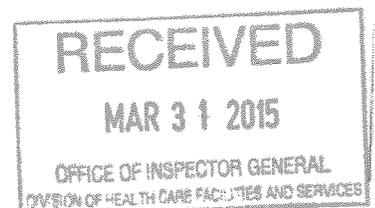


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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		
(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 25 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 okay 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 facility did not follow the facility policy regarding investigation and completing the required Verification of Investigation form because they believed abuse had not occurred.	F 226	F 281 Services Provided Meet Professional Standards What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 was transferred to the Baptist Hospital East on 2/3/2015. 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 new resident's have the potential to be affected by the alleged deficient practice. Inter Disciplinary Team (IDT) team will conduct audits on all residents admitted within the last thirty days to ensure the care plan meets the activity and/or behavior needs by 3/30/15. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? IDT team will be in-serviced by the Registered Nurse Assessment Coordinator on the requirements for care planning by 3/17/15. Care plans will be audited by quarterly by the care	3/31/15	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined the facility failed to ensure care plans for newly admitted residents were developed to meet the activity or behavior needs for one (1) of six (6) sampled residents. (Resident #1) The findings include: The facility did not provide a policy regarding the development of resident care plans. 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	F 281			



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

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

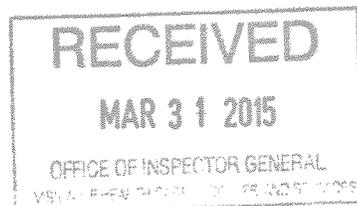
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/03/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(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 281	<p>Continued From page 26 requiring 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 or Mental Status (BIMS) exam due to the resident was rarely/never understood. Continued review of the MDS revealed the resident needed 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>Review of Occupational Therapy (OT) Plan of Care, with a Start of Care date of 01/26/15, revealed prior to admission Resident #1 lived at home with the spouse and was mostly independent with functional mobility tasks, without the use of an assistive device. The resident walked short distances at home and would wander around the house. The OT Plan of Care assessment stated Resident #1 required minimal assistance with functional transfers and to go from sitting to standing. OT notes on 01/30/15 stated Resident #1 required increased verbal cues to arouse and remain alert which impacted progress with all established goals.</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-pysch unit. He stated the resident was significantly cognitively impaired and was experiencing relocation shock with behaviors.</p>	F 281	<p>plan team to ensure that they match the behavior and activity needs identified by the resident assessment. After review and revision of the new care plans, DNS and ADNS will audit five new resident's chart weekly to ensure compliance with the policy. Audits to be completed weekly for four weeks, biweekly for four weeks, then monthly for four months.</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> <p>The DNS will bring the audit result sto the QAPI committee for two quarterly meetings. Any issues identified will be addresses by employee re-education and/or revision of this plan to reach compliance.</p>		

RECEIVED
MAR 31 2015
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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

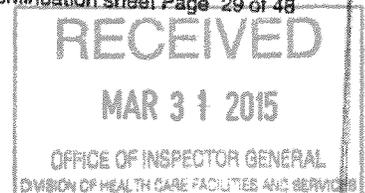
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/03/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(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 281	Continued From page 27 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 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	F 281			



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

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

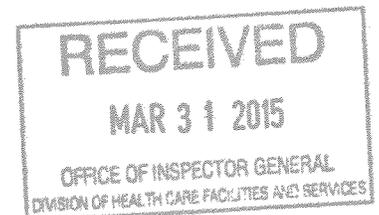
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/03/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(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 281	<p>Continued From page 28</p> <p>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.</p> <p>Interview with Registered Nurse #5, on 03/02/15 at 1:35 PM, revealed Resident #1 was in a constant state of motion after admission. RN #5 stated after admission the resident would walk around the facility pushing his/her wheelchair. RN #5 stated Resident #1 was a challenge and was always trying to get up out of bed and the chair. RN #5 stated the staff had to constantly be by the resident's side for fear the resident would fall due to an unsteady gait. RN #5 stated he had given Resident #1 Ativan several times due to the resident's constant state of motion. RN #5 stated he believed the resident would get upset with the redirection given to sit or remain in the bed because of the gender difference.</p> <p>Telephone interview with Registered Nurse #3, on 03/02/15 at 10:56 AM, revealed Resident #1 was a new admission and her assessment of Resident #1 and the resident's spouse was they were very anxious about being in a nursing facility. She stated after admission Resident #1 was very active and needed constant 1:1 attention from staff. She stated she worked primarily in the evening and nursing was responsible for providing diversional activities for</p>	F 281		



