

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

PRINTED: 04/04/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/01/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS An Abbreviated Survey was conducted on 04/01/14 to investigate KY21465. The Division of Health Care found the allegation to be substantiated with deficiencies cited at highest scope and severity of a "D".	F 000			
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	F 225	1. The 50.00 missing from Resident #1's pouch was reimbursed to Resident #1. Resident #1's personal items remained secured in the lockbox until he was discharged on 3/25/14. The lock on Resident #3's nightstand was replaced and he/she was provided a key. Resident # 4 discharged home on 4/1/14. 2. All residents have the potential to be affected. 3. Mandatory in-service education was provided to all employees on the Abuse Policy, options available to residents for securing valuables including Resident Trust Fund, nightstands with locking drawers, and lock boxes, by DON & 11-7 RN House Supervisor on 4/2/14, 4/4/14, 4/5/14, 4/6/14, & 4/7/14. No employee will be allowed to work after 4/7/14 unless mandatory in-service education has been received. Education for all employees also included procedure to follow if resident valuables were found unsecured or if resident requested to secure valuables. In-service education was provided by the Executive Director to DON, ADON, DCE, Unit Managers, House Supervisors, and Social Workers on 4/6/14, and 4/7/14.	4/7/14	

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

TITLE

(X6) DATE

[Signature]

[Signature] Executive Director 4/7/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her 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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F 225	<p>Continued From page 1</p> <p>representative and to other officials in accordance with State law (including to the State survey and 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 observation, interview, record review, and review of the facility's investigation, admission booklet, and Abuse Policy, it was determined the facility failed to ensure allegations of misappropriation of resident property were thoroughly investigated and reported to the facility's Executive Director for one (1) of four (4) sampled residents. Resident #1 reported money missing from a pouch the resident gave to facility staff for safe keeping. The resident gave \$52.00, a credit card, ID cards including Social Security card, and Driver License to facility staff on 02/12/14. Those items had been placed in a small zipper type pouch. The facility nurse failed to secure the resident's money and personal items. The nurse put the pouch that contained the resident's money and cards in an unlocked drawer at the nurses' station. Four days later, the same nurse remembered the pouch was in the unlocked drawer. When the nurse counted the resident's money, there was only \$2.00 in the pouch. The nurse failed to report the missing money.</p> <p>On 03/14/14, the resident requested the money and discovered there was only \$2.00 in cash. The facility conducted an investigation; however, they failed to interview all staff who had worked between February 12-16 and had access to the</p>	F 225	<p>Reporting Alleged Violation Abuse Policy Revised 2013, Clarification of Nursing Home Reporting Requirements for Alleged Violations of Mistreatment, Neglect, and Abuse, Including Injuries of Unknown Source and Misappropriation of Resident Property (Ref: S&C: -05-09), Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (Ref: S&C: 11-30-NH), and information related to conducting a thorough investigation. These designated staff members will not be allowed to work after 4/7/14 unless in-service has been received.</p> <p>All investigations will be conducted by the ED or DNS. In the event neither of these people are in the center, the charge nurse will initiate the investigation procedure.</p> <p>Keys were obtained for all night stands on the 400 unit so each room would be equipped with a night stand with a lockable drawer.</p> <p>All night stands on the 300 unit were checked to ensure keys were available for all night stands on the 300 unit.</p> <p>The Admissions Coordinator will be responsible for maintaining the duplicate keys for all night stands on the 300 and 400 units.</p> <p>The facility purchased additional lock boxes that can be mounted inside nightstand drawers for use on the 100 & 200 units if requested by residents.</p>	



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F 225 Continued From page 2
resident's money in the unlocked drawer. The facility did not re-educate all staff on the Abuse Policy, failed to notify the Medical Director of the deficient practice, and failed to develop and implement corrective actions to ensure this would not occur with other residents.

