STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18G007	A. BUILDING _____ B. WING _____	C 07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BINGHAM GARDENS	4401 LOUISE UNDERWOOD WAY LOUISVILLE, KY 40216

(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
W 000	INITIAL COMMENTS A complaint investigation (KY32014 and KY32028) and a COVID-19 focused infection control survey was initiated on 07/21/2020 and concluded on 07/31/2020. The facility was found to be in compliance with 42 CFR 483.470 Physical Environment and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Complaint #KY32028 was unsubstantiated. Complaint #KY32014 was substantiated. Immediate Jeopardy was identified at 42 CFR 483.420 Client Protections (W0122). Standard level deficient practice was identified at W0149. Immediate Jeopardy was identified on 07/31/2020, was determined to exist on 06/17/2020, and is ongoing. Review of Client #1's Individual Life Plan (ILP) revealed the client had a history of pica behavior (the persistent eating of substances that have no nutritional value) and required two staff members to supervise the client. One staff member was required to be within two (2) arms' length of the client, and one staff member was required to be within unobstructed line of sight. Further review revealed staff were required to sweep Client #1's surroundings and remove items, including batteries and other items the client could possibly ingest, to ensure they were not available. On 06/17/2020, staff failed to maintain Client #1's required supervision and the client ingested a battery. Client #1 was transferred to the hospital where it was confirmed he/she had ingested the battery and laxatives were recommended to assist with passage of the battery. In addition, on 07/10/2020, staff failed to supervise Client #1 per	W 000		

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	18G007	A. BUILDING _____ B. WING _____	C 07/31/2020

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W 000	Continued From page 1 the planned level of supervision and Client #1 reported that he/she had swallowed a "toilet bolt." Client #1 was transferred to the hospital where an x-ray confirmed the client had a metallic hex nut fastener in his/her stomach.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview, record review, and review of the facility's policies and video surveillance footage, it was determined the facility failed to ensure clients were protected from neglect for one (1) of three (3) sampled clients (Client #1). Review of Client #1's Individual Life Plan (ILP) revealed the client had a history of pica behavior (the persistent eating of substances that have no nutritional value) and required two staff members to supervise the client. However, on 06/17/2020 and 07/10/2020, staff failed to supervise the client per the ILP and the client ingested foreign objects (battery and metal hex nut). The findings include: Review of the policy titled, "Abuse and Neglect Protocol-Bingham Gardens," dated 04/01/2019, revealed all residents would be free from neglect. Review of the facility's policy titled, "Facility Risk Management Protocol," revised October 2019,	W 122		

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	18G007	A. BUILDING _____ B. WING _____	C 07/31/2020

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W 122	Continued From page 2 Appendix A, revealed neglect was defined as "lack of supervision for individual with known special needs." Review of the medical record for Client #1 revealed the facility admitted the client on 07/12/2018 with diagnoses that included Moderate Intellectual Disability Disorder, Pica, Generalized Anxiety Disorder, Antisocial Personality Disorder, and Unspecified Disruptive, Impulse-Control, and Conduct Disorder. Review of Client #1's Individual Life Plan (ILP) revealed the client had a history of pica behavior (the persistent eating of substances that have no nutritional value) and required two staff members to supervise the client. One staff member was required to be within two (2) arms' length of the client, and one staff member was required to be within unobstructed line of sight. Further review revealed staff were required to sweep Client #1's surroundings and remove items, including batteries and other items the client could possibly ingest, to ensure they were not available. a. Review of an Incident Report (IR) dated 06/17/2020 at 2:15 PM revealed Direct Support Professional (DSP) #1 was providing line of sight supervision for Client #1 and DSP #2 was to be within two (2) arms' reach of the client. The report revealed the client obtained the television remote and swallowed a battery before staff could intervene. Per the incident report, the client was transferred to the hospital for evaluation and treatment. The hospital treatment recommendation was the administration of laxatives to assist with passage of the battery. A review of facility video surveillance of the incident on 06/17/2020 revealed after making a	W 122		