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

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

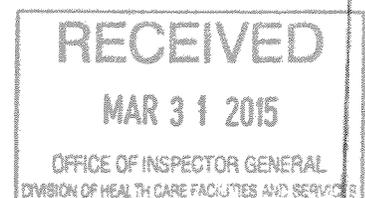
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/03/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(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 281	<p>Continued From page 29</p> <p>residents during that time. She stated she did not remember if diversional activities were provided for Resident #1, but remembered the resident not being happy with staff redirection. She stated the weekend before the resident was sent out to the hospital the resident was very sedated and quiet which was unusual for the resident.</p> <p>Review of Social Services note, on 01/30/15 at 11:18 AM, revealed the Social Worker completed Resident #1 cognitive and mood 5-day Scheduled Minimum Data Set assessment and noted Resident #1 was verbal, but nonsensical and was alert and oriented to self only. Documentation continued to state the assessment questions were posed to the spouse regarding the resident's stay at the facility. The Social worker documented the spouse stated Resident #1 had been short tempered with the staff during the past week.</p> <p>Telephone interview with Social Services, on 03/02/15 at 11:30 AM, revealed she completed the 5-day Scheduled Minimum Data Set on 01/30/15. She stated after the spouse indicated the resident had been short tempered with staff she did not look into the reason for this behavior. She stated the facility had over one hundred residents and the Social Service Department was not able to work with every resident that had behaviors. She stated nursing was more involved with residents exhibiting behaviors and if they needed assistance they would call Social Services. She stated nursing had not requested her involvement with Resident #1's behaviors. However, she stated she was aware the resident</p>	F 281			



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

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

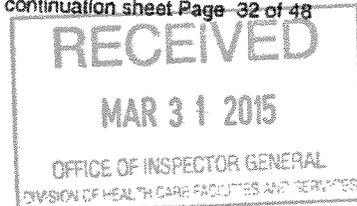
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/03/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(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 281	<p>Continued From page 30</p> <p>continually tried to get out of bed and wheelchair requiring staff to provide frequent redirection. She stated Social Services was responsible for developing care plans for residents that exhibited behaviors; however, she did not know how she missed developing a care plan for Resident #1, and it must have been overlooked.</p> <p>Review of Resident #1's Activity Assessment note on, 01/27/15 at 12:24 PM, revealed the resident liked to sing and listen to gospel music. The resident's hobbies were gardening, fishing and crossword puzzles. The resident liked to watch television and to be around animals. The resident also liked to choose his/her own bedtime and when to bathe.</p> <p>Interview with the Activities Director (AD) on, 03/02/15 at 9:30 AM, revealed Resident #1 attended 4 activities of choice after admission on 01/23/15. The AD stated if a resident was in need of diversional activities due to behaviors nursing would ask for their assistance. She stated nursing had not ask for their assistance regarding Resident #1. The AD stated after conducting a resident activity assessment an activity care plan was developed and placed in the chart within 72 hours. Review of the chart with the AD revealed Resident #1 did not have a care plan for activities. She stated she was not sure how she missed developing Resident #1's care plan. She stated she participated in the facility's morning meeting where they discussed resident's with activity needs or changes in condition. She stated she did not remember discussing Resident #1 in any one of the meetings prior to the resident being discharged.</p>	F 281			



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

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

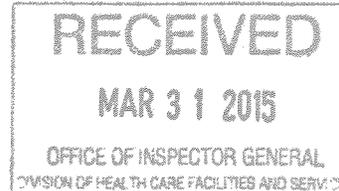
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/03/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(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 281	Continued From page 31 Interview with the Assistant Director of Nursing (ADON), on 02/27/15 at 1:20 PM, revealed leadership met every day to discuss residents with behaviors or changes in condition. However, she did not remember talking about Resident #1. She stated the facility should have developed a care plan for diversional activities and/or behaviors to direct staff prior to administering medication. She also stated the facility report did not contain evidence that leaders spoke about or developed interventions regarding Resident #1's behaviors or change in condition. Interview with the Director of Nursing (DON) on, 03/02/15 at 2:45 PM, revealed nursing staff should have used other interventions prior to administering medication for behaviors and documented those interventions. She stated the facility should have developed a care plan related to activities and or behaviors that would have directed staff in how to deal with Resident #1's behaviors prior to administering medications. She stated facility leaders met daily to discuss resident's with change of conditions or behaviors; 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 was just missed. Interview with the Administrator (ADM), on	F 281			



