

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

PRINTED: 03/09/2015
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 03/03/2015
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	INITIAL COMMENTS An Abbreviated survey was initiated on 02/26/15 and concluded on 03/03/15 to investigate KY 22883 and KY 22884. The Division of Health Care substantiated the allegations with related deficiencies cited.	F 000	<u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u>		
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	F 157 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 was transferred to Baptist Hospital East on 02/03/2015. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Current vital signs for all residents will be reviewed 03/30/2015 by the Unit Managers and/or Charge nurse for abnormal values. If the Physician and/or Nurse Practitioner are unaware of the abnormal values, they will be notified by the unit manager	3/31/15	

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

X C Jole

TITLE

X NHA

(X6) DATE

X 3/31/15

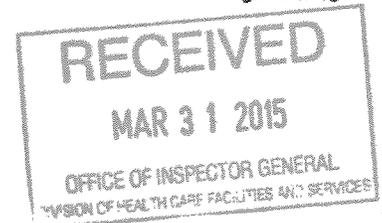
ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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If continuation sheet Page 1 of 48

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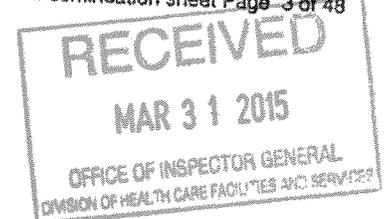
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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure residents physicians were notified after a change in condition such as a fever or side effects from medication administration for one (1) of six (6) sampled residents (Resident #1). The facility administered an as needed antianxiety without documentation of side effects, when Resident #1 sustained a decline in condition, requiring the transfer to a hospital for treatment. The facility failed to notify the physician until the need for hospitalization. The findings include: Review of the facility's policy regarding Notification of Change in Resident Health Status, dated November 2014, revealed a guideline statement to ensure proper notifications were made when a resident had a change in health status. The center would consult the resident's Physician, Nurse Practitioner or Physician Assistant, and if known, notify the resident's legal representative or an interested family member when there was: acute illness or a significant change in the resident's physical, mental or psychosocial health; or, a need to alter treatment significantly i.e. a need to discontinue an existing form of treatment due to adverse consequences; or, to commence a new form of treatment; or, a decision to transfer or discharge the resident from the center. Appropriate notification time was immediate.	F 157	and/or charge nurse. All residents receiving anti-anxiety as needed will be reviewed for possible side effects by the Director of Nursing (DNS) and/or Assistant Director of Nursing (ADNS). The Physician and/or Nurse Practitioner will be notified of residents experiencing side effects from as needed anti-anxiety medications. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The Director of Clinical Education (DCE) will educate all licensed nursing staff and certified nursing assistants on change of condition and using Stop and Watch tools to communicate change of condition 03/30/2015. The Stop and Watch tool is located at each nurses station for changes noted that are not life threatening. The DCE will audit five licensed nursing staff and/or certified nursing assistants per week for their knowledge and understanding of the change in resident condition for four weeks. The audits will be turned into the DNS and/or ADNS. The DNS/DCE will educate licensed nursing staff on Physician notification		



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F 157	<p>Continued From page 2</p> <p>Review of Resident #1's clinical record revealed the facility admitted the resident on 01/23/15 with diagnoses of Alzheimer's, Anxiety, Malnutrition, Dysphagia, Hypertension and Encephalopathy. The resident was at the facility for eleven (11) days before developing a change in condition that required a transfer to the hospital on 02/03/15.</p> <p>Review of Resident # 1's, 5-day Scheduled Minimum Data Set (MDS) assessment, completed on 01/30/15, revealed the facility was unable to assess the resident using a Brief Interview for Mental Status (BIMS) exam due to the resident was rarely/never understood. Continued review of the MDS revealed the facility assessed the resident as needing limited assistance with eating, and did not indicate signs or symptoms of a swallowing disorder. The MDS indicated on the 5-day assessment that the resident had only walked once or twice since admission and needed the assistance of two to transfer.</p> <p>Interview with Resident #1's Psychiatrist, on 03/02/15 at 2:45 PM, revealed Resident #1 was admitted to the facility from an acute care hospital gero-psych unit. He stated the resident was significantly cognitively impaired and was experiencing relocation shock with behaviors. The Psychiatrist stated the staff reported the resident was exhibiting behaviors of getting up out of the bed and chair. He stated the risk verses benefit of falling or not was his rationale for prescribing the 0.5 mg of Ativan for the resident's restless behavior. The Psychiatrist stated he assessed the resident and spoke with the resident's spouse on 01/30/15. He stated at that time the resident was awake and alert. He stated on admission the resident was taking</p>	F 157	<p>when a change of condition occurs 03/04/2015. The unit manager and/or charge nurse will review vital signs daily for four weeks to ensure any abnormal values have been reported to the Physician and/or Nurse Practitioner.</p> <p>The DCE will educate licensed nursing staff on the use of as needed medications and side effects of anti-anxiety medications. The DNS, ADNS and/or Weekend Supervisor will monitor the use of as needed anti-anxiety medication and possible side effects daily for four weeks. Regular use of as needed medications and/or side effects will be referred to the Physician and/or Nurse Practitioner.</p> <p>The DNS and/or ADNS will review charting on all resident's receiving an anti-anxiety as needed, two times a week to ensure documentation of side effects are included beginning 03/04/2015. Reviews will be conducted two times a week for four weeks, then monthly for four months. Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance</p>		