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W 122	Continued From page 3	W 122		

phone call, Client #1 picked up the remote control and removed the battery cover. The client then ingested a battery, placed the cover back on the remote control, and placed the remote back on a table. The event of the client removing/ingesting the battery occurred over an approximately eight (8) second period. During this time, DSP #1 was observed turning his back on the client and interacting with another client. Further review of the video revealed DSP #2 was observed hitting a couch with a blocking pad while her head was turned away from Client #1.

b. A review of the facility report of unusual incident dated 07/10/2020 at 6:48 PM, revealed Client #1 reported to staff that he/she ingested a bolt from the toilet. The client was transferred to the hospital for evaluation and treatment and a hexagonal metallic foreign body was confirmed to be in the client's stomach. Review of the Resident Care Notes revealed the client was transferred back to the facility on 07/11/2020 at 12:55 AM.

Observation of facility video surveillance for 07/10/2020 at approximately 6:41 PM revealed DSP #4 and DSP#5 were observed looking out of Client#1's bedroom door. DSP #4 was not within arms' reach and DSP #5 was not within line of sight of Client #1.

Interview with the Community Director on 07/30/2020 at 2:48 PM, revealed the staff member providing the line of sight supervision was required to observe the client at all times, and the staff member providing the within arms' reach supervision, was required to stay within two (2) arms' reach of the client. The Community Director stated staff were required to do pica

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18G007	A. BUILDING _____ B. WING _____	C 07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 122	Continued From page 4 sweeps of the client's environment when the client moved from one environment to another and should have checked the client's environment for items that could be ingested. According to the Community Director, if staff were not following levels of supervision it was considered neglect. Refer to F149.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview, record review, and review of the facility's policy and video surveillance it was determined the facility failed to implement facility policy to protect one (1) of three (3) sampled clients from neglect (Client #1). The findings include: Review of the facility's policy titled, "Facility Risk Management Protocol," revised October 2019, Appendix A, revealed neglect was defined as "lack of supervision for individual with known special needs." Review of the policy titled, "Abuse and Neglect Protocol," dated 04/01/2019, revealed all residents would be free from neglect.	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18G007	A. BUILDING _____ B. WING _____	C 07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 149	Continued From page 5 Review of the medical record for Client #1 revealed the facility admitted the client on 07/12/2018 with diagnoses that included Moderate Intellectual Disability Disorder, Pica, Generalized Anxiety Disorder, Antisocial Personality Disorder, Unspecified Disruptive, Impulse-Control, and Conduct Disorder. A review of the Individual Life Plan (ILP) with a revision date of 06/09/2020 revealed Client #1 had an extensive history of pica behaviors. Per the ILP, the client had a behavior support plan and a crisis intervention plan developed for the pica behavior, which directed staff to follow the client's level of supervision and to conduct sweeps of the environment to look for items that Client #1 could potentially ingest when Client #1 went from one environment to another. Further review of the ILP revealed the client level of supervision was two (2) staff members; one staff member was required to be within two (2) arms' length of the client, and one staff member was required to be within unobstructed line of sight. If client #1 attempted pica behaviors staff were required to block and intervene in an attempt to prevent the behavior. Observation of Client #1 on 07/22/2020 at 2:50 PM, revealed the client lying in bed, awake, with three (3) staff members in the room near the client's bed wearing full Personal Protective Equipment (PPE). Interview with Client #1 at 2:50 PM on 07/22/2020, revealed the client stated he/she swallowed a bolt from the toilet and that his/her stomach had been bothering him/her. Client #1 denied swallowing other objects.	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18G007	A. BUILDING _____ B. WING _____	C 07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 149	Continued From page 6 a. Review of an Incident Report (IR), dated 06/17/2020 at 2:15 PM, revealed Direct Support Professional (DSP) #1 completed the incident report and marked the type of incident as Pica. According to the report, two (2) staff members were providing supervision for Client #1. DSP #1 was providing line of sight supervision and DSP #2 was to be within two (2) arms' reach of the client. The report revealed the client obtained the remote and swallowed a battery before staff could intervene. Per the incident report, the client was sent to the hospital for evaluation and treatment. Further review revealed the incident was followed up with an internal/special investigation. A review of the Hospital x-ray report dated 06/17/2020 at 5:27 PM revealed Client #1 had a 3.6-centimeter linear radiopaque foreign body in the region of the stomach. A review of resident care notes revealed when the client returned from the hospital the client was ordered to receive Magnesium Citrate (a laxative), five (5) ounces now and five (5) ounces in 12 hours. Review of the facility's "Internal/Special Investigation Report," dated 06/28/2020, revealed the facility initiated an investigation of the pica incident on 06/17/2020. Client #1 was confirmed to have swallowed an AA battery from the remote control and according to hospital records, the battery was in the client's stomach. The facility concluded that based on the preponderance of evidence and review of video, the staff followed Client #1's level of supervision and no abuse or neglect was suspected. However, the facility failed to identify staff's failure to provide Client #1's assessed level of supervision to prevent Client #1 from ingesting a battery.	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18G007	A. BUILDING _____ B. WING _____	C 07/31/2020