The findings include:

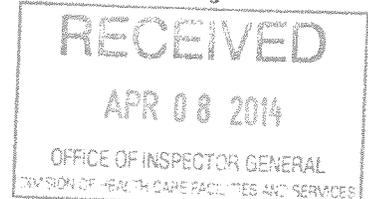
Review of the facility's Abuse Policy, revised 2013, revealed the policy included misappropriation of resident property. The policy stated it was the responsibility of all employees to immediately report any alleged violation of abuse, neglect, injuries of unknown source and misappropriation of resident property. Such allegations were to be reported to the Executive Director of the center immediately. The facility would take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown source, and misappropriation of resident property. The center would investigate each such alleged violation thoroughly and report to state agencies as required by state and federal law. The Executive Director or Director of Nursing (DON) would conduct all investigations that would include interviews of employees who may have knowledge of the alleged incident. The center would make reasonable efforts to determine the cause of the allegation and take corrective actions consistent with investigative findings. Appropriate steps would be taken to prevent recurrence of the incident to include in-services or other measures and those steps would be documented.

Review of the admission booklet, under the title Personal Property and Funds, (revised December 2011), revealed the center would make

F 225 Social services staff conducted interviews with all residents on 4/2/14, 4/3/14, and 4/4/14 to ask residents if they had any valuables that needed to be secured and to educate residents on options to secure valuables including; the Resident Trust Fund, nightstands with locking drawers, and lockboxes that can be installed inside nightstand drawers. If residents were unable to be interviewed, social services contacted the resident's responsible party to conduct the interview.

A QAPI meeting was held on 4/2/14 to discuss the actions taken, including the options available to residents for securing valuables including Resident Trust Fund, nightstands with locking drawers, and lock boxes, Abuse Policy, resident interviews to ask residents if they had valuables that need to be secured and options available to residents for securing valuables including Resident Trust Fund, nightstands with locking drawers, and lock boxes, also, procedure to follow if resident valuables were found unsecured or if resident requested to secure valuables. The information from meeting was reviewed with Medical Director by DON on 4/3/14.

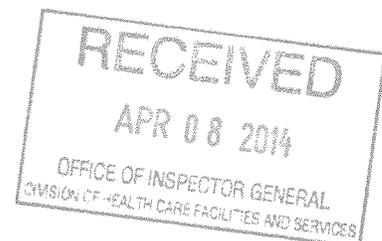
A QAPI meeting was held on 4/7/14 to discuss progress of plan and the plan to address F226. In addition to the plan outlined above, in-service education is being conducted by ED pertaining to thoroughness of abuse investigations and the abuse investigative process.



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F 225	<p>Continued From page 3</p> <p>reasonable efforts to safeguard belongings that the resident kept in their possession. Upon written authorization, the center would hold personal funds for the resident in a manner consistent with all federal and state laws and regulations.</p> <p>Review of the clinical record for Resident #1 revealed the resident had been discharged to home on 03/25/14. The resident had resided on the 400 Unit. The clinical record revealed the facility admitted Resident #1 on 02/10/14 after hospitalization for Transient Cerebral Ischemia (stroke). The resident was to have a short term stay to receive therapy. Review of the admission assessment, dated 2/17/14, revealed the facility assessed the resident to have a mild cognition impairment with a Brief Interview Mental Status score of eight (8) out of fifteen (15). Review of the Speech Therapy discharge notes, dated 03/24/14, revealed the resident had 90% accuracy with sequencing and demonstrated functional problem solving/reasoning with 85% accuracy. Continued review of the admission assessment, under the section titled preferences for customary routine and activities, revealed the resident responded to the question "how important is it to you to have a place to lock your things to keep them safe?" that it was very important.</p> <p>Interview with the DON, on 04/01/14 at 8:35 AM, revealed the resident resided on the 400 Unit. She stated each resident's room on the 400 Unit had a night stand equipped with a lock and a key was provided to residents upon request.</p> <p>Observation of the 400 Unit, on 04/01/14 at 8:40-9:30 AM, revealed all rooms had a night</p>	F 225	<p>4. Social Services staff will conduct follow up interviews with 5 residents per week for 3 months to ensure residents do not have any issues with securing valuables in locking nightstand drawers, lockboxes, or Resident Trust Fund. Results of these interviews will be reported weekly/monthly during QAPI meeting.</p> <p>The Admission Coordinator will check all rooms prior to admission to ensure a key is available in the room at the time of admission as part of the room readiness check. A record of the finding of these checks will be reported during the weekly/monthly QAPI meeting.</p> <p>A QAPI meeting will be held weekly for 4 weeks then bi-weekly for 4 weeks, then monthly thereafter. The committee will review effectiveness and compliance with the plan to ensure residents have a secure place to keep their personal belongings, and will review, revise, update, and develop action plans, based on any issues identified in review of audits</p> <p>If the medical director is unavailable in person on a weekly basis, he will review progress by phone with the Executive Director and/or DON, or during his weekly visit.</p> <p>It is ultimately the Administrator's job to validate all parts of the POC are implemented and compliance is achieved and continues.</p>	



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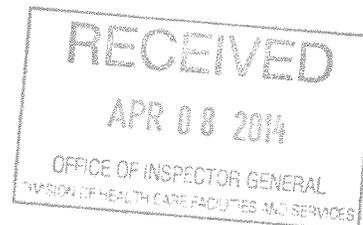
F 225 Continued From page 4
stand equipped with a lock; however, not all had keys.