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		
(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 281	Continued From page 32 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. 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 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 281	F 309 Provide Care/Services for Highest Well Being What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 was transferred to the Baptist Hospital East on 2/3/2015. 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. Residents admitted within the last 30 days will be reviewed for behaviors related to relocation shock by the DNS and/or ADNS and the IDT 03/25/2015. Behaviors may include, but are not limited to: restlessness, increased fatigue, anxiety, depression and/or insomnia. Any resident who may be exhibiting behaviors related to relocation shock will be referred to the physician or nurse practitioner. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?	3/31/15	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 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 with behaviors related to relocation shock received the necessary care and services to maintain the highest physical and mental well-being for one (1) of six (6) sampled residents. (Resident #1)	F 309			



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

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

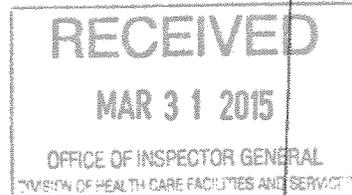
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/03/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(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 309	Continued From page 33 The findings include: Review of facility's policy regarding Medication Administration, dated May 2012, revealed when administering as needed (PRN) medications at times other than the medication pass, the dose may be prepared in the medication cart storage area and taken to the resident's bedside, leaving the cart locked and secured. Medications were to be administered in accordance with the written orders of the prescriber. If a dose seemed to be unrelated to the resident's current diagnosis or conditions, the nurse calls the pharmacy for clarification or if necessary contacts the prescriber for clarification. This interaction with the pharmacy or prescriber and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate. Monitoring of side effects or medication related problems occurs continually, but particularly after medication administration and especially after the first few doses of a new medication. When PRN medications are administered, the following documentation is provided: Complaints or symptoms for which the medications was given. Results achieved from giving the dose and the time results were noted. Review of facility's policy regarding Notification of Change in Resident Health Status, dated November 2014, revealed a guideline statement to ensure that proper notifications are 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 is:	F 309	The DCE will educate all licensed nursing staff and certified nursing assistants on 03/30/15 on the importance of monitoring and communicating behaviors with residents who are newly admitted. All residents admitted to the facility within the last thirty days will be monitored daily by the Unit Manager and/or Charge Nurse for signs and/or symptoms of relocation shock. Any signs of increased or new behaviors will be reported to the Physician or Nurse Practitioner. The DNS and/or ADNS and the IDT will review residents admitted to the facility within the last thirty days weekly and as needed for behavioral changes related to relocation shock beginning 03/24/2015. The DNS and/or ADNS will provide the Physician and/or Nurse Practitioner weekly updates regarding residents who are admitted within the last thirty days.		

RECEIVED
MAR 31 2015
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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		
(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 309	<p>Continued From page 34</p> <p>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.</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 Mental Status (BIMS) exam due to the resident was rarely/never understood. Continued review of the MDS revealed the resident needed 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>Review of the Occupational Therapy (OT) Plan of Care, with a Start of Care date of 01/26/15, revealed prior to admission Resident #1 lived at home with the spouse and was mostly independent with functional mobility tasks, without the use of an assistive device. The resident</p>	F 309	<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> <p>The DNS and/or ADNS will bring the results of the weekly 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. Charts of the newly admitted residents will be reviewed by the IDT daily for one week after admission, then weekly for 4 weeks, then quarterly in conjunction with assessment and care plan review.</p>	



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
---	---

(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
--------------------	--	---------------	---	----------------------

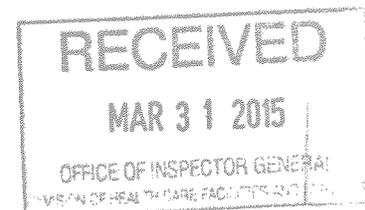
F 309	Continued From page 35 walked short distances at home and would wander around the house. The OT Plan of Care assessment stated Resident #1 required minimal assistance with functional transfers and to go from sitting to standing. OT notes, on 01/30/15, stated Resident #1 required increased verbal cues to arouse and remain alert which impacted progress with all established goals. Review of Social Services note, on 01/30/15 at 11:18 AM, revealed the Social Worker completed Resident #1's cognitive and mood 5-day Scheduled Minimum Data Set assessment and noted Resident #1 was verbal but nonsensical and was alert and oriented to self only. Documentation continued to state the assessment questions were posed to the spouse regarding the resident's stay at the facility. The Social Worker documented the spouse stated Resident #1 had been short tempered with the staff during the past week. Telephone interview with Social Services, on 03/02/15 at 11:30 AM, revealed she completed the 5-day Scheduled Minimum Data Set on 01/30/15. She stated after the spouse indicated the resident had been short tempered with staff she did not look into the reason for this behavior. She stated the facility had over one hundred residents and the social service department was not able to work with every resident that had behaviors. She stated nursing was more involved with residents exhibiting behaviors and if they needed assistance they would call Social Services. She stated nursing had not requested her involvement with Resident #1's behaviors. However, she stated she was aware the resident continually tried to get out of bed and wheelchair	F 309		
-------	---	-------	--	--