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W 149	Continued From page 7 Review of the facility's video surveillance footage from 06/17/2020, revealed at approximately 2:15 PM, Client #1 came out of the bedroom to use the phone. The client sat down at a desk where a remote control and cell phone were observed lying on the desk. The client picked up the remote control and placed the remote on a table directly behind him/her. Client #1 picked up a cell phone from the desk and handed the cell phone to another staff member that was not assigned to the client. Client #1 completed his/her call on the house phone, turned around, picked up the remote control, and removed the battery cover. The client then ingested a battery, placed the cover back on the remote control, and placed the remote back on the table. The event of the client removing/ingesting the battery occurred over an approximately eight (8) second period. During this time, DSP #1 was observed turning his back on the client and interacting with another client. DSP #2 was not observing Client #1 while the client was using the phone, and was not within the required two (2) arms' reach of the client when the client ingested the battery. In addition, no staff were observed to block or attempt to intervene to prevent Client #1 from the pica behavior. Interview with DSP #1 on 07/30/2020 at 1:03 PM, revealed he was assigned to provide "line of sight supervision" for Client #1 on 06/17/2020, and was watching the client use the phone. According to DSP #1, he was required to observe the client at all times and to maintain line of sight supervision in case the client displayed a behavior that required intervention. DSP #1 stated the client was "so fast" that he did not see the client ingest the battery.	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18G007	A. BUILDING _____ B. WING _____	C 07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BINGHAM GARDENS	4401 LOUISE UNDERWOOD WAY LOUISVILLE, KY 40216