F 225

Observation of Resident #4's room, on 04/01/14 at 8:55 AM, revealed a night stand with a lock. Interview with the resident stated he/she did not know the top drawer to the night stand would lock. The resident was not offered a key to lock the drawer. In addition, the resident did not know what was available to keep their valuables secure. The resident stated he/she had not kept money at the facility, but the resident had a cell phone. He/She further stated he/she had not received any information about the resident trust fund.

Observation of Resident #3's room, on 04/01/14 at 9:15 AM revealed two night stands with locks and no keys. Interview with the resident revealed the resident kept money in a purse in the night stand located across from the resident's bed and not within the resident's reach. The resident stated the drawer where he/she kept the purse, was not locked and the resident had not been offered a key. The resident stated he/she left the purse with money in the unlocked drawer when they went to therapy and other places in the facility.

Interview with the Maintenance Director, on 04/01/14 at 9:40 AM, revealed he was aware that there were no keys for all of the night stand locks. He said he had spoken with a locksmith last week regarding getting new locks with keys made for those night stands without keys. He did not say how many locks did not have a key. He explained a new key had to be made whenever a resident lost a key.



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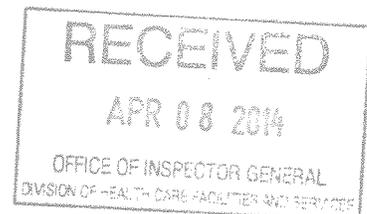
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F 225 Continued From page 5
Interview with the Social Service Director, on 04/01/14 at 9:46 AM, revealed she was the person who conducted the investigation regarding Resident #1's missing money. She stated on 02/12/14, Resident #1 gave money, credit card, ID cards, and driver license to an Occupational Therapist (OT) to lock up in a secure location. She stated the OT and a nurse (LPN#1) counted the money before placing in a zipper pouch and the money amount was \$52.00. On 03/14/14, Resident #1 requested the money because the resident was going out to eat with his/her family. When the resident opened the pouch, there was only \$2.00 and the cards in the pouch. Interviews with staff during the investigation revealed LPN #1 had not placed the pouch with the resident's money and cards into the locked box located in the medication room. The nurse had put the pouch in an unlocked drawer at the nurses' station. She stated all staff had access to the unlocked drawer because that is where the central supply key is kept. She continued to say the nurse forgot about the pouch and was off work for several days until 02/16/14. When the nurse remembered the pouch, he counted with the next shift nurse and found only \$2.00 was in the pouch. The nurse placed the pouch with the resident's money and cards into a locked box in the medication room. The nurse did not report that most of the resident's money was missing because he assumed the resident had gotten the money out. The Social Worker stated the nurse was suspended during the investigation. She indicated the investigation was completed and the allegation was substantiated. She stated the nurse received counseling and education prior to returning to work. When asked if all staff were retrained after the incident, she revealed a Read and Sign training method was implemented

