

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> RECEIVED SEP 23 2015 </div>		(X3) DATE SURVEY COMPLETED R 08/12/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
{F 323}	<p>Continued From page 47</p> <p>been trained. Training completed 07/31/15. Any staff that had not been trained will not work until training had been completed. Starting on 06/09/15 Nurses and CNAs received training on the meaning of 1:1 by DNS. Seventy-seven (77) nurses and CNAs have received training as of 07/31/15. Attendance is checked by DNS, ADNS and Nursing Supervisors. If a CNA or Nurse was on leave or vacation, they were scheduled to have the education prior to shift upon return. Golden Living Camelot does not utilize Agency staffing.</p> <p>4. One on one competency audit interviews for the one on one (1:1) supervision training follow-up started 07/29/15 with Certified Nursing Assistant (CNA) and nursing staff, Registered Nurse (RN), and Licensed Practical Nurse (LPN). This was completed by Nursing Consultant, ED, and Nursing Supervisors. Forty-eight (48) interviews had been done. Going forward five (5) interviews would be done on varied shifts each day for two (2) weeks and then five (5) times per week for one month. Any deficits were retrained at the time of the interview with the CNA or Nurse.</p> <p>5. Rehabilitation Manager identified residents that had been evaluated by therapy in the last three (3) months or on therapy caseload as of 07/23/15 without any issues noted. Thirty-seven (37) residents had been evaluated. Thirty-seven (37) care plans were revised by nursing and therapy to include gait and transfer information. Those care plans had been reviewed and revised as indicated. On 07/17/15 CNA care cards were revised to assure consistent language was used throughout the building for CNA care.</p>	{F 323}				

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{F 323}	<p>Continued From page 48</p> <p>6. Training on Tell a Nurse program was done with ten (10) therapists starting 07/16/15 by the Director of Rehabilitation. Training with therapists was completed on 07/24/15. Starting on 07/16/15, DNS trained forty-three (43) of forty-four (44) nurses on the Tell a Nurse program. Training for nurses was completed on 07/30/15. The one remaining nurse would be trained prior to working a shift by the DNS, Assistant Director of Nursing Services (ADNS), or Nursing Supervisor.</p> <p>7. Checked the Tell A Nurse binders on each nursing unit for communication sheet, check care plan and care sheet to assure any changes were added to the care plan and the CNA care sheet. Audits were completed on 07/15/15 through 08/04/15 by DNS, ADNS, ED, Nursing Supervisor or Nurse Consultant subsequent to Tell A Nurse form to observe service and confirm it was consistent with Tell A Nurse information. On 07/23/15 the Nurse Consultant completed an audit of the Tell a Nurse process. Each binder was reviewed to assure communication sheets were in place, and care plans and care sheets were reviewed to assure accuracy. Three (3) care plans were updated or changed by the Nurse Consultant. Follow up was completed with the nurse. The modifications included more specific information to a care plan regarding transfers, and supervision to licensed nurse to assure update of CNA care sheet. On the two other cases it was assured that the care plan and CNA care sheets matched and both were updated.</p> <p>8. Starting 07/30/15 when a 1:1 was done, the Unit Manager brought the 1:1 supervision documentation to the clinical start up for a check of the documentation. The Administrator, DNS, or Nursing Supervisor would complete an audit of</p>	{F 323}		
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{F 323}	Continued From page 49 1:1's at varied times daily to assure one to one supervision was being done according to protocol. 9. Starting on 07/23/15 the DNS, ADNS, or Nurse Supervisor continue to check that changes were made to the care plans from therapy evaluations at the daily clinical start up. The nurse brought the binder to clinical start up, when a Tell A Nurse form had been completed. Therapy, Nursing Consultant/ DNS or ADNS checked the Tell A Nurse form and assured care plan updates and care sheet updates were completed using the Tell A Nurse Audit Form. 10. An Ad Hoc Quality Assurance Process Improvement (QAPI) meeting was held on 07/23/15 to discuss and validate that the results of the therapy evaluations were updated to the care plans and the CNA care cards. This was conducted by the Administrator, DNS, ADNS, Social Worker, Therapist, and Medical Director and will continue weekly times four (4) weeks, then bi-weekly times four (4) weeks, then monthly thereafter. The monitoring and auditing of the Tell A Nurse program would be done by the DNS, ADNS, or Nurse Supervisor. Additional Ad Hoc QAPI held on 07/29/15 to update system of checks and validate current systems. Ad Hoc QAPI for entire system held on 07/29/15 including Competency Interview system. The State Survey Agency validated the removal of Immediate Jeopardy on 08/12/15 as follows: 1. Review of Resident #1 nurses note, dated 06/08/15, revealed Resident #1 was assessed by RN #2 the Nursing Supervisor and sent to emergency department post fall on 06/08/15 at	{F 323}				