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W 149	Continued From page 8 Interview with DSP #2 on 07/30/2020 at 12:37 PM, revealed she was assigned to Client #1 on 06/17/2020, and was assigned to be within arms' reach of the client. Further interview revealed she did not work with Client #1 often. According to DSP #2, she was not within two (2) arms' reach of Client #1 because she wears glasses, which the client did not like. Further interview revealed she did not observe Client#1 ingest a battery on 06/17/2020, or intervene because she was killing an insect that was about to bite another client. An interview with the Risk Management Director on 07/30/2020 at 2:11 PM, revealed she conducted an investigation of the incident. According to the Risk Management Director, she did not consider staff neglect because she thought Client #1 was within his/her level of supervision. The Risk Management Director stated DSP #3 (newly hired staff) was near the client when the client swallowed the battery and she was not aware DSP #3 was not assigned to provide supervision for Client #1. Interview with the Community Director on 07/30/2020 at 2:48 PM, revealed he was responsible for the day-to-day operation of the facility and reviewed all incident reports. The Community Director stated he made rounds in the community daily to ensure staff followed each client's level of supervision. According to the Community Director, he was not aware that Client #1 was out of his/her level of supervision because the Risk Manager informed him that the client was in his/her level of supervision on 06/17/2020. Per the Community Director, the staff member providing the line of sight supervision was required to observe the client at all times, and the staff member providing the within arms' reach	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18G007	A. BUILDING _____ B. WING _____	C 07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
W 149	Continued From page 9 supervision was required to stay within two arms' reach of the client. The Community Director stated staff were required to do pica sweeps of the client's environment when the client moved from one environment to another and should have checked the client's environment for items that could be ingested when the client went from the bedroom to the living room. The Community Director stated both staff were to attempt to intervene and block if the client had a pica behavior. According to the Community Director, if staff were not following levels of supervision, per the facility protocol, it was considered neglect. b. A review of an IR dated 07/10/2020 at 6:52 PM, revealed DSP #4 completed the report. According to the report, at 6:48 PM, Client #1 requested to use the bathroom and staff (DSP #4 and DSP #5) took the client to the bathroom. The client informed DSP #4 and DSP #5 that he/she had swallowed a bolt. Client #1 was sent to the hospital and according to the hospital x-ray report the client had a hexagonal metal foreign body in the stomach. A review of the Emergency Room Record dated 07/10/2020 at 8:31 PM, revealed Client #1 was diagnosed with foreign body ingestion. A review of the hospital x-ray report, dated 07/10/2020 at 9:39 PM, revealed a 2.2-centimeter diameter hexagonal metallic foreign body within the distal stomach. Interview with DSP #4 on 07/22/2020 at 3:19 PM, revealed she was assigned to be within arms' reach of Client #1 on 07/10/2020. DSP #4 stated she and DSP #5 took the client to the bathroom after the client asked to use the bathroom. DSP #4 stated she was in the bathroom with Client #1,	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18G007	A. BUILDING _____ B. WING _____	C 07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BINGHAM GARDENS	4401 LOUISE UNDERWOOD WAY LOUISVILLE, KY 40216

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W 149	Continued From page 10	W 149		

and she maintained arms' reach supervision and DSP #5 was behind her. According to DSP #4, she did not see Client #1 swallow a nut but looked at the toilet after the client reported he/she had swallowed a nut and observed a bolt was loose. The DSP stated she then informed the supervisor.

Interview with DSP #5 on 07/23/2020 at 10:39 AM, revealed she was covering a break for another staff member assigned to Client #1 on 07/10/2020, and the client asked to use the bathroom. DSP #5 stated she and DSP #4 went with Client #1 to the bathroom. According to DSP #5, she did not maintain line of sight supervision of Client #1 because DSP #4 was between her and the client. Further interview revealed she did not see Client #1 ingest a nut while he/she was in the bathroom. The DSP stated she was not aware the client ingested anything until the client told staff he/she had ingested a "bolt." The DSP stated she saw the loose bolt and informed the supervisor.

Observation of facility video surveillance on 07/10/2020 at approximately 6:41 PM, revealed DSP #4 and DSP#5 were observed looking out of Client#1's bedroom door. The staff were not providing the client's required level of supervision as DSP #4 was not within arms' reach and DSP #5 was not within line of sight of Client #1.

