealed she worked remotely from home and completed the Post Analysis Fall form after Resident #8's fall on 07/27/15. She had identified Resident #8 had not received the daily restorative care the resident should have and thought maybe the resident had experienced a decline in ability so she ordered; a therapy screen/evaluation, the resident's toileting program to be reevaluated and for restorative to provide services daily.</p> <p>Review of the Comprehensive Care Plan for Resident #8 revealed a plan was developed on 07/28/10, with updated goals and a target date for 11/13/15. The problem stated the resident was at risk for falls due to a history of falls, balance problems during transfers due to an immobility syndrome related to Cerebral Vascular Accident with right sided hemiparesis. The goal stated the resident would safely transfer with staff assistance with no injuries through next review. The approaches directed physical therapy to perform an evaluation to determine a possible</p>	F 323			

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F 323	<p>Continued From page 29</p> <p>decline in transfer ability, staff to assist with toileting as resident would allow and keep environment well lit and free of clutter, restorative nursing as ordered for transfer training, sit to stand at hand rail or hemi-walker times three, assess for increased joint stiffness, decline in mobility or signs and symptoms of pain.</p> <p>Review of Certified Nursing Aide Care sheet, undated, revealed no mention of Resident #8's toileting program needs or schedule. The form noted the resident required assistance with transfers and extensive assistance with activities of daily living; however, not the assistance of how many. The only special precaution listed on the form was for the resident to have a mat to the bedside.</p> <p>Review of the resident's clinical record revealed no evidence a therapy screen was completed after the fall on 07/27/15. Review of the Physical Therapy Screen Form, dated 08/05/15, revealed the resident was screened on 08/05/15 and therapy noted an evaluation was not indicated for Resident #8 and stated the resident had not experienced a decline.</p> <p>Review of Post Fall Analysis/Plan, dated 08/08/15, revealed Resident #8 experienced a fall on 08/08/15 at 10:00 AM again at the time of the facility's smoking break. The documentation stated the resident had recently been evaluated by therapy and required extensive assistance with transfers. A toileting program was implemented on 08/05/15 related to functional incontinence; however, the resident attempted to transfer self to the toilet. A Restorative Program was ordered; however, the resident had only received twelve (12) of twenty-eight (28) sessions and from</p>	F 323		



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F 323	<p>Continued From page 30</p> <p>07/27/15 to 08/07/15 the resident had only received two (2) fifteen (15) minute sessions. The recommended interventions were to perform an immediate assessment to report changes to the physician, provide assistance with transfers and provide toileting program and restorative as ordered. These interventions were the same interventions listed on the 07/27/15 Post Fall Analysis form and no new interventions were added to the falls care plan to prevent another fall for Resident #8.</p> <p>Interview with LPN #12, on 08/10/15 at 8:35 AM, revealed the staff was busy assisting other residents when they heard Resident #8 hollering for assistance. The resident was found on the floor in the bathroom after trying to transfer to the toilet unassisted. LPN #12 stated she was not sure what the toileting program requirements were for Resident #8 or if restorative was helping with toileting. The facility had been using the restorative nursing staff as Certified Nursing Assistants when the aides called in and they needed staff to cover and believed they had done so on the day of Resident #8's fall on 08/08/15.</p> <p>Interview with the Restorative Nurse on, 08/05/15 at 1:32 PM, revealed staff normally just left her a note or verbally requested she perform an evaluation for a resident. She had not received one for Resident #8 and had not completed a toileting program or restorative reassessment. On 08/06/15 at 10:40 AM, the Restorative Nurse stated she had revised Resident #8's plan of care related to Functional Incontinence and the resident would be offered toileting assistance before and after supper, at bedtime and every three (3) hours during the night and as necessary.</p>	F 323			