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F 157	Continued From page 3 Haldol, Aricept, Namenda and Remeron. He stated he discontinued the resident's Haldol medication because the resident was drooling and leaning forward in the wheel chair when he assessed the resident on 01/27/15. He stated nursing had not notified him of this behavior prior to his assessment. He stated at that time he prescribed Depakote 125 mg by mouth three times a day and 250 mg by mouth at bedtime for behaviors. He stated he ordered 0.5 mg of Ativan to be given as needed for agitation every six hours and the Ativan was for nursing to administer when the resident experienced break through behaviors. He stated medications ordered as needed were to be used few and far between. He stated his goal was to discontinue the as needed Ativan prescription once the Depakote was at a therapeutic level and the resident's behaviors were better controlled. He stated he was in the facility on 02/03/15 the day the resident was transferred to the hospital. He stated the resident was lethargic and had experienced a decline with a possible diagnosis of Aspiration Pneumonia. He stated he did not know the resident was receiving the 0.5 mg Ativan without documented signs and symptoms of break through behaviors of agitation. He stated since he was not there it was up to nursing judgment on when or whether to give the 0.5 mg of Ativan. He stated nursing did not discuss the resident behaviors or request him to change the as needed Ativan order with him prior to or on 02/03/15. The Psychiatrist stated when he discussed the resident's condition with the spouse the spouse informed him they were not happy with the nursing care Resident #1 was receiving at the facility.	F 157	How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS and/or ADNS will bring the results of the audits to the QAPI committee for three monthly meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits. Each resident actively receiving an as needed anti-anxiety medication will be monitored every 90 days as part of the Gradual Dose Reduction (GDR) meeting. Medication use will be monitored with quarterly review assessments by DNS, Social Services, Physician and consulting Pharmacist for appropriate use and dosage.		

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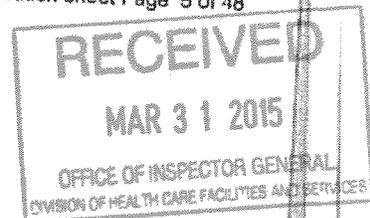
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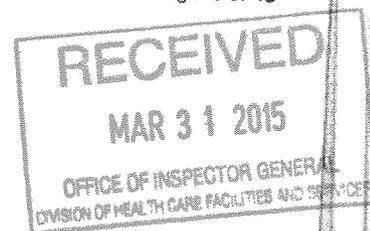
F 157	<p>Continued From page 4</p> <p>Review of the nursing notes, dated 01/24/15 at 4:35 PM, revealed nursing documented Resident #1 was administered Haldol 0.5 mg by mouth with no documented signs and symptoms of behaviors indicating agitation.</p> <p>Review of the Nursing documentation of administering a second dose of Haldol 0.5 mg, on 01/24/15 at 8:37 PM, with no documented signs or symptoms of behaviors indicating the resident was experiencing agitation.</p> <p>Continued review of the Nursing documentation of administering Haldol 0.5 mg by mouth, on 01/25/15 at 6:50 PM, with no documented sign or symptoms of behaviors indicating agitation. A general note made by Nursing, on 01/25/15 at 11:50 PM, five hours after giving a dose of Haldol, stated that at 7:00 PM Haldol was given for restless/anxious behavior with no other symptoms documented.</p> <p>Nursing documented, on 01/26/15 at 3:26 PM, the administration of Haldol 0.5 mg by mouth to Resident #1 with no description of behaviors indicating agitation or anxiety. Again on 01/26/15 at 6:55 PM nursing administered 0.5 mg Haldol intramuscular with no documented signs or symptoms of behaviors indicating agitation or anxiety. Nursing documented a general note one hour and thirty five minutes after Ativan administration, on 01/26/15 at 8:30 PM, which stated the resident had required one-on-one attention from staff this shift, attempting to transfer self unsafely from wheelchair, safety alarm sounding. The resident's balance was very unsteady when ambulating with staff assist. The resident became slightly agitated with redirection from staff to sit back in wheelchair after several of</p>	F 157		
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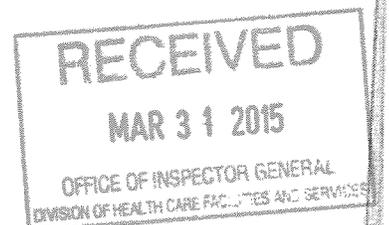
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F 157	<p>Continued From page 5 leaning forward.</p> <p>Review of the nursing documentation made prior to 01/27/15 revealed no documented evidence nursing assessed the resident for signs and symptoms of Haldol side effects after each time the medication was administered or that the physician was notified of signs or symptoms of Haldol side effects</p> <p>Review of the Nursing note, on 01/27/15 at 1:23 PM, revealed the resident was leaning forward and drooling more today than yesterday. The Psychiatrist was in to see the resident and thought the same, that the leaning and drooling was a side effect of the Haldol. New orders received to discontinue the Haldol and begin Depakote and as needed Ativan.</p> <p>Continued review of the nursing notes revealed Resident #1 received the first 2 doses of Ativan 0.5 mg on 01/28/15 at 8:38 AM and 8:15 PM and 2 doses of Ativan 0.5 mg, on 01/29/15 at 3:37 AM and 6:18 PM with no documented signs or symptoms of behaviors indicating agitation or if the resident exhibited side effects.</p> <p>Review of the Nursing documentation of the administration of 3 doses of Ativan 0.5 mg on 01/30/15 at 8:34 AM, 1:55 PM, and 8:20 PM. Nursing documented the administration of 2 doses of Ativan 0.5 mg on 01/31/15 at 8:29 AM and 3:49 PM. Nursing documented the administration of 3 doses of Ativan 0.5 mg on 02/01/15, and 1 dose of Ativan 0.5 mg on 02/02/15 at 8:05 AM. Review of nursing documentation for each Ativan administration revealed nursing did not document resident signs</p>	F 157			