An interview with the Qualified Intellectual Disabilities Professional (QIDP) on 07/28/2020 at 2:56 PM, revealed Client #1 had lived at the facility for two years. The client had an extensive history of pica behavior that was present on admission. The QIDP stated an Individual Life Plan had been developed for Client #1, which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 149	Continued From page 11 included a positive behavior support plan and a crisis intervention plan to help manage the client's pica behavior. According to the QIDP, Client #1 was to have two staff members assigned to provide supervision, one staff member with in two arms' reach at all times, and one staff member in unobstructed line of sight at all times. The QIDP stated if the client exhibited behaviors the staff were to intervene and block to prevent the pica behavior. An interview with the Community Director on 07/30/2020 at 2:48 PM, revealed the staff involved in the incident on 07/10/2020, were off work pending the outcome of the investigation. The investigation into this incident was in progress. According to the Community Director, staff were required to stay within line of sight and arms' reach of Client #1, per the facility protocol. Further interview with the Community Director revealed per the ILP, pica sweeps were completed by staff but were not required to be documented, until after the incident occurred on 07/10/2020. The Community Director stated there was not a need for both staff members to be looking out the client's bedroom door. The Community Director stated staff had a two-way radio with them to contact the supervisor or summon help if needed. Per the Community Director, Client #1 was more at risk for pica behaviors if the client was not being provided supervision in accordance with the Individual Life Plan.	W 149		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100198	A. BUILDING: _____ B. WING _____	C 07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BINGHAM GARDENS	4401 LOUISE UNDERWOOD WAY LOUISVILLE, KY 40216

(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) COMPLETE DATE
I 000	Initial Comments A complaint investigation (KY32014 and KY32028) and a COVID-19 focused infection control survey was initiated on 07/21/2020 and concluded on 07/31/2020. Complaint #KY32028 was unsubstantiated. Complaint #KY32014 was substantiated and deficient practice was identified. No deficient practice was identified related to the infection control survey. A Type "A" Citation was issued to the facility on 08/04/2020.	I 000		
I 012	902 KAR 20:086-3(6) Section 3. Administration and Operation (6) Patient rights. Patient rights shall be provided for pursuant to KRS 216.510 to 216.525. This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policy and video surveillance it was determined the facility failed to implement facility policy to protect one (1) of three (3) sampled clients from neglect (Client #1). The findings include: Review of the facility's policy titled, "Facility Risk Management Protocol," revised October 2019,	I 012		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100198	A. BUILDING: _____ B. WING _____	C 07/31/2020

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(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) COMPLETE DATE
I 012	Continued From page 1 Appendix A, revealed neglect was defined as "lack of supervision for individual with known special needs." Review of the policy titled, "Abuse and Neglect Protocol," dated 04/01/2019, revealed all residents would be free from neglect. Review of the medical record for Client #1 revealed the facility admitted the client on 07/12/2018 with diagnoses that included Moderate Intellectual Disability Disorder, Pica, Generalized Anxiety Disorder, Antisocial Personality Disorder, Unspecified Disruptive, Impulse-Control, and Conduct Disorder. A review of the Individual Life Plan (ILP) with a revision date of 06/09/2020 revealed Client #1 had an extensive history of pica behaviors. Per the ILP, the client had a behavior support plan and a crisis intervention plan developed for the pica behavior, which directed staff to follow the client's level of supervision and to conduct sweeps of the environment to look for items that Client #1 could potentially ingest when Client #1 went from one environment to another. Further review of the ILP revealed the client level of supervision was two (2) staff members; one staff member was required to be within two (2) arms' length of the client, and one staff member was required to be within unobstructed line of sight. If client #1 attempted pica behaviors staff were required to block and intervene in an attempt to prevent the behavior. Observation of Client #1 on 07/22/2020 at 2:50 PM, revealed the client lying in bed, awake, with three (3) staff members in the room near the client's bed wearing full Personal Protective Equipment (PPE).	I 012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100198	A. BUILDING _____ B. WING _____	C 07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BINGHAM GARDENS	4401 LOUISE UNDERWOOD WAY LOUISVILLE, KY 40216