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F 323	<p>Continued From page 31</p> <p>Interview with the Restorative Nurse, on 08/11/15 at 9:05 AM, revealed there were ninety six (96) residents on the restorative program and four (4) staff to deliver the restorative program requirements. The restorative staff consisted of three (3) restorative aides and her to deliver the program requirements seven (7) days a week. She stated she worked the weekend on 08/08/15 in a supervisory role and was not aware Resident #8 had experienced another fall.</p> <p>Continued interview with the ADON, on 08/10/15 at 9:00 AM, revealed the resident experienced another fall on 08/08/15 trying to transfer to the toilet again. She again completed the Post Analysis Fall Form and put the same interventions from the 07/27/15 fall as recommendations. She stated if these interventions were implemented they would prevent another fall. She stated when staff provide the toileting program as scheduled the resident would be assisted to the toilet and falls would be prevented.</p> <p>Interview with the Rehabilitation Director, on 08/06/15 at 11:30 AM, revealed when Resident #8 fell on 07/27/15 she was not told of the request for the screen until 08/05/15 and it was done immediately after being requested. Normally she finds out about the request in the morning meeting the day after the fall; however, after reviewing her notes she stated the team did not request a therapy screen for Resident #8's fall during the morning meeting on 07/28/15 or any day after that.</p> <p>Interview with the Director of Nursing, on 08/12/15 at 5:20 PM, revealed she did not</p>	F 323		

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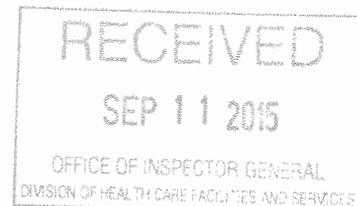
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F 323	<p>Continued From page 32</p> <p>remember speaking about Resident #8's falls or care plan interventions related to toileting or restorative programs. Communication amongst the interdisciplinary team was an identified concern. She stated the facility needed to work on identifying the root cause after an incident or fall occurred in order to develop and implement relevant interventions to prevent another occurrence.</p> <p>Interview with the Administrator, on 08/12/15 at 5:50 PM, revealed after Resident #8's fall the facility should have ensured the resident received the required assistance for toileting and restorative that was care planned. The Administrator stated she made rounds daily, had an open door policy and insisted staff call her when there were falls or other concerns; however, there were issues she was still not aware of, like Resident #8's late therapy screen. She stated she had identified the facility staff still needed additional education and required supervision to ensure communication occurred and resident needs were met. She stated they were working on that presently.</p> <p>Observation, on 08/10/15 at 3:00 PM, of Resident #8 revealed the resident was outside in the courtyard smoking. Interview with Resident #8 at this time revealed the resident could answer "yes" and "no" questions by shaking his/her head and saying yes and no. The resident shook head up and down and said "yes" to remembering the falls that occurred on 07/27/15 and 08/08/15, where he/she attempted to transfer without assistance to the toilet and fell. Resident #8 responded "yes" and shook head up and down as to whether he/she asked for assistance by yelling or using call light. The resident was asked if anyone</p>	F 323			

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F 323	<p>Continued From page 33</p> <p>answered the yells for assistance and the resident shook his/her head back and forth and said "no". The resident shook head up and down and said "yes" and began to cry regarding ever having incontinent episodes due to staff not assisting with toileting timely. Again the resident shook head up and down and said "yes" when asked if this was upsetting.</p> <p>3. Review of Resident #10's clinical record revealed the facility admitted the resident on 01/07/14 with diagnoses of Dementia with Behavioral Disturbances, Spinal Stenosis, Depression and Macular Degeneration.</p> <p>Review of Resident #10's Annual Minimum Data Set (MDS) assessment, completed on 06/11/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of three (3) meaning the resident was not interviewable.</p> <p>Review of the Comprehensive Care Plan for Resident #10 revealed a plan was developed on 01/08/14, with updated goals and a target date for 10/01/15. The problem stated the resident was at risk for falls due to history of falls due to unsteady balance, attempts to get up unassisted and anxious behavior. The goal stated the resident would not receive any injuries from falls through the next review. The approaches directed the staff to ensure the bed and seat belt alarm to wheelchair was in place at all times and offer diversional activities such as snacks, music or pictures and toilet as scheduled.</p> <p>Review of the Post Fall Analysis/Plan forms, dated 07/10/15 at 4:22 PM, 08/01/15 at 3:35 PM and 08/03/15 at 9:00 AM (day shift falls), revealed</p>	F 323			