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F 157	<p>Continued From page 6 or symptoms of agitation or if the resident was exhibiting side effects.</p> <p>Interview with Speech Therapist, on 03/02/15 at 1:25 PM, revealed she was consulted to assess Resident #1's swallowing ability on 01/26/15. She stated she had downgraded Resident #1's diet from mechanical soft texture to puree after assessing the resident during the breakfast meal on 02/02/15. She stated on 02/02/15 she attempted to feed Resident #1 lunch; however, the resident was very lethargic and after putting a spoon full of pureed food into the resident's mouth the resident clamped his/her jaw shut and just held the liquid in their mouth. She stated she had to use a tongue depressor to open the resident's mouth and scoop out the liquid to ensure the resident did not aspirate the liquid into his/her lungs. She stated she was worried about the resident's inability to clear the throat so she did not continue.</p> <p>Review of the Physician orders, dated 01/23/15, revealed the resident was ordered a regular mechanical soft textured diet and on 02/02/15 it was changed to a regular pureed textured diet with thickened liquid honey consistency.</p> <p>Continued review of the Nursing notes, on 02/02/15 at 12:41 PM, revealed Resident #1 presented with lethargy and inability to clear his/her throat, and lung sounds were present with rhonchi (course rattle). The resident was unable to swallow or cough with enough force to clear the throat. Blood Pressure 122/64, Heart Rate 87, Oxygen Saturation 88% (normal 95-100% if level is below 90 % it was considered low resulting in</p>	F 157			



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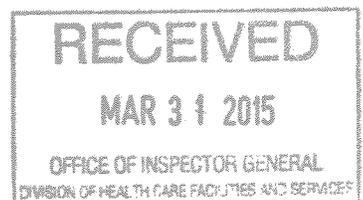
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F 157	<p>Continued From page 7</p> <p>not enough oxygen in the blood) suctioning was performed and oxygen saturation increased to 92%.</p> <p>Interview with Registered Nurse (RN) #5, on 02/27/15 at 11:15 AM, revealed she administered 0.5 mg Ativan to the resident the morning of 02/02/15 at 8:05 AM, and normally after each administration of Ativan 0.5 mg the resident would sleep for 4 to 6 hours. She stated Resident #1 was frequently restless and would constantly try to climb out of the bed and get out of the wheelchair. RN #5 stated nursing was routinely administering the Ativan to try and calm the resident and prevent him/her from trying to get up or walk unassisted by staff.</p> <p>Continued interview with RN #5, revealed she assessed Resident #1 and identified his/her change in condition around noon on 02/02/15. She stated she thought the resident was coming down with something because he/she was not responding normally. She stated she informed Nurse Manager #2 of Resident #1's change in condition and left a note for the physician in the facility communication book. She stated that was the facility's process and the nurse manager was responsible for making the decision to call the physician or wait for the nurse practitioner to come in and assess the resident.</p> <p>Interview with Unit Manager #1, on 02/27/15 at 11:50 AM, revealed RN #6 informed her of Resident #1's change in condition. She stated she knew the nurse practitioner would be in later so she decided to not call the physician at that time. Unit Manager #1 stated the facility used a communication book to document resident</p>	F 157			

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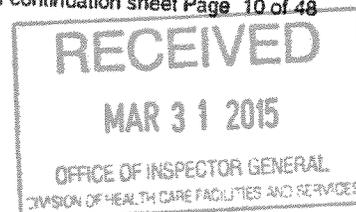
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F 157	<p>Continued From page 8</p> <p>information they wanted to share with the physician or nurse practitioner. She stated RN #6 had put a copy of the nursing note she made in the book but it was removed after the nurse practitioner had seen the resident. Review of the communication book on, 02/27/15 with the Unit Manager, revealed no information was in the book regarding Resident #1's change in condition on 02/02/15 or 02/03/15. She stated after looking back and according to their policy she should have called the physician after RN #6 told her about the resident's change in condition. She also stated the night shift staff should have contacted the physician when the resident was not improving. She stated the nurse practitioner came in sometime after 4:00 PM on 02/02/15, and she informed him of the resident's change in condition. She stated the nurse practitioner diagnosed the resident with a possible case of Aspiration Pneumonia and ordered the resident to receive antibiotics and breathing treatments.</p> <p>Review of the Nurse Practitioner Progress Notes, dated 02/02/15, revealed the resident was seen for lethargy and a diagnosis of possible Aspiration Pneumonia. The plan written was for the resident to receive antibiotics and breathing treatments. The Nurse Practitioner also documented may need to back off of Depakote and Ativan related to Lethargy.</p> <p>Review of the Nursing documentation on, 02/02/15 at 11:21 PM, revealed Resident #1 remained lethargic responding only to tactile/painful stimulus, diminished breath sounds with occasional scattered rhonchi. On 02/03/15 at 12:45 AM, nursing documented Resident #1 was difficult to arouse with no verbal response. Nursing noted Resident #1 had an axillary</p>	F 157		