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I 012	Continued From page 2 Interview with Client #1 at 2:50 PM on 07/22/2020, revealed the client stated he/she swallowed a bolt from the toilet and that his/her stomach had been bothering him/her. Client #1 denied swallowing other objects. a. Review of an Incident Report (IR), dated 06/17/2020 at 2:15 PM, revealed Direct Support Professional (DSP) #1 completed the incident report and marked the type of incident as Pica. According to the report, two (2) staff members were providing supervision for Client #1. DSP #1 was providing line of sight supervision and DSP #2 was to be within two (2) arms' reach of the client. The report revealed the client obtained the remote and swallowed a battery before staff could intervene. Per the incident report, the client was sent to the hospital for evaluation and treatment. Further review revealed the incident was followed up with an internal/special investigation. A review of the Hospital x-ray report dated 06/17/2020 at 5:27 PM revealed Client #1 had a 3.6-centimeter linear radiopaque foreign body in the region of the stomach. A review of resident care notes revealed when the client returned from the hospital the client was ordered to receive Magnesium Citrate (a laxative), five (5) ounces now and five (5) ounces in 12 hours. Review of the facility's "Internal/Special Investigation Report," dated 06/28/2020, revealed the facility initiated an investigation of the pica incident on 06/17/2020. Client #1 was confirmed to have swallowed an AA battery from the remote control and according to hospital records, the battery was in the client's stomach. The facility concluded that based on the preponderance of evidence and review of video, the staff followed Client #1's level of supervision and no abuse or	I 012		

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I 012	Continued From page 3 neglect was suspected. However, the facility failed to identify staff's failure to provide Client #1's assessed level of supervision to prevent Client #1 from ingesting a battery. Review of the facility's video surveillance footage from 06/17/2020, revealed at approximately 2:15 PM, Client #1 came out of the bedroom to use the phone. The client sat down at a desk where a remote control and cell phone were observed lying on the desk. The client picked up the remote control and placed the remote on a table directly behind him/her. Client #1 picked up a cell phone from the desk and handed the cell phone to another staff member that was not assigned to the client. Client #1 completed his/her call on the house phone, turned around, picked up the remote control, and removed the battery cover. The client then ingested a battery, placed the cover back on the remote control, and placed the remote back on the table. The event of the client removing/ingesting the battery occurred over an approximately eight (8) second period. During this time, DSP #1 was observed turning his back on the client and interacting with another client. DSP #2 was not observing Client #1 while the client was using the phone, and was not within the required two (2) arms' reach of the client when the client ingested the battery. In addition, no staff were observed to block or attempt to intervene to prevent Client #1 from the pica behavior. Interview with DSP #1 on 07/30/2020 at 1:03 PM, revealed he was assigned to provide "line of sight supervision" for Client #1 on 06/17/2020, and was watching the client use the phone. According to DSP #1, he was required to observe the client at all times and to maintain line of sight supervision in case the client displayed a behavior that	I 012		

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I 012	Continued From page 4 required intervention. DSP #1 stated the client was "so fast" that he did not see the client ingest the battery. Interview with DSP #2 on 07/30/2020 at 12:37 PM, revealed she was assigned to Client #1 on 06/17/2020, and was assigned to be within arms' reach of the client. Further interview revealed she did not work with Client #1 often. According to DSP #2, she was not within two (2) arms' reach of Client #1 because she wears glasses, which the client did not like. Further interview revealed she did not observe Client#1 ingest a battery on 06/17/2020, or intervene because she was killing an insect that was about to bite another client. An interview with the Risk Management Director on 07/30/2020 at 2:11 PM, revealed she conducted an investigation of the incident. According to the Risk Management Director, she did not consider staff neglect because she thought Client #1 was within his/her level of supervision. The Risk Management Director stated DSP #3 (newly hired staff) was near the client when the client swallowed the battery and she was not aware DSP #3 was not assigned to provide supervision for Client #1. Interview with the Community Director on 07/30/2020 at 2:48 PM, revealed he was responsible for the day-to-day operation of the facility and reviewed all incident reports. The Community Director stated he made rounds in the community daily to ensure staff followed each client's level of supervision. According to the Community Director, he was not aware that Client #1 was out of his/her level of supervision because the Risk Manager informed him that the client was in his/her level of supervision on 06/17/2020. Per the Community Director, the staff member	I 012		