RECEIVED
MAR 31 2015
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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		
(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 309	Continued From page 36 requiring staff to provide frequent redirection. 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-pysch 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 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 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	F 309			



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

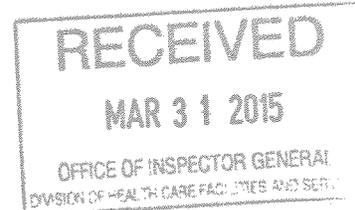
PRINTED: 03/09/2015
FORM APPROVED
OMB NO. 0938-0391

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		
(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 309	<p>Continued From page 37</p> <p>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.</p> <p>Review of the Physician orders, dated 01/23/15, revealed the physician ordered Haldol 0.5 mg, one tablet by mouth every 4 hours as needed for agitation/anxiety and Haldol 0.5 mg intramuscular every 4 hours as needed for severe agitation for Resident #1. Continued review of the physician orders revealed the Haldol was discontinued on 01/27/15 and Ativan 0.5 mg was ordered to be given as needed for agitation every six hours.</p> <p>Interview with Registered Nurse #5 on, 03/02/15 at 1:35 PM, revealed Resident #1 was in a constant state of motion after admission. RN #5 stated after admission the resident would walk around the facility pushing his/her wheelchair. RN #5 stated Resident #1 was a challenge and was always trying to get up out of bed and the chair. RN #5 stated the staff had to constantly be by the resident's side for fear the resident would fall due to an unsteady gait. RN #5 stated he/she had given Resident #1 Ativan several times due to the resident's constant state of motion. RN #5 stated</p>	F 309			

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

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

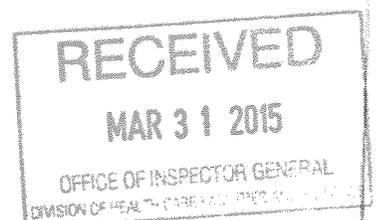
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/03/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(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 309	<p>Continued From page 38</p> <p>he/she believed the resident would get upset with the redirection given to sit or remain in the bed because of the gender difference.</p> <p>Telephone interview with Registered Nurse #3, on 03/02/15 at 10:56 AM, revealed Resident #1 was a new admission and her assessment of Resident #1 and the resident's spouse was they were very anxious about being in a nursing facility. She stated after admission Resident #1 was very active and needed constant 1:1 attention from staff. She stated she worked primarily in the evening and nursing was responsible for providing diversional activities for residents during that time. She stated she did not remember if diversional activities were provided for Resident #1, but remembered the resident not being happy with staff redirection. She stated the weekend before the resident was sent out to the hospital the resident was very sedated and quiet which was unusual for the resident.</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>Nursing documented 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 signs</p>	F 309			



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

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

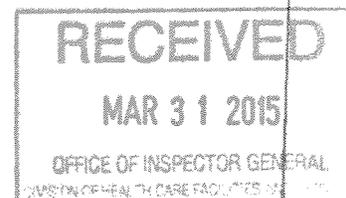
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/03/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(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 309	<p>Continued From page 39</p> <p>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 signs or symptoms documented.</p> <p>Nursing documentation continued, on 01/26/15 at 3:26 PM, revealed 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 S&S 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 resident had required one-on-one attention from staff this shift, attempting to transfer self unsafely from wheelchair, safety alarm sounding. Balance very unsteady when ambulating with staff assist. Resident became slightly agitated with redirection from staff to sit back in wheelchair after several times.</p> <p>Review of the Nursing note documentation, on 01/27/15 at 1:23 PM, revealed the resident was leaning forward and drooling more today than yesterday. Psychiatrist was into 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>Review of nursing documentation made prior to 01/27/15 revealed no documented evidence nursing assessed the resident for signs or symptoms of Haldol side effects after each time</p>	F 309			