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{F 323}	<p>Continued From page 50 5:17 PM.</p> <p>2. Review of "Evaluation-Plan of Care policy, undated, and "Tell A Nurse" form, undated, on 08/10/15, revealed the Therapy Evaluation policy and procedure was reviewed and updated to include the Tell A Nurse form by the Director of Rehabilitation, ED, and the Kentucky Area Vice President of Golden Living. Interview with the Rehabilitation Director, on 08/10/15 at 11:00 AM, and Administrator, on 08/10/15 at 8:45 AM, revealed the policy was reviewed and procedure updated to include the Tell A Nurse communication form and completed on 07/16/15.</p> <p>3. Review of In-service records, dated 08/09/15, revealed seventy-seven (77) staff had been trained by the Administrator and Director of Nursing on one to one staffing. Training included the definition of 1:1 staffing, steps to provide 1:1 supervision, and the required documentation for 1:1 supervision. Interview with Nursing Supervisor #2, on 08/10/15 at 3:50 PM and Licensed Practical Charge Nurse #3 revealed they had received training on 1:1 resident care and could correctly define 1:1 and knew what to document regarding 1:1 supervision.</p> <p>4. Review of one on one (1:1) Competency Interview audits and Daily Assignment Sheets, revealed forty eight (48) staff, including CNAs, RNs, and LPNs, on varied shifts had been interviewed regarding 1:1 supervision. Interviews began on 07/29/15 and were completed daily until 08/09/15 by Nursing Consultant, Administrator, and Nursing Supervisors. Interview with Administrator, on 08/10/15 at 8:45 AM, revealed she conducted 1:1 Competency interviews, and had done more than the required five each day</p>	{F 323}		

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{F 323}	Continued From page 51 during the first 2 weeks. She stated any staff person requiring retraining was done at the time of the interview. Interview with Certified Nursing Assistant #10, on 08/10/15 at 3:10 PM, revealed she received training on 1:1 supervision and had been interviewed after training to determine if she could recite what she was required to do. Interview with Licensed Practical Nurse #7, on 08/11/15 at 1:55 PM, stated she had received training regarding 1:1 supervision and had been interviewed afterwards to check if she knew her responsibility regarding 1:1 supervision. She stated she was to ensure the CNA's documented their 1:1 observations and that staff could not leave the resident unless provided relief. Interview with Registered Nurse #2, on 08/10/15 at 11:00 AM, revealed she had received training on 1:1 supervision and had been interviewed after the training to determine her knowledge of the 1:1 process. She stated her responsibility was to ensure documentation was completed by the CNA and that staff was not to leave the resident unless another staff member relieved them. 5. Review of the facility's document titled Level of Assist from 05/01/15 to current, revealed thirty-seven (37) residents had been evaluated by therapy during that time. Record review of those thirty seven (37) resident care plans and CNA care cards, revealed gait and transfer information was included on the care plans and CNA care cards. Interview with Rehabilitation Manager, on 08/10/15 at 11:00 AM, revealed she identified 37 residents had been evaluated by therapy in the last 3 months, and resident care plans were updated to include gait and transfer information. Interview with Director of Nursing, on 08/10/15 at 10:40 AM, revealed CNA care cards were revised on 07/17/15 to assure consistent language was	{F 323}			