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I 012	Continued From page 5 providing the line of sight supervision was required to observe the client at all times, and the staff member providing the within arms' reach supervision was required to stay within two arms' reach of the client. The Community Director stated staff were required to do pica sweeps of the client's environment when the client moved from one environment to another and should have checked the client's environment for items that could be ingested when the client went from the bedroom to the living room. The Community Director stated both staff were to attempt to intervene and block if the client had a pica behavior. According to the Community Director, if staff were not following levels of supervision, per the facility protocol, it was considered neglect. b. A review of an IR dated 07/10/2020 at 6:52 PM, revealed DSP #4 completed the report. According to the report, at 6:48 PM, Client #1 requested to use the bathroom and staff (DSP #4 and DSP #5) took the client to the bathroom. The client informed DSP #4 and DSP #5 that he/she had swallowed a bolt. Client #1 was sent to the hospital and according to the hospital x-ray report the client had a hexagonal metal foreign body in the stomach. A review of the Emergency Room Record dated 07/10/2020 at 8:31 PM, revealed Client #1 was diagnosed with foreign body ingestion. A review of the hospital x-ray report, dated 07/10/2020 at 9:39 PM, revealed a 2.2-centimeter diameter hexagonal metallic foreign body within the distal stomach. Interview with DSP #4 on 07/22/2020 at 3:19 PM, revealed she was assigned to be within arms' reach of Client #1 on 07/10/2020. DSP #4 stated she and DSP #5 took the client to the bathroom	I 012		

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I 012	Continued From page 6 after the client asked to use the bathroom. DSP #4 stated she was in the bathroom with Client #1, and she maintained arms' reach supervision and DSP #5 was behind her. According to DSP #4, she did not see Client #1 swallow a nut but looked at the toilet after the client reported he/she had swallowed a nut and observed a bolt was loose. The DSP stated she then informed the supervisor. Interview with DSP #5 on 07/23/2020 at 10:39 AM, revealed she was covering a break for another staff member assigned to Client #1 on 07/10/2020, and the client asked to use the bathroom. DSP #5 stated she and DSP #4 went with Client #1 to the bathroom. According to DSP #5, she did not maintain line of sight supervision of Client #1 because DSP #4 was between her and the client. Further interview revealed she did not see Client #1 ingest a nut while he/she was in the bathroom. The DSP stated she was not aware the client ingested anything until the client told staff he/she had ingested a "bolt." The DSP stated she saw the loose bolt and informed the supervisor. Observation of facility video surveillance on 07/10/2020 at approximately 6:41 PM, revealed DSP #4 and DSP#5 were observed looking out of Client#1's bedroom door. The staff were not providing the client's required level of supervision as DSP #4 was not within arms' reach and DSP #5 was not within line of sight of Client #1. An interview with the Qualified Intellectual Disabilities Professional (QIDP) on 07/28/2020 at 2:56 PM, revealed Client #1 had lived at the facility for two years. The client had an extensive history of pica behavior that was present on admission. The QIDP stated an Individual Life	I 012		

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I 012	Continued From page 7 Plan had been developed for Client #1, which included a positive behavior support plan and a crisis intervention plan to help manage the client's pica behavior. According to the QIDP, Client #1 was to have two staff members assigned to provide supervision, one staff member with in two arms' reach at all times, and one staff member in unobstructed line of sight at all times. The QIDP stated if the client exhibited behaviors the staff were to intervene and block to prevent the pica behavior. An interview with the Community Director on 07/30/2020 at 2:48 PM, revealed the staff involved in the incident on 07/10/2020, were off work pending the outcome of the investigation. The investigation into this incident was in progress. According to the Community Director, staff were required to stay within line of sight and arms' reach of Client #1, per the facility protocol. Further interview with the Community Director revealed per the ILP, pica sweeps were completed by staff but were not required to be documented, until after the incident occurred on 07/10/2020. The Community Director stated there was not a need for both staff members to be looking out the client's bedroom door. The Community Director stated staff had a two-way radio with them to contact the supervisor or summon help if needed. Per the Community Director, Client #1 was more at risk for pica behaviors if the client was not being provided supervision in accordance with the Individual Life Plan.	I 012		