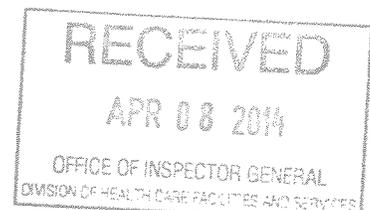
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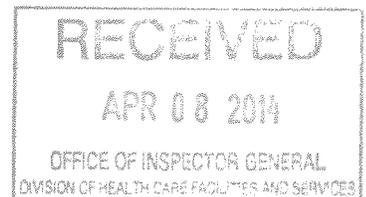
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F 225	<p>Continued From page 6 regarding information about misappropriation of resident property. A copy of this information was placed in the mailbox of each Unit Managers. The Nurse Managers were to go over with staff and have them sign. She could not answer as how she determined staff understood the material provided.</p> <p>Interview with the OT, on 04/01/14 at 10:00 AM, revealed on 02/12/14, she went to Resident #1's room to teach self-care tasks including bathing. The resident had a bag of personal items from the hospital that had clothing in it. The resident told the OT he/she wanted to send the clothing home to be washed. As the OT removed the clothing from the bag, she discovered the resident had money, credit cards, driver's license, and ID cards (Social Security card) in the pocket of a pair of jeans. These items were loose in the pocket, no wallet found. She told the resident it would be a good idea to lock up those items. The resident agreed. She stated she did not think of the locked drawer in the resident's room. She took the money and personal items to the nurses' desk of the 400 Unit and gave it to License Practical Nurse (LPN) #1. The OT stated she and the nurse counted the money and confirmed it was \$52.00. The OT provided a small zipper pouch to put the resident's money and other items in to prevent them from being lost. She stated she handed the pouch to LPN #1 but did not see where the nurse put the pouch. The nurse told her they would take care of locking up the money. She then left the nurses' desk. She stated a couple of days later, in a therapy session; the resident told her he/she could not find the money. She reminded the resident the facility had locked up the money. The resident's daughter was present during the therapy session</p>	F 225		



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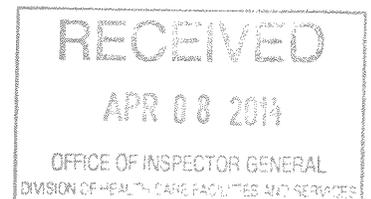
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F 225	<p>Continued From page 7 and she said, "Oh, good."</p> <p>The OT confirmed there was \$52.00 when the pouch was given to LPN #1 on 02/12/13. However, on 03/14/14, the resident requested his/her money to go out to eat. The OT was standing beside the resident when the staff handed the resident the pouch. When the resident opened the pouch, all the cards were there but only \$2.00 in cash was in the pouch.</p> <p>Interview with LPN #1, on 04/01/14 at 10:47 AM, revealed on 02/12/14, he was charting at the nurses' station when the OT came to the desk and told him Resident #1 had a wad of loose money, credit cards and ID cards. He said the OT came back with a small zipper pouch and they counted the money. He recalled one \$20 dollar bill, a couple of tens and five dollar bills, and two (2) one dollar bills. He thought the amount was \$52 dollars. The OT placed the money and cards into the pouch and handed it to him. LPN #1 stated he was busy at the time, so he placed the pouch in the top drawer of the nurses' desk. He revealed the drawer was unlocked. The key to the central supply room was kept in the same unlocked drawer and all staff had access to those keys. He indicated he called the daughter and let her know about the money and cards. She asked about a check. The nurse opened the pouch and looked inside and found a personal check made out to cash in the pouch. The nurse informed the daughter and she told him to leave it there in case the resident needed money. The nurse said he put the pouch back into the unlocked drawer. He indicated he had intended to put the money pouch in the locked box in the medication room when he counted the narcotics with the nurse from the next shift. However, when his shift</p>	F 225		



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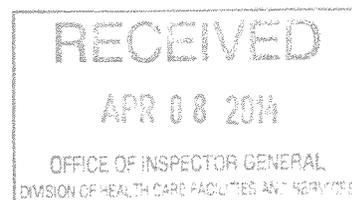
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F 225	<p>Continued From page 8</p> <p>ended, he gave report to the nurse and forgot to lock up the pouch that held the resident's money and cards. He stated he had not informed the nurse on the next shift about the resident's money, he had not told anyone. LPN #1 stated he was the last person in possession of the resident's money that shift.</p> <p>Continued interview with LPN #1 revealed he was off the next couple of days. Upon his return, he was at the nurses' desk charting when CNA #1 opened the unlocked drawer to obtain the key to the central supply room. She asked the nurse if he knew Resident #1 had a pouch in the drawer. The nurse said that triggered his memory and he recalled he had not locked up the resident's money. This was on 02/16/14, four (4) days after the resident gave the facility their money for safe keeping. The nurse removed the pouch from the unlocked drawer and counted the money with the second shift nurse, RN #2. There was \$2.00 in the pouch. LPN #1 then placed the pouch in the locked box in the medication room. When she asked if he reported the amount of money was less than on 02/12/14, he told her no. The nurse said he assumed Resident #1 had requested money to be removed from the pouch; however, he did not ask the resident or any staff to confirm this. The nurse stated when the resident requested the money on 03/14/14, he realized the resident had not taken the money out and he felt bad because he had not locked up the money. The nurse revealed he did receive training on abuse, and did not recall if it included misappropriation of property. The nurse did not know about the resident trust fund and although he knew about the lock box in the medication room, he had failed to secure the resident's money and cards.</p>	F 225			