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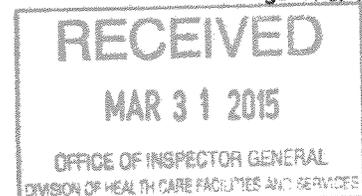
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F 157	<p>Continued From page 9</p> <p>temperature of 101.2; diminished breathe sounds to bilateral lower lobes with expiratory crackles, and the resident's nail beds were pale with sluggish capillary refill.</p> <p>Interview with Registered Nurse (RN) #1 on, 02/27/15 at 2:30 PM, revealed she did not think Resident #1 experienced a change in condition on the night of 02/03/15 when she took care of him/her. She stated since the nurse practitioner had seen the resident earlier in the day she did not see the need to contact the physician about the temperature of 101.2 or change in the nail beds or the change in response to stimulus to only painful. She stated lethargy and difficulty to arouse, in addition to, not responding to painful stimulus was the same to her.</p> <p>Interview with Resident #1's Primary Care Physician, on 03/02/15 at 1:05 PM, revealed he would have wanted to be notified at 11:21 PM when nursing identified the resident had a temperature of 101.2.</p> <p>Continued review of the nursing documentation on, 02/03/15 at 3:20 PM, revealed Resident #1 was not verbally responsive and was receiving oxygen at 4 liters per nasal cannula. Continued review of the medical record revealed there was no documented evidence nursing obtained a physician order for the oxygen therapy.</p> <p>Interview with RN #2 on 03/02/15 at 12:35 PM, revealed she was told in report on the morning of 02/03/15 that Resident #1 did not do well during the night shift. She stated Resident #1 received oxygen when she assumed care of the resident that morning and did not realize an order was not obtained for the administration of the oxygen</p>	F 157			



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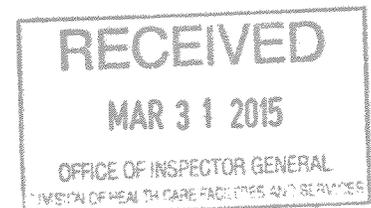
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F 157	<p>Continued From page 10</p> <p>therapy. She stated she was concerned about the resident experiencing dehydration because he/she was not taking in enough fluids. She stated at the end of her shift she obtained another set of vitals and the resident's blood pressure had dropped. She stated she notified the Unit Manager of the resident's change in condition and then left for the day. She stated the Unit Manager took care of notifying the physician of a change in condition.</p> <p>Review of the Nursing documentation on, 02/03/15 at 3:20 PM, revealed Resident #1 was noted to have ash colored nail beds with sluggish capillary refill. Resident #1's blood pressure was 86/50, heart rate 88; oxygen saturation on 4 liters of oxygen was 90%. The resident's lungs were congested bilaterally with productive cough noted. The Nurse Practitioner was notified of the resident's condition and ordered the resident to be sent to the emergency room for evaluation.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 02/27/15 at 1:20 PM, revealed unless it was an emergency, nursing would not contact the physician during the middle of the night. She stated that was the reason for the communication book. She stated nursing would put non-emergent resident information in the book for the physician or nurse practitioner to read when they came into the facility. She stated nursing did not audit medication administration records to determine if, as needed medication, was administered according to the physician orders or if nursing documented signs and symptoms for the medications use. She stated leadership met every day to discuss residents with behaviors or changes in condition that occurred the day</p>	F 157		



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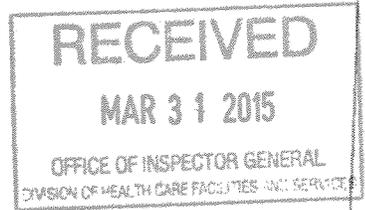
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F 157	<p>Continued From page 11</p> <p>before. However, she did not remember discussing Resident #1's change in condition that occurred on 02/02/15 on the morning of 02/03/15 or prior to the resident being transferred to the hospital.</p> <p>Interview with the Director of Nursing (DON), on 03/02/15 at 2:45 PM, revealed staff should have contacted the physician timely after the resident experienced a change in condition and should have obtained an order for the administration of the oxygen therapy. She stated facility leaders met daily to discuss resident's that had a change in condition or behaviors the prior day; however, they have no evidence they met to discuss Resident #1's behaviors or change in condition. She stated she had no recollection of providing direction to staff regarding Resident #1's care. The DON stated recently several residents and employees contracted a stomach virus and maybe they were distracted with dealing with those situations that Resident #1 just was missed.</p> <p>Interview with the Administrator (ADM), on 03/02/15 at 2:00 PM, revealed he believed leadership discussed Resident #1's behaviors in morning meetings, but had no documentation of those discussions or interventions put in place after those meetings. The ADM stated he was not aware there was a delay in physician notification of Resident #1's change in condition and that the physician would have wanted to be contacted once Resident #1 had a temperature of 101.2. He stated he believed the facility just was unable to get to know the resident well enough to implement the necessary interventions to meet the behavior or activity needs prior to the resident being sent to the emergency room. He stated he</p>	F 157			