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	18G007	A. BUILDING _____ B. WING _____	C 07/31/2020

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E 000	Initial Comments A COVID-19 focused Emergency Preparedness survey was initiated on 07/21/2020 and concluded on 07/31/2020. The facility was found to be in compliance with 42 CFR 483.475 Emergency Preparedness related to E0024. No deficient practice was identified.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

Andy Beshear
Governor

Donetta Ball, Human Services Program Branch Manager
Division of Health Care
116 Commerce Avenue
London, Kentucky 40744
(606) 330-2030
Fax: (606) 330-2054
http://chfs.ky.gov/agencies/os/oig

Eric C. Friedlander
Secretary

Adam Mather
Inspector General

August 11, 2020

ELECTRONIC MAIL (chad.newby@newvista.org)

Mr. Chad Newby
Bingham Gardens
4401 Louise Underwood Way
Louisville, Kentucky 40216

Dear Mr. Newby:

On July 31, 2020, an abbreviated survey and COVID-19 focused infection control survey was completed at your facility by the Division of Health Care to determine if your facility was in compliance with federal participation requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. During this survey, Immediate Jeopardy was identified at 42 CFR 483.420 Client Protections. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations. No deficient practice was identified related to the focused infection control survey.

Based on our determination of Immediate Jeopardy in your facility, this office is recommending termination of your provider agreement effective August 23, 2020, to the State Medicaid Agency and the Centers for Medicare and Medicaid Services Regional Office. The Division of Health Care will conduct a revisit prior to the expiration of the recommended 23-day termination if we receive a written allegation of removal of the Immediate Jeopardy.

You will receive a formal notice from the State Medicaid Agency describing your rights to due process under 907 KAR1:671. If you should have questions regarding this information, please contact our office.

Sincerely,

Donetta Ball

Donetta Ball
Human Services Program Branch Manager

DB:et:lk

Enclosures

c: CMS Regional Office

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

Andy Beshear
Governor

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August 11, 2020

ELECTRONIC MAIL (chad.newby@newvista.org)

Mr. Chad Newby
Bingham Gardens
4401 Louise Underwood Way
Louisville, Kentucky 40216

Dear Mr. Newby:

The Division of Health Care completed a complaint investigation and infection control survey at your facility on July 31, 2020. This survey was conducted to determine compliance with state licensure requirements. The survey found that your facility failed to meet minimum state licensure requirements for operation of an intermediate care facility for individuals with intellectual disabilities. The deficiencies cited are listed on the enclosed Statement of Deficiencies/Plan of Correction document. No deficient practice was identified related to the infection control survey.

As part of the investigation process, each facility is required to submit a written plan for the correction of all deficiencies noted during the survey. The plan shall specify:

- The date by which the violation shall be corrected;
- The specific measures utilized to correct the violation; and
- The specific measures utilized to ensure the violation will not recur.

902 KAR 20:008 Section 2.(5)(b) requires that a plan for correction of licensure deficiencies be submitted to this agency **within ten (10) days from receipt of this letter**. The plan, outlining methods of correction and proposed completion dates for each deficiency, should be incorporated in the column provided on the enclosed form. The form should be signed by you or an authorized representative and received in this office **within ten (10) days of receipt of this letter**. You should **make a copy** of the form for your records.

Please mail your plan of correction to the following address:

Donetta Ball
Human Services Program Branch Manager
Division of Health Care
116 Commerce Avenue
London, Kentucky 40744

Should you prefer faxing or emailing the plan of correction please fax it to 606-330-2054 or email it to lisa.koger@ky.gov.

Continued failure to meet minimum state licensure requirements will result in a recommendation for revocation of a license to operate an intermediate care facility for individuals with intellectual disabilities.

If you have any questions, please contact our office.

Sincerely,

Donetta Ball

Donetta Ball
Human Services Program Branch Manager

DB:et:lk

Enclosure