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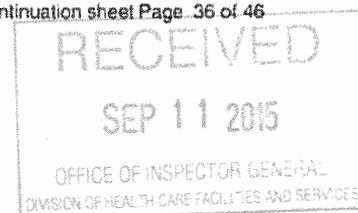
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F 323	<p>Continued From page 34</p> <p>Resident #10 experienced non-injury falls from the wheelchair on each of these dates. Continued review of the documentation revealed with all three falls the resident was found on the floor in the common area by the nurses station, and the seat belt alarm was not sounding and was found to be turned off. Review of interventions to be put in place after each fall revealed they were the same for all three falls. The interventions were to immediately assess the resident and monitor for three (3) days, ensure the proper working order of the seat belt alarm and to ensure it was turn on each shift, and to provide supervision and offer diversional activities of resident's choice.</p> <p>Review of the resident's clinical record revealed these checks could not be located and the facility was unable to provide evidence that the seat belt alarm was checked each shift for proper working order.</p> <p>Interview with East Unit Nursing Supervisor, on 08/10/15 at 3:50 PM, revealed she was working on 07/10/15 and had seen a resident "fiddling" with Resident #10's seat belt alarm box prior to the resident being found on the floor and thought maybe that resident might have turned it off. The nurse stated she was busy with the smoking residents and did not follow up regarding the wandering resident.</p> <p>Interview with the House Supervisor, on 08/10/15 at 3:40 PM, revealed the UM was busy on 07/10/15, she found out the staff was busy with other residents during the falls and she did not address the suspected resident who had been turning the alarms off. There was no system to check alarms and staff could not always meet Resident #10's needs and could not provide one</p>	F 323		

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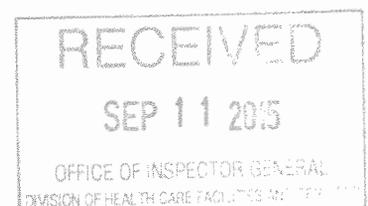
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F 323	<p>Continued From page 35 on one supervision.</p> <p>Interview with CNA #10, on 08/10/15 at 3:10 PM, revealed when she worked she usually was assigned to take care of Resident #10. She was not sure if she worked on the days Resident #10 fell and just could not remember. She stated if she did work she was probably busy with other residents when Resident #10 fell. She stated she would check the resident's alarm to ensure it was on each time she put the resident in the wheelchair, but there was no required documentation for that check. She continued to state she had never seen Resident #10 turn off the alarm and did not think the resident would be able to do that. She stated she had seen other wandering residents "fiddle" with Resident #10's alarm and they had one resident that went around turning off alarms regularly. She stated when the resident needed to go to the bathroom or was bored was when the resident would attempt to get out of the wheelchair. She stated if you took care of those two needs the resident would not attempt to get up.</p> <p>Interview with East Unit Nursing Supervisor, on 08/10/15 at 3:50 PM, revealed nursing did not document the verification that resident alarms were checked daily or per shift for functionality. She stated there were no orders to do so for any resident with an alarm. The Nursing Supervisor also stated Resident #10 was provided items such as puzzles/coloring books and crayons for diversional activities. But usually did not attend the scheduled activities because the resident needed constant redirection by staff due to setting off the seat belt alarm.</p> <p>Interview with the Director of Nursing, on 08/11/15</p>	F 323			



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F 323	<p>Continued From page 36</p> <p>at 1:00 PM, revealed the facility did not document if the residents' bed/chair/seat belt alarms were checked for functionality. She stated that would have to be put in as a physician's order for it to transfer over to the medication or treatment record for the nursing staff to provide documentation that they were checked for proper functioning. Documenting those types of checks had not been a routine practice for the facility. However, review of the falls analysis form revealed the staff were to check the alarm every shift. She had identified the staff was not providing the necessary supervision or diversional activities to prevent the resident from trying to get up from the wheelchair unassisted. The DON stated she was aware of the wandering resident who turned the alarms off; however, no interventions had been put in place.</p> <p>Interview with Administrator, on 08/11/15 at 1:45 PM, revealed the Director of Nursing and Assistant Director of Nursing brought it to her attention that the interdisciplinary team did not determine the interventions documented on the Post Falls Analysis form after each of Resident #10's falls were all the same and that each time the resident's alarm was found to be turned off. She stated all she could do was apologize the interventions were not effective in preventing another fall. The facility was still in the learning process when it came to determining the root cause of falls and developing care plan interventions after incidents.</p> <p>The facility took the following actions to remove the Immediate Jeopardy on 08/01/15 as follows:</p> <p>1. On 06/08/15 Resident #1 was assessed by RN #2 the Nursing Supervisor and immediately sent</p>	F 323		