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{F 323}	Continued From page 52 used throughout the building. 6. Review of in-service records, dated 07/16/15, revealed ten (10) therapists had been trained on Tell a Nurse program by the Director of Rehabilitation. Interview with the Director of Rehabilitation, on 08/10/15 at 11:00 AM, revealed she had trained 10 therapists on the Tell A Nurse program. Interview with the Occupational Therapist, on 08/10/15 at 11:10 AM, revealed she had received training by the Director of Rehabilitation regarding the Tell A Nurse program which included filling out the form and verbally providing a report to nursing staff of their assessment findings. Additional review of in-service record, dated 07/16/15, revealed forty-three (43) nurses had attended training on the Tell A Nurse program by the DNS. Interview with Licensed Practical Nurse #7, on 08/11/15 at 1:55 PM, revealed he/she had been trained on the Tell A Nurse program, including the location and purpose of the Tell a Nurse binder, and the process for updating care plans and CNA care sheet after therapy evaluation. 7. Review completed on 08/10/15, of the Tell A Nurse Binder communication sheets, resident care plans, and CNA care sheets, revealed changes and updates from the Tell A Nurse form were updated on the resident care plan and CNA care sheets. Interview with the Administrator, on 08/10/15 at 8:45 AM, and Director of Nursing, on 08/10/15 at 10:40 AM, revealed they had conducted audits of the Tell A Nurse communication sheet, resident care plans, and CNA care sheets to confirm that	{F 323}			

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{F 323}	<p>Continued From page 53 information was consistent on all documents.</p> <p>Interview with Nurse Consultant, on 08/10/15 at 10:45 AM, and Nursing Supervisor #2, on 08/10/15 at 3:50 PM, revealed they completed audits of the Tell A Nurse process on 07/23/15, including reviewing the Tell A Nurse binders to assure communication sheets were in place, and care plans and care sheets were reviewed for accuracy. In addition, they revealed three (3) care plans were updated to include more specific information regarding transfers, and supervision to licensed nurse to assure update of CNA care sheet. Review of the three care plans, revealed care plans and CNA care sheets were updated with therapy's recommendations for assistance with transfers and walking.</p> <p>8. Observation of the clinical start up meeting, on 08/06/15 at 9:00 AM, revealed the Unit Manager of the Alzheimer's Care Unit (ACU) had one resident on 1:1 supervision. The 1:1 documentation was discussed and reviewed by the DON. Review of the 1:1 documentation for the resident, revealed 1:1 documentation was complete, and the ED, DNS, or Nursing Supervisor had completed a daily audit of the documentation. Review of Golden Living Center Camelot E.D. Stand-Up Meeting sheets from 07/31/15-08/05/15, revealed 1:1 documentation was reviewed daily during the clinical start up meeting.</p> <p>9. Observation of the clinical start up meeting, on 08/06/15 at 9:00 AM, revealed the Tell A Nurse binders on each nursing unit were reviewed with no new Tell A Nurse forms completed the previous day. Review of the Tell A Nurse forms from 07/23/15, resident care plans, and CNA care</p>	{F 323}		
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{F 323}	Continued From page 54 sheets, revealed therapy evaluations from the Tell A Nurse form were updated on the resident care plan and CNA care sheets to reflect therapy recommendations. Interview with the DNS, on 08/12/15 at 5:20 PM, revealed she checked the Tell A Nurse form and assured care plans and CNA care sheets were updated using the Tell A Nurse Audit Form. 10. Review of the Ad Hoc Quality Assurance Process Improvement (QAPI) sign in sheets, and agendas dated 07/23/15 and 07/29/15, revealed the Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, Therapist and Medical Director were in attendance. Interview with the Administrator, on 08/12/15 at 5:50 PM, revealed the QAPI team met weekly if not more frequently. In addition, the QAPI team discussed the results of therapy evaluations and ensured care plans and CNA care cards were updated. Interview with the Director of Nursing, on 08/12/15 at 5:20 PM, revealed she was responsible for the monitoring and auditing of the Tell A Nurse program. She stated she reviewed the Tell A Nurse communication sheet in the daily clinical start up meeting and completed audits to ensure care plans and CNA care sheets were updated as needed. Interview with the Medical Director, on 08/12/15 at 1:45 PM, revealed he met weekly with the facility QA committee members to discuss the information brought to the committee by its members. He stated the Tell A Nurse form and communication process was discussed and actions were developed at the meeting. He stated the 1:1 supervision process was also discussed along with audit findings.	{F 323}				

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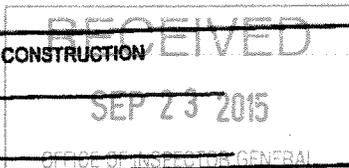
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{F 323}	Continued From page 55	{F 323}		
{F 353} SS=D	<p>Review of the QAPI sign in sheets, revealed QAPI meetings were held on 07/23/15, 