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

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

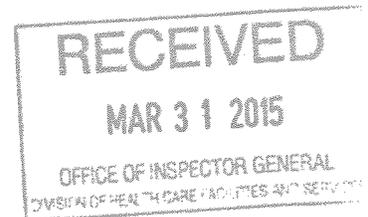
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/03/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(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 309	<p>Continued From page 40 the medication was administered or that the physician was notified of signs or symptoms of Haldol side effects.</p> <p>Continued review of nursing notes revealed the facility administered the resident 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 S&S of behaviors indicating agitation or if the resident exhibited side effects.</p> <p>Nursing documented 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 the nursing documentation for each Ativan administration revealed nursing did not document the resident's signs 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 pureed after assessing the resident during a 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 his/her mouth. She stated</p>	F 309		



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		
(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 309	<p>Continued From page 41</p> <p>she had to use a tongue depressor to open the resident's mouth and scooped 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>Review of the Nursing notes, on 02/02/15 at 12:41 PM, revealed Resident #1 presented with lethargy and inability to clear the 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 is considered low resulting in not enough oxygen in the blood).</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>	F 309		



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

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

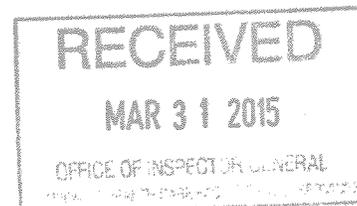
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/03/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(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 309	<p>Continued From page 42</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 the Nurse Manager 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. The Unit Manager stated the facility used a communication book to document resident information that they wanted to share with the physician or nurse practitioner. She stated RN #5 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 #5 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 and she informed him of the resident's change in</p>	F 309			



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

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

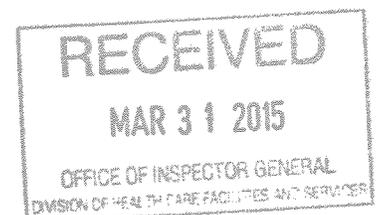
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/03/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(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 309	<p>Continued From page 43 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 temperature of 101.2; diminished breathe sounds to bilateral lower lobes with expiratory crackles, and the residents 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. She stated since the Nurse Practitioner had seen the resident early 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>	F 309			



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

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

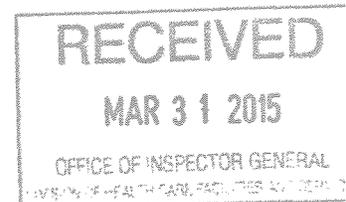
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/03/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(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 309	<p>Continued From page 44</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>Review of 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 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.</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.</p>	F 309		



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

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

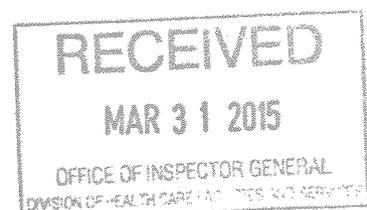
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/03/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(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 309	<p>Continued From page 45</p> <p>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 she was unable to find an order for Resident #1's oxygen administered by nursing on 02/03/15. She stated 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. Review of the communication book on 02/27/15 revealed no information was in the book regarding Resident #1. 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. However, she did not remember talking about Resident #1. She stated the facility should have developed a care plan for diversional activities and/or behaviors to direct staff prior to administering medication. She also stated the teams report did not contain evidence the team spoke about or developed interventions regarding Resident #1's behaviors or change in condition.</p> <p>Interview with the Director of Nursing (DON), on 03/02/15 at 2:45 PM, revealed the facility did not monitor the use of Resident #1's Ativan. She stated nursing did not document assessments regarding the behaviors exhibited that warranted</p>	F 309			



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		
(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 309	Continued From page 46 its administration or if the resident demonstrated medication side effects. The DON stated nursing staff should have used other interventions prior to administering medication for behaviors and documented those interventions. She stated the facility should have developed a care plan related to activities and or behaviors that would have directed staff in how to deal with Resident #1's behaviors prior to administering medications. She also stated 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 with change of conditions or behaviors; 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. 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. The ADM was not aware nursing was administering oxygen at 4 liter via nasal cannula to Resident #1 without an order. He stated he	F 309			



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		
(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 309	Continued From page 47 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 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 309			