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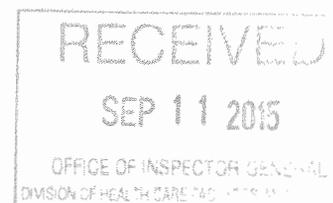
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F 323	<p>Continued From page 37 to the hospital.</p> <p>2. On 07/16/15, the Director of Rehabilitation and Executive Director (ED) reviewed the Therapy Evaluation policy and agreed the policy was followed and that communication would be enhanced by updating to include "Tell a Nurse" for the evaluation process. This was also discussed on the phone with Kentucky Area Vice President of Golden Living on 07/16/15. The previous policy did not include communication upon evaluation. This was completed on 07/16/15.</p> <p>3. On 06/09/15 the facility started training supervisors on one to one (1:1) supervision staffing by the Administrator and Director of Nursing (DNS); seventy-seven (77) staff had been trained. Training completed 07/31/15. Any staff that had not been trained will not work until training had been completed. Starting on 06/09/15 Nurses and CNAs received training on the meaning of 1:1 by DNS. Seventy-seven (77) nurses and CNAs have received training as of 07/31/15. Attendance is checked by DNS, ADNS and Nursing Supervisors. If a CNA or Nurse was on leave or vacation, they were scheduled to have the education prior to shift upon return. Golden Living Camelot does not utilize Agency staffing.</p> <p>4. One on one competency audit interviews for the one on one (1:1) supervision training follow-up started 07/29/15 with Certified Nursing Assistant (CNA) and nursing staff, Registered Nurse (RN), and Licensed Practical Nurse (LPN). This was completed by Nursing Consultant, ED, and Nursing Supervisors. Forty-eight (48) interviews had been done. Going forward five (5) interviews would be done on varied shifts each</p>	F 323			

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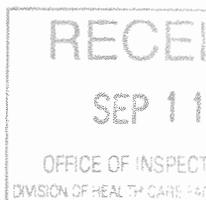
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F 323	<p>Continued From page 38</p> <p>day for two (2) weeks and then five (5) times per week for one month. Any deficits were retrained at the time of the interview with the CNA or Nurse.</p> <p>5. Rehabilitation Manager identified residents that had been evaluated by therapy in the last three (3) months or on therapy caseload as of 07/23/15 without any issues noted. Thirty-seven (37) residents had been evaluated. Thirty-seven (37) care plans were revised by nursing and therapy to include gait and transfer information. Those care plans had been reviewed and revised as indicated. On 07/17/15 CNA care cards were revised to assure consistent language was used throughout the building for CNA care.</p> <p>6. Training on Tell a Nurse program was done with ten (10) therapists starting 07/16/15 by the Director of Rehabilitation. Training with therapists was completed on 07/24/15. Starting on 07/16/15, DNS trained forty-three (43) of forty-four (44) nurses on the Tell a Nurse program. Training for nurses was completed on 07/30/15. The one remaining nurse would be trained prior to working a shift by the DNS, Assistant Director of Nursing Services (ADNS), or Nursing Supervisor.</p> <p>7. Checked the Tell A Nurse binders on each nursing unit for communication sheet, check care plan and care sheet to assure any changes were added to the care plan and the CNA care sheet. Audits were completed on 07/15/15 through 08/04/15 by DNS, ADNS, ED, Nursing Supervisor or Nurse Consultant subsequent to Tell A Nurse form to observe service and confirm it was consistent with Tell A Nurse information. On 07/23/15 the Nurse Consultant completed an audit of the Tell a Nurse process. Each binder</p>	F 323			



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F 323	Continued From page 39 was reviewed to assure communication sheets were in place, and care plans and care sheets were reviewed to assure accuracy. Three (3) care plans were updated or changed by the Nurse Consultant. Follow up was completed with the nurse. The modifications included more specific information to a care plan regarding transfers, and supervision to licensed nurse to assure update of CNA care sheet. On the two other cases it was assured that the care plan and CNA care sheets matched and both were updated.  8. Starting 07/30/15 when a 1:1 was done, the Unit Manager brought the 1:1 supervision documentation to the clinical start up for a check of the documentation. The Administrator, DNS, or Nursing Supervisor would complete an audit of 1:1's at varied times daily to assure one to one supervision was being done according to protocol.  9. Starting on 07/23/15 the DNS, ADNS, or Nurse Supervisor continue to check that changes were made to the care plans from therapy evaluations at the daily clinical start up. The nurse brought the binder to clinical start up, when a Tell a Nurse form had been completed. Therapy, Nursing Consultant/ DNS or ADNS checked the Tell A Nurse form and assured care plan updates and care sheet updates were completed using the Tell A Nurse Audit Form.  10. An Ad Hoc Quality Assurance Process Improvement (QAPI) meeting was held on 07/23/15 to discuss and validate that the results of the therapy evaluations were updated to the care plans and the CNA care cards. This was conducted by the Administrator, DNS, ADNS, Social Worker, Therapist, and Medical Director	F 323			