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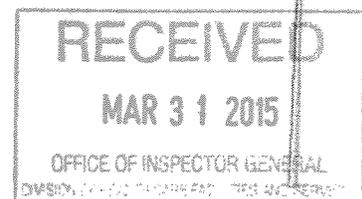
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F 157	Continued From page 12 had not provided direction to nursing or other staff in regards to additional interventions that could have addressed the resident's activity or behavior needs.	F 157	F 225 Investigate/Report allegations/Individuals	3/31/15	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Meeting held with family member on 03/11/2015 to ensure that he understands the facilities visiting policy and what the perception is from the events that occurred between he and his mother. Training has occurred with staff on 03/17/2015, including the Nursing Home Administrator (NHA) on 03/16/2015, to ensure that all incidents are investigated per facility policy. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected. In the event of an employee, resident, friend, visitor or family member who reports an alleged violation regarding potential abuse, neglect, injuries of unknown source, and/or misappropriations of resident property, the NHA, per the abuse policy (revision date 2014), will place the suspected perpetrator on immediate		



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F 225	<p>Continued From page 13 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to conduct a thorough investigation into two (2) separate allegations of potential abuse. The facility failed to conduct interviews of potential witnesses or document the findings and any actions taken after each allegation was made. In addition, the facility failed to notify all appropriate regulatory agencies of the two suspected allegations of abuse for one (1) of six (6) sampled residents (Resident #2).</p> <p>The findings include:</p> <p>Review of the facility's Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property policy, dated December 2014, revealed the company would take the following steps to prevent, detect and report abuse, neglect, injuries of unknown origin and the misappropriation of resident property (alleged violations). If the suspected perpetrator was a vendor, visitor, or volunteer the Executive Director would take all appropriate measures immediately to secure the safety and wellbeing of the resident. Measures may include disallowing contact between the resident and alleged perpetrator while an investigation was conducted. Any employee who suspected an</p>	F 225	<p>investigatory suspension while the NHA completes the investigation of the alleged abuse or neglect. The NHA will have the suspected perpetrator, including family members, leave the property immediately for the protection of the resident.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>On 3/16/15, the NHA and DNS were re-educated on the Abuse Policy (revision date 2014) regarding resident protection by the Field Service Clinical Director (FSCD) when an alleged violation has been reported and the direct responsibilities of the NHA to remove the suspected perpetrator from the property immediately. Employee's are to be placed on immediate investigatory suspension while completing the investigation. Family members and/or visitors would be restricted from visitation during this investigation.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p>		



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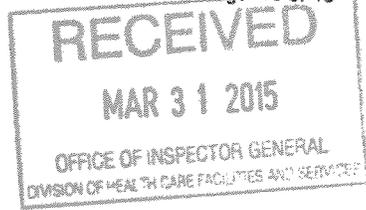
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F 225	Continued From page 14 alleged violation would immediately notify the Executive Director. The Executive Director would also notify the appropriate state agency, in accordance with state law, as well as notify immediate management. The results of the investigations must be reported by the Executive Director to the appropriate state agency, as required by state law, within five (5) working days of the alleged violation. The investigation would include interviews of employees, visitors, residents, volunteers and vendors who may have knowledge of the alleged incident. Factual information only would be documented, not assumptions, speculations, or conclusions. Written statements from involved parties would not be requested as all information would be documented on the Verification of Investigation form. The documentation of the investigation would be kept in the Executive Director's office in a secure administrative file. The medical record would be reviewed to determine the resident's past history and condition and its relevance to the alleged violation. The center would make reasonable efforts to determine the cause of the alleged violation and take corrective action consistent with the investigative findings and to eliminate any ongoing dangers to the resident. The Director of Nursing in conjunction with other clinicians would initiate or revise a care plan to reflect the resident's condition and measures to be taken to prevent recurrence, where appropriate. Review of the facility's Adult Protective Services Notification documentation, dated 02/10/15, revealed the report stated, the concern was related to the way the son treats/speaks to the nurses and Resident #2. According to the nurse,	F 225	FSCD will audit incidents and the grievance log for any potentially reportable incidents. Audits will be completed weekly for four weeks, then monthly for four months. The audits will be provided to the NHA, who will bring the audit results to two quarterly QAPI committee meetings. Any issue with lack of compliance will be addressed through revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule of additional audits if needed.		