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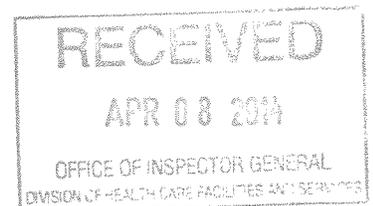
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/01/2014
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F 225	Continued From page 9 Review of the facility's investigation, revealed the facility had not interviewed all staff working on 02/12/14 through 02/16/14 that may have seen or had knowledge of the alleged incident. The Social Worker had interviewed staff working on 03/14/14. The facility's investigation did not address the failure of LPN #1 to report the amount of money in the resident's pouch went from \$52.00 to \$2.00 in four days. The facility documented staff training began on 03/14/14, but it did not indicate when all staff was trained. The information provided in the training was to discuss options for residents to secure their belongings. The methods listed were: lock box/drawer with a key in residents' rooms or the resident trust fund. However, interviews found Residents #3 and #4 were not offered a key to secure their property. The investigation revealed the facility did not report the missing money to the police. Review of training records revealed not all staff had been trained prior to the initiation of the abbreviated survey. Interview with the Staff Development Nurse, on 04/01/14 at 4:17 PM, revealed she was unaware of the incident regarding Resident #1's missing money. She stated she did not educate by using Read and Sign because it was not usually effective. She was told to start retraining staff on the abuse policy regarding misappropriation of resident property today. She had conducted face to face training starting with the day shift staff. She provided a staff roster indicating half of the staff had been trained to date. Another interview with the DON and Social Worker, on 04/01/14 at 4:40 PM, revealed this incident regarding Resident #1's missing money	F 225			



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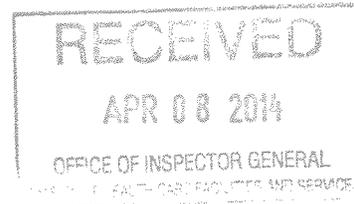
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F 225	Continued From page 10 had not been discussed in a Quality Assurance meeting and the Medical Director had not been informed. The DON stated the corrective actions implemented to ensure this did not occur again, were re-training of staff and the nurses were not allowed to receive money for safe keeping from residents. Residents would be provided the option of a locked drawer or box or to place the money in the resident's trust fund. The DON stated no audits or monitoring had occurred to date to ensure compliance.	F 225		
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 observation, interview, record review, and review of the facility's Abuse Policy, and admission information, it was determined the facility failed to implement their Abuse Policy in regard to an allegation of Misappropriation of resident property for one (1) of four (4) sampled residents. Upon facility staff's recommendation, Resident #1 gave the facility \$52.00, credit cards, identification cards (including Social Security), and driver's license for safe keeping on 02/12/14. The facility failed to offer to hold resident's personal funds in the resident trust fund and failed to secure the money and other valuables in a locked area. The resident's valuables were placed in a pouch and then put in an unlocked	F 226	1. The 50.00 missing from Resident #1's pouch was reimbursed to Resident #1. Resident #1's personal items remained secured in the lockbox until he was discharged on 3/25/14. The lock on Resident #3's nightstand was replaced and he/she was provided a key. Resident # 4 discharged home on 4/1/14. 2. All residents have the potential to be affected. 3. Mandatory in-service education was provided to all employees on the Abuse Policy, options available to residents for securing valuables including Resident Trust Fund, nightstands with locking drawers, and lock boxes, by DON & 11-7 RN House Supervisor on 4/2/14, 4/4/14, 4/5/14, 4/6/14, & 4/7/14. No employee will be allowed to work after 4/7/14 unless mandatory in-service education has been received. Education for all employees also included procedure to follow if resident valuables were found unsecured or if resident requested to secure valuables.	4/7/14