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F 323	<p>Continued From page 40</p> <p>and will continue weekly times four (4) weeks, then bi-weekly times four (4) weeks, then monthly thereafter. The monitoring and auditing of the Tell A Nurse program would be done by the DNS, ADNS, or Nurse Supervisor. Additional Ad Hoc QAPI held on 07/29/15 to update system of checks and validate current systems. Ad Hoc QAPI for entire system held on 07/29/15 including Competency Interview system.</p> <p>The State Survey Agency validated the removal of Immediate Jeopardy on 08/12/15 as follows:</p> <ol style="list-style-type: none"> <li>1. Review of Resident #1 nurses note, dated 06/08/15, revealed Resident #1 was assessed by RN #2 the Nursing Supervisor and sent to emergency department post fall on 06/08/15 at 5:17 PM.</li> <li>2. Review of "Evaluation-Plan of Care policy, undated, and "Tell A Nurse" form, undated, on 08/10/15, revealed the Therapy Evaluation policy and procedure was reviewed and updated to include the Tell A Nurse form by the Director of Rehabilitation, ED, and the Kentucky Area Vice President of Golden Living. Interview with the Rehabilitation Director, on 08/10/15 at 11:00 AM, and Administrator, on 08/10/15 at 8:45 AM, revealed the policy was reviewed and procedure updated to include the Tell A Nurse communication form and completed on 07/16/15.</li> <li>3. Review of in-service records, dated 06/09/15, revealed seventy-seven (77) staff had been trained by the Administrator and Director of Nursing on one to one staffing. Training included the definition of 1:1 staffing, steps to provide 1:1 supervision, and the required documentation for 1:1 supervision. Interview with Nursing Supervisor</li> </ol>	F 323			

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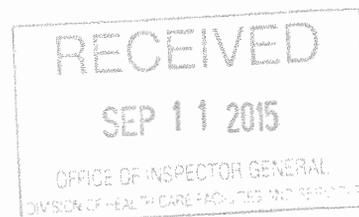
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OMB NO. 0938-0391

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	Continued From page 41 #2, on 08/10/15 at 3:50 PM and Licensed Practical Charge Nurse #3 revealed they had received training on 1:1 resident care and could correctly define 1:1 and knew what to document regarding 1:1 supervision.  4. Review of one on one (1:1) Competency Interview audits and Daily Assignment Sheets, revealed forty eight (48) staff, including CNAs, RNs, and LPNs, on varied shifts had been interviewed regarding 1:1 supervision. Interviews began on 07/29/15 and were completed daily until 08/09/15 by Nursing Consultant, Administrator, and Nursing Supervisors. Interview with Administrator, on 08/10/15 at 8:45 AM, revealed she conducted 1:1 Competency interviews, and had done more than the required five each day during the first 2 weeks. She stated any staff person requiring retraining was done at the time of the interview. Interview with Certified Nursing Assistant #10, on 08/10/15 at 3:10 PM, revealed she received training on 1:1 supervision and had been interviewed after training to determine if she could recite what she was required to do. Interview with Licensed Practical Nurse #7, on 08/11/15 at 1:55 PM, stated she had received training regarding 1:1 supervision and had been interviewed afterwards to check if she knew her responsibility regarding 1:1 supervision. She stated she was to ensure the CNA's documented their 1:1 observations and that staff could not leave the resident unless provided relief. Interview with Registered Nurse #2, on 08/10/15 at 11:00 AM, revealed she had received training on 1:1 supervision and had been interviewed after the training to determine her knowledge of the 1:1 process. She stated her responsibility was to ensure documentation was completed by the CNA and that staff was not to leave the resident	F 323			