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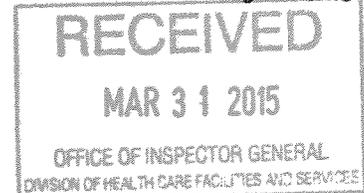
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F 225	<p>Continued From page 15</p> <p>she heard the resident's son yelling at the resident and the nurse heard the resident say he/she must have done something bad.</p> <p>Interview with Social Services, on 02/27/15 at 9:35 AM, revealed nursing notified her regarding a report made by Resident #2's neighbor that they heard yelling coming from Resident #2's room and something hitting the wall. The Social Service worker stated she spoke with Resident #2 about the incident and the resident stated the son was stressed, but that everything was O.K. Social Services stated she only spoke with the nurse caring for Resident #2 at the time of the incident and did not interview other residents or staff to determine if they heard or witnessed anything. She stated she had heard about another incident in which Registered Nurse Manager #2 had reported to Resident #2's Psychiatrist that she had overheard Resident #2's son yelling at the resident. She stated the Psychiatrist wanted the incident reported to Adult Protective Services. She stated the Psychiatrist said the son needed to know the appropriate behavior when interacting with Resident #2. The Psychiatrist said the behavior was considered verbal abuse and needed to be reported. She stated the facility scheduled a meeting with the son to discuss the situation and behavior; however, it was canceled and rescheduled. Social Services stated she did not complete a Verification of Investigation form as required by the facility policy.</p> <p>Interview with Registered Nurse Manager (RN) #2, on 02/27/15 at 9:00 AM, revealed she overheard Resident #2's son yelling at Resident #2 a couple of weeks ago. She stated sometime after</p>	F 225		



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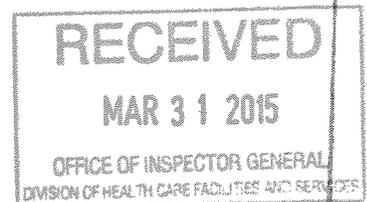
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F 225	<p>Continued From page 16</p> <p>the incident, Resident #2's Psychiatrist was in the facility to see the resident and it was at that time she spoke with the Psychiatrist about the son's behavior. She stated she considered the incident to be verbal abuse, but did not report it at the time because she believed this was normal behavior for Resident #2 and the son. However, after speaking with the Psychiatrist he ordered the facility to report the incident to Adult Protective Services because he believed it was a reportable event.</p> <p>Review of Resident #2's clinical record revealed the facility admitted the resident on 07/14/14 with diagnoses of Dementia, Anxiety, Chronic Pain, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and Colostomy.</p> <p>Review of Resident # 2's Quarterly Minimum Data Set (MDS) assessment, completed on 01/19/15, revealed the facility assessed the resident using a Brief Interview for Mental Status (BIMS) exam and the facility assessed the resident with a score of fourteen (14) out of fifteen (15) indicating cognitively intact.</p> <p>Review of the Physician Progress Notes, dated 02/10/15, revealed the Psychiatrist wrote contact Adult Protective Services on behavior reported by nursing, on behavior son directed toward resident and nurse.</p> <p>Review of the nursing notes, dated 02/11/15 at 11:08 AM, revealed the Executive Director made a general note stating in follow up to Physician's order, Adult Protective Services had been notified concerning son's reported behavior.</p> <p>Interview with Resident #2's Psychiatrist, on</p>	F 225			



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F 225	<p>Continued From page 17</p> <p>03/02/15 at 2:45 PM, revealed the nurse manager reported to him that she overheard Resident #2's son yelling at Resident #2 and then hitting the wall with his fist. The Psychiatrist stated the incident was potential verbal abuse and needed to be reported to the authorities. The Psychiatrist stated he wrote an order for the facility to report the incident to Adult Protective Services because he believed the incident was not being taken seriously. The Psychiatrist stated he called Adult Protective Services and reported the incident also.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 02/27/15 at 10:15 AM, revealed she was aware of two separate concerns regarding Resident #2's son's behavior. The ADON stated the facility did not document actions taken or information obtained regarding the incidents that occurred. The ADON stated another resident reported to nursing they heard someone yelling in Resident #2's room and then heard something hit the wall around 1:00 AM a few weeks ago. She stated the night nurse was interviewed and reported she did not hear any yelling coming from Resident #2's room. The ADON stated the nurse reported to them she went into Resident #2's room around 1:00 AM and found the son was still there and the resident had just been in the bathroom. She stated the nurse asked the son to leave because it was so late and believed the noise came from the resident hitting the wall with the walker. The ADON stated with that information it was determined no abuse had occurred. However, the ADON stated no other residents or staff were interviewed to determine if they had heard yelling or something hitting the wall in Resident #2's room. She stated the second incident was regarding a nurse</p>	F 225		



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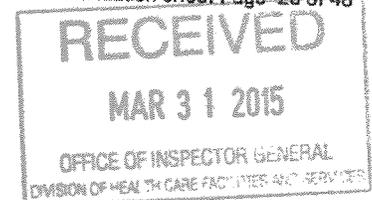
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F 225	<p>Continued From page 18</p> <p>overhearing Resident #2's son not speaking to the resident in a nice tone. She stated a nurse spoke to Resident #2's Psychiatrist about the behavior and the Psychiatrist ordered Adult Protective Services contacted. The ADON also stated she could not provide evidence the facility investigated the incidents because they had not followed their policy and documented their findings or investigation actions on their Verification of Investigation form.</p> <p>Interview with the Director of Nursing (DON), on 02/27/15 at 10:15 AM, revealed the facility dropped the ball regarding the two incidents involving Resident #2 and the son. She stated each situation should have been investigated by interviewing all potential witnesses and staff and the information gathered should have been documented on the Verification of Investigation form. The DON stated she did not believe abuse occurred because the behavior between the son and Resident #2 was their normal behavior and Resident #2 reported no harm and everything was okay.</p> <p>Interview with the Administrator (ADM), on 03/02/15 at 2:00 PM, revealed Resident #2's son had some disagreements with his staff and thought that behavior was not reportable. He stated it was not until Resident #2's Psychiatrist wrote the order to contact Adult Protective Services did he report the incident where the son had yelled at Resident #2. He stated this was normal behavior between the son and the resident. He stated the resident said he/she was O.K. and that was an indication to him, that no abuse occurred. He stated he reported the incident because he would get in trouble for not following a doctors order. The ADM stated the</p>	F 225			