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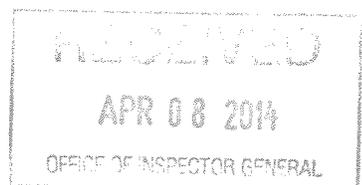
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F 226	<p>Continued From page 11</p> <p>drawer at the nurse's station that was accessible to anyone. After four days, the nurse remembered the resident's valuables were not locked in a secured area and was going to place them in a locked box in the locked medication room. However, when the nurse counted the money, there was only \$2.00 left in the pouch. The nurse failed to report the discrepancy and facility administration was unaware of the missing money until Resident #1 requested the money on 03/14/14.</p> <p>The facility failed to ensure their investigation included interviews with all staff that had opportunity and access to the money. The facility did not re-educate all staff on the Abuse Policy, failed to notify the Medical Director of the deficient practice, and failed to develop and implement corrective actions to ensure this would not occur with other residents. In addition, during the abbreviated survey, it was found the facility did not correct the deficient practice and residents' valuables were still not secure.</p> <p>The findings include:</p> <p>Review of the facility's Abuse Policy, revised 2013, revealed the policy included misappropriation of resident property. The policy stated it was the responsibility of all employees to immediately report any alleged violation of abuse, neglect, injuries of unknown source and misappropriation of resident property. Such allegations were to be reported to the Executive Director of the center immediately. The facility would take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown source, and misappropriation of resident property. The center would investigate each such alleged</p>	F 226	<p>In-service education was provided by the Executive Director to DON, ADON, DCE, Unit Managers, House Supervisors, and Social Workers on 4/6/14, and 4/7/14. Reporting Alleged Violation Abuse Policy Revised 2013, Clarification of Nursing Home Reporting Requirements for Alleged Violations of Mistreatment, Neglect, and Abuse, Including Injuries of Unknown Source and Misappropriation of Resident Property (Ref: S&C: -05-09), Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (Ref: S&C: 11-30-NH), and information related to conducting a thorough investigation. These designated staff members will not be allowed to work after 4/7/14 unless in-service has been received.</p> <p>All investigations will be conducted by the ED or DNS. In the event neither of these people are in the center, the charge nurse will initiate the investigation procedure.</p> <p>Keys were obtained for all night stands on the 400 unit so each room would be equipped with a night stand with a lockable drawer.</p> <p>All night stands on the 300 unit were checked to ensure keys were available for all night stands on the 300 unit.</p> <p>The Admissions Coordinator will be responsible for maintaining the duplicate keys for all night stands on the 300 and 400 units.</p>	



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F 226	<p>Continued From page 12</p> <p>violation thoroughly and report to state agencies as required by state and federal law. The Executive Director or Director of Nursing (DON) would conduct all investigations that would include interviews of employees who may have knowledge of the alleged incident. The center would make reasonable efforts to determine the cause of the allegation and take corrective actions consistent with investigative findings. Appropriate steps are taken to prevent recurrence of the incident to include in-services or other measures and those steps would be documented.</p> <p>Interview with the DON, on 04/01/14 at 8:35 AM, revealed Resident #1 had been discharged on 03/25/14. She stated the resident resided on the 400 Unit while at the facility. She stated each resident's room on the 400 Unit had a night stand equipped with a lock and a key was provided to residents upon request.</p> <p>Observation of the 400 Unit, on 04/01/14 at 8:40-9:30 AM, revealed all rooms had a night stand equipped with a lock; however, not all had keys. Refer to F225.</p> <p>Interview with the Maintenance Director, on 04/01/14 at 9:40 AM, revealed not all of the night stand locks had keys. He had spoken with a locksmith last week about getting new locks with keys made.</p> <p>Review of the clinical record revealed the facility admitted Resident #1 on 02/10/14 after hospitalization for Transient Cerebral Ischemia (stroke). The resident was to have a short term stay to receive therapy. Review of the admission assessment, dated 2/17/14, revealed the facility</p>	F 226	<p>The facility purchased additional lock boxes that can be mounted inside nightstand drawers for use on the 100 & 200 units if requested by residents.</p> <p>Social services staff conducted interviews with all residents on 4/2/14, 4/3/14, and 4/4/14 to ask residents if they had any valuables that needed to be secured and to educate residents on options to secure valuables including; the Resident Trust Fund, nightstands with locking drawers, and lockboxes that can be installed inside nightstand drawers. If residents were unable to be interviewed, social services contacted the resident's responsible party to conduct the interview.</p> <p>A QAPI meeting was held on 4/2/14 to discuss the actions taken, including the options available to residents for securing valuables including Resident Trust Fund, nightstands with locking drawers, and lock boxes, Abuse Policy, resident interviews to ask residents if they had valuables that need to be secured and options available to residents for securing valuables including Resident Trust Fund, nightstands with locking drawers, and lock boxes, also, procedure to follow if resident valuables were found unsecured or if resident requested to secure valuables. The information from meeting was reviewed with Medical Director by DON on 4/3/14.</p> <p>A QAPI meeting was held on 4/7/14 to discuss progress of plan and the plan to address F226. In addition to the plan outlined above, in-service education is being conducted by ED pertaining to thoroughness of abuse investigations and the abuse investigative process.</p>	