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F 323	<p>Continued From page 42 unless another staff member relieved them.</p> <p>5. Review of the facility's document titled Level of Assist from 05/01/15 to current, revealed thirty-seven (37) residents had been evaluated by therapy during that time. Record review of those thirty seven (37) resident care plans and CNA care cards, revealed gait and transfer information was included on the care plans and CNA care cards. Interview with Rehabilitation Manager, on 08/10/15 at 11:00 AM, revealed she identified 37 residents had been evaluated by therapy in the last 3 months, and resident care plans were updated to include gait and transfer information. Interview with Director of Nursing, on 08/10/15 at 10:40 AM, revealed CNA care cards were revised on 07/17/15 to assure consistent language was used throughout the building.</p> <p>6. Review of in-service records, dated 07/16/15, revealed ten (10) therapists had been trained on Tell a Nurse program by the Director of Rehabilitation. Interview with the Director of Rehabilitation, on 08/10/15 at 11:00 AM, revealed she had trained 10 therapists on the Tell A Nurse program. Interview with the Occupational Therapist, on 08/10/15 at 11:10 AM, revealed she had received training by the Director of Rehabilitation regarding the Tell A Nurse program which included filling out the form and verbally providing a report to nursing staff of their assessment findings.</p> <p>Additional review of in-service record, dated 07/16/15, revealed forty-three (43) nurses had attended training on the Tell A Nurse program by the DNS. Interview with Licensed Practical Nurse #7, on 08/11/15 at 1:55 PM, revealed he/she had been trained on the Tell A Nurse program,</p>	F 323			



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F 323	<p>Continued From page 43</p> <p>including the location and purpose of the Tell a Nurse binder, and the process for updating care plans and CNA care sheet after therapy evaluation.</p> <p>7. Review completed on 08/10/15, of the Tell A Nurse Binder communication sheets, resident care plans, and CNA care sheets, revealed changes and updates from the Tell A Nurse form were updated on the resident care plan and CNA care sheets.</p> <p>Interview with the Administrator, on 08/10/15 at 8:45 AM, and Director of Nursing, on 08/10/15 at 10:40 AM, revealed they had conducted audits of the Tell A Nurse communication sheet, resident care plans, and CNA care sheets to confirm that information was consistent on all documents.</p> <p>Interview with Nurse Consultant, on 08/10/15 at 10:45 AM, and Nursing Supervisor #2, on 08/10/15 at 3:50 PM, revealed they completed audits of the Tell A Nurse process on 07/23/15, including reviewing the Tell A Nurse binders to assure communication sheets were in place, and care plans and care sheets were reviewed for accuracy. In addition, they revealed three (3) care plans were updated to include more specific information regarding transfers, and supervision to licensed nurse to assure update of CNA care sheet. Review of the three care plans, revealed care plans and CNA care sheets were updated with therapy's recommendations for assistance with transfers and walking.</p> <p>8. Observation of the clinical start up meeting, on 08/06/15 at 9:00 AM, revealed the Unit Manager of the Alzheimer's Care Unit (ACU) had one resident on 1:1 supervision. The 1:1</p>	F 323			

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F 323	<p>Continued From page 44</p> <p>documentation was discussed and reviewed by the DON. Review of the 1:1 documentation for the resident, revealed 1:1 documentation was complete, and the ED, DNS, or Nursing Supervisor had completed a daily audit of the documentation. Review of Golden Living Center Camelot E.D. Stand-Up Meeting sheets from 07/31/15-08/05/15, revealed 1:1 documentation was reviewed daily during the clinical start up meeting.</p> <p>9. Observation of the clinical start up meeting, on 08/06/15 at 9:00 AM, revealed the Tell A Nurse binders on each nursing unit were reviewed with no new Tell A Nurse forms completed the previous day. Review of the Tell A Nurse forms from 07/23/15, resident care plans, and CNA care sheets, revealed therapy evaluations from the Tell A Nurse form were updated on the resident care plan and CNA care sheets to reflect therapy recommendations. Interview with the DNS, on 08/12/15 at 5:20 PM, revealed she checked the Tell A Nurse form and assured care plans and CNA care sheets were updated using the Tell A Nurse Audit Form.</p> <p>10. Review of the Ad Hoc Quality Assurance Process Improvement (QAPI) sign in sheets, and agendas dated 07/23/15 and 07/29/15, revealed the Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, Therapist and Medical Director were in attendance. Interview with the Administrator, on 08/12/15 at 5:50 PM, revealed the QAPI team met weekly if not more frequently. In addition, the QAPI team discussed the results of therapy evaluations and ensured care plans and CNA care cards were updated.</p> <p>Interview with the Director of Nursing, on</p>	F 323			