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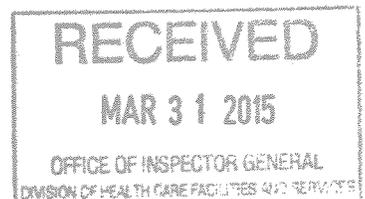
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F 225	Continued From page 19 facility did not follow their policy in regards to completing the Verification of Investigation form when an allegation of abuse was made.	F 225	F 226 Develop/Implment Abuse/Neglect, ETC Policies	3/31/15	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to operationalize their policy and procedure after two (2) separate allegations of potential abuse were made. The facility failed to conduct interviews of potential witnesses, report allegations timely to all required state agencies, and document their findings and actions taken after each allegation was made for one (1) of six (6) sampled residents. (Resident #2) The findings include: Review of the facility's Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property policy, dated December 2014, revealed the company would take the following steps to prevent, detect and report abuse, neglect, injuries of unknown origin and the misappropriation of resident property (alleged violations). If the suspected	F 226	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Meeting held with family member on 03/11/2015 to ensure that he understands the facilities visiting policy and what the perception is from the events that occurred between he and his mother. Training has occurred with staff, including the NHA, to ensure that all incidents are investigated per facility policy. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected. In the event of an employee, resident, friend, visitor or family member who reports an alleged violation regarding potential abuse, neglect, injuries of unknown source, and/or misappropriations of resident property, the NHA, per the abuse policy (revision date 2014), will place the suspected perpetrator on immediate investigatory suspension while the NHA completes the investigation of the alleged abuse or neglect. The NHA		



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PRINTED: 03/09/2015
FORM APPROVED
OMB NO. 0938-0391

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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 226	Continued From page 20 perpetrator was a vendor, visitor, or volunteer the Executive Director would take all appropriate measures immediately to secure the safety and wellbeing of the resident. Measures may include disallowing contact between the resident and alleged perpetrator while an investigation was conducted. Any employee who suspected an alleged violation would immediately notify the Executive Director. The Executive Director would also notify the appropriate state agency, in accordance with state law, as well as notify immediate management. The results of the investigations must be reported by the Executive Director to the appropriate state agency, as required by state law, within five (5) working days of alleged violation. The investigation would include interviews of employees, visitors, residents, volunteers and vendors who may have knowledge of the alleged incident. Factual information only would be documented, not assumptions, speculations, or conclusions. Written statements from involved parties would not be requested as all information would be documented on the Verification of Investigation form. The documentation of the investigation would be kept in the Executive Director's office in a secure administrative file. The medical record would be reviewed to determine the resident's past history and condition and its relevance to the alleged violation. The center would make reasonable efforts to determine the cause of the alleged violation and take corrective action consistent with the investigative findings and to eliminate any ongoing dangers to the resident. The Director of Nursing in conjunction with other clinicians would initiate or revise a care plan to reflect the resident's condition and measures to be taken to prevent recurrence, where appropriate.	F 226	will have the suspected perpetrator, including family members, leave the property immediately for the protection of the resident. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? On 3/17/15 all staff received general training on Abuse reporting. On 3/16/15, the NHA and DNS were re-educated on the Abuse Policy (revision date 2014) regarding resident protection by the FSCD when an alleged violation has been reported and the direct responsibilities of the NHA to remove the suspected perpetrator from the property immediately. Employee's are to be placed on immediate investigatory suspension while completing the investigation. Family members and/or visitors would be restricted from visitation during this investigation. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? FSCD will audit incidents and the grievance log for any potentially reportable incidents. Audits will be		