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F 226	<p>Continued From page 13</p> <p>assessed the resident to have a mild cognition impairment with a Brief Interview Mental Status score of eight (8) out of fifteen (15). The resident responded to the usual and customary routine question, how important it was to have a place to lock your things to keep them safe, as being very important.</p> <p>Interview with the Social Service Director, on 04/01/14 at 9:46 AM, revealed she was the person who conducted the investigation regarding Resident #1's missing money. She stated on 03/14/14, the resident requested money that he/she had given facility staff to lock in a secure setting. When the resident was given the pouch that held the resident's money, credit card, ID cards, and driver license, the resident alleged there was money missing. Her investigation revealed on 02/12/14, an Occupational Therapist (OT) recommended the resident allow the staff to lock up their money, credit card, ID cards, and Driver License in a secure location. She stated the OT and a nurse (LPN#1) counted the money before placing in a zipper pouch and the money amount was \$52.00. Her interviews with the nursing staff of that unit revealed the OT gave the pouch to LPN#1 to lock up in the metal box located in the medication room. However, interview with LPN #1 revealed the nurse had put the pouch in an unlocked drawer at the nurses' station instead. She revealed anyone had access to the unlocked drawer. She continued to say the nurse forgot about the pouch and was off work for several days until 02/16/14. However, review of the work schedule revealed LPN #1 worked on 02/13/14. On 02/16/14, the nurse remembered the pouch. He removed the pouch from the unlocked drawer and counted the money with the evening shift nurse. The nurse told her there was</p>	F 226	<p>4. Social Services staff will conduct follow up interviews with 5 residents per week for 3 months to ensure residents do not have any issues with securing valuables in locking nightstand drawers, lockboxes, or Resident Trust Fund. Results of these interviews will be reported weekly/monthly during QAPI meeting.</p> <p>The Admission Coordinator will check all rooms prior to admission to ensure a key is available in the room at the time of admission as part of the room readiness check. A record of the finding of these checks will be reported during the weekly/monthly QAPI meeting.</p> <p>A QAPI meeting will be held weekly for 4 weeks then bi-weekly for 4 weeks, then monthly thereafter. The committee will review effectiveness and compliance with the plan to ensure residents have a secure place to keep their personal belongings, and will review, revise, update, and develop action plans, based on any issues identified in review of audits</p> <p>If the medical director is unavailable in person on a weekly basis, he will review progress by phone with the Executive Director and/or DON, or during his weekly visit.</p> <p>It is ultimately the Administrator's job to validate all parts of the POC are implemented and compliance is achieved and continues.</p>	

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F 226	<p>Continued From page 14</p> <p>only \$2.00 left in the pouch. LPN #1 placed the pouch with the resident's money and cards into a locked box in the medication room and did not report the resident's missing money to anyone. When she asked him why he did not report the missing money, he told her he assumed the resident had gotten the money out. The Social Worker stated the nurse was suspended during the investigation. She indicated the investigation was completed with a finding that the allegation was substantiated. She stated the nurse received counseling and education prior to returning to work. The Social Worker stated all staff were retrained after the incident, and she revealed information regarding misappropriation of resident property was placed in the mailbox of each Unit Managers. The Nurse Managers were to go over with staff and have them sign. This was a Read and Sign method. She could not explain how she determined staff understood the material provided.</p> <p>Interview with the OT, on 04/01/14 at 10:00 AM, revealed on 02/12/14, she went to Resident #1's room to teach self-care tasks including bathing. The resident had a bag of personal items from the hospital that had clothing in it. The resident told the OT he/she wanted to send the clothing home to be washed. As the OT removed the clothing from the bag, she discovered the resident had money, credit cards, driver's license, and ID cards (Social Security card) in the pocket of a pair of jeans. These items were loose in the pocket, no wallet found. She told the resident it would be a good idea to lock up those items. The resident agreed. She stated she did not think of the locked drawer in the resident's room. She took the money and personal items to the nurses' desk of the 400 Unit and gave it to License</p>	F 226		

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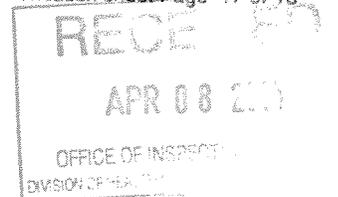
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F 226	<p>Continued From page 15</p> <p>Practical Nurse (LPN) #1. The OT stated she and the nurse counted the money and confirmed it was \$52.00. The OT provided a small zipper pouch to place the money and other items in to prevent them from being lost. She stated she handed the pouch to the nurse but did not see where the nurse put the pouch. She stated the nurse told her they would take care of locking up the money. She then left the desk. She stated a couple of days later, in a therapy session, the resident told her he/she could not find the money. I reminded the resident the facility had locked up the money. The resident's daughter was present during the therapy session and she said, "Oh, good."</p> <p>On 03/14/14, the resident requested his/her money to go out to eat. The OT was standing beside the resident when the staff handed the resident the pouch. When the resident opened the pouch, all the cards were there but there was only \$2.00 in the pouch. The OT confirmed there was \$52.00 when the pouch was given to LPN #1 on 02/12/13.</p> <p>Interview with LPN #1, on 04/01/14 at 10:47 AM, revealed on 02/12/14, he was charting at the nurses' station when the OT came to the desk and told him Resident #1 had a wad of loose money, credit cards and ID cards. He said the OT came back with a small zipper pouch and they counted the money. He thought the amount was \$52 dollars. LPN #1 stated he was busy at the time so he placed the pouch in the top drawer of the nurses' desk. He revealed the drawer was unlocked. The keys to the central supply room were kept in the same unlocked drawer and all staff had access to those keys. The nurse stated he forgot about the pouch and did not lock it up</p>	F 226			

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F 226	<p>Continued From page 16</p> <p>prior to leaving work that day. He stated he had not told the evening shift nurse about the resident's pouch. He said he was off the next couple of days. Upon his return, he was at the nurses' desk charting when CNA #1 opened the unlocked drawer to obtain the keys to central supply. She asked the nurse if he knew Resident #1 had a pouch in the drawer. The nurse said that triggered his memory and he recalled he had not locked up the resident's money. This was on 02/16/14. The nurse removed the pouch from the unlocked drawer and counted the money with the second shift nurse, RN #2. There was \$2.00 in the pouch. LPN #1 then placed the pouch in the locked box in the medication room. He did not report the missing money. The nurse stated when the resident requested the money on 03/14/14, he realized the resident had not taken the money out and he felt bad because he had not locked up the money.</p> <p>Review of the facility's investigation, revealed the facility had not followed their abuse policy in regard to interviewing staff who may have knowledge of the alleged incident. The Social Service Director failed to interview all staff that was working February 12-16, 2014, the days the resident's money was in the unlocked drawer. The facility's investigation did not address the failure of LPN #1 to report the amount of money in the resident's pouch went from \$52.00 to \$2.00 in four days. The facility documented staff training began on 03/14/14, but it did not indicate when all staff was trained. The information provided in the training was to discuss options for residents to secure their belongings. The methods listed were: lock box/drawer with a key in residents' rooms or the resident trust fund. The investigation revealed the facility did not report the missing money to the</p>	F 226		



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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - HILLCREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 17 police. Review of training records revealed not all staff had been trained prior to the initiation of the abbreviated survey. Observation and interview with Residents #3 and #4 during the survey revealed the facility had not secured all residents property as alleged. Another interview with the DON and Social Worker, on 04/01/14 at 4:40 PM, revealed this incident regarding Resident #1's missing money had not been discussed in a Quality Assurance meeting and the Medical Director had not been informed. The DON stated interventions to prevent reoccurrence were re-training of staff and that the nurses were not allowed to receive money for safe keeping from residents. Residents are provided the option of a locked drawer or box and to place money in the resident's trust fund. The DON further stated no audits or monitoring had occurred to date to ensure compliance.	F 226			