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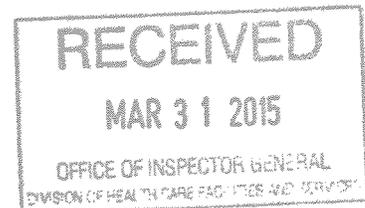
F 226	Continued From page 21 Review of Resident #2's clinical record revealed the facility admitted the resident on 07/14/14 with diagnoses of Dementia, Anxiety, Chronic Pain, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and Colostomy. Review of Resident # 2's Quarterly Minimum Data Set (MDS) assessment, completed on 01/19/15, revealed the facility assessed the resident using a Brief Interview for Mental Status (BIMS) exam and determined the resident scored a fourteen (14) out of fifteen (15) indicating cognitively intact. Review of facility's Adult Protective Services Notification documentation, dated 02/10/15, revealed the report stated, the concern was related to the way the son treats/spoke to the nurses and Resident #2. According to the nurse, she heard the resident's son yelling at the resident and the nurse heard the resident say he/she must have done something bad. Interview with Social Services, on 02/27/15 at 9:35 AM, revealed nursing notified her regarding a report made by Resident #2's neighbor that they heard yelling coming from Resident #2's room and something hitting the wall. The Social Service worker stated she spoke with Resident #2 about the incident and the resident stated the son was stressed, but that everything was OK. Social Services stated she only spoke with the nurse caring for Resident #2 at the time of the incident and did not interview other residents or staff to determine if they heard or witnessed anything. She stated she had heard about	F 226	completed weekly for four weeks, then monthly for four months. The audits will be provided to the NHA, who will bring the audit results to two quarterly QAPI committee meetings. Any issue with lack of compliance will be addressed through revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule of additional audits if needed.	
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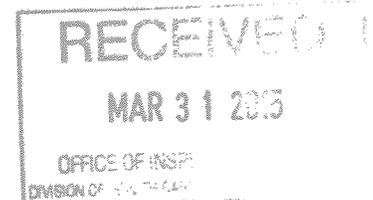
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F 226	<p>Continued From page 22</p> <p>another incident in which Registered Nurse Manager #2 had reported to Resident #2's Psychiatrist that she had overheard Resident #2's son yelling at the resident. She stated the Psychiatrist wanted the incident reported to Adult Protective Services. She stated the Psychiatrist said the son needed to know the appropriate behavior when interacting with Resident #2. The Psychiatrist said the behavior was considered verbal abuse and needed to be reported. She stated the facility scheduled a meeting with the son to discuss the situation and behavior; however, it was canceled and rescheduled. Social Services stated she did not complete a Verification of Investigation form as required by the facility policy.</p> <p>Interview with Registered Nurse Manager (RN) #2, on 02/27/15 at 9:00 AM, revealed she over heard Resident #2's son yelling at Resident #2 a couple of weeks ago. She stated sometime after the incident, Resident #2's Psychiatrist was in the facility to see the resident and it was at that time she spoke with the Psychiatrist about the son's behavior. She stated she considered the incident to be verbal abuse but did not report it at the time because she believed this was normal behavior for Resident #2 and the son. However, after speaking with the Psychiatrist he ordered the facility to report the incident to Adult Protective Services because he believed it was a reportable event.</p> <p>Review of the Physician Progress Notes, dated 02/10/15, revealed the Psychiatrist wrote contact Adult Protective Services on behavior reported by nursing, on behavior son directed toward resident and nurse.</p>	F 226		



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F 226	Continued From page 23 Review of the nursing notes, dated 02/11/15 at 11:08 AM, revealed the Executive Director made a general note stating in follow up to Physician's order, Adult Protective Services had been notified concerning the son's reported behavior. Interview with Resident #2's Psychiatrist, on 03/02/15 at 2:45 PM, revealed the Nurse Manager reported to him that she overheard Resident #2's son yelling at Resident #2 and then hitting the wall with his fist. The Psychiatrist stated the incident was potential verbal abuse and needed to be reported to the authorities. The Psychiatrist stated he wrote an order for the facility to report the incident to Adult Protective Services because he believed the incident was not being taken seriously. The Psychiatrist stated he called Adult Protective Services and reported the incident also. Interview with the Assistant Director of Nursing (ADON), on 02/27/15 at 10:15 AM, revealed she was aware of two separate concerns regarding Resident #2's son's behavior. The ADON stated the facility did not document actions taken or information obtained regarding the incidents that occurred. The ADON stated another resident reported to nursing that they heard someone yelling in Resident #2's room and then heard something hit the wall around 1:00 AM a few weeks ago. She stated the night nurse was interviewed and stated she did not hear any yelling coming from Resident #2's room. The ADON stated the nurse reported to them she went into Resident #2's room around 1:00 AM and found the son was still there and the resident had just been in the bathroom. She stated the nurse asked the son to leave because it was so	F 226			



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F 226	<p>Continued From page 24</p> <p>late and believed the noise came from the resident hitting the wall with the walker. The ADON stated with that information it was determined no abuse had occurred. However, the ADON stated no other residents or staff were interviewed to see if they had heard yelling or something hitting the wall in Resident #2's room. She stated the second incident was regarding a nurse overhearing Resident #2's son not speaking to the resident in a nice tone. She stated a nurse spoke to Resident #2's Psychiatrist about the behavior and the Psychiatrist ordered Adult Protective Services contacted. The ADON also stated she could not provide evidence the facility investigated the incidents because they had not followed their policy and documented their findings or investigation actions on their Verification of Investigation form.</p> <p>Interview with the Director of Nursing (DON), on 02/27/15 at 10:15 AM, revealed the facility dropped the ball regarding the two incidents involving Resident #2's and the son. She stated the staff had not followed the policy and did not complete the Verification of Investigation form. In addition, the DON stated she believed no abuse occurred because the behavior between the son and Resident #2 was their normal behavior and Resident #2 reported everything was okay.</p> <p>Interview with the Administrator (ADM), on 03/02/15 at 2:00 PM, revealed Resident #2's son had some disagreements with his staff and thought the behavior was not reportable. He stated it was not until Resident #2's Psychiatrist wrote the order to contact Adult Protective</p>	F 226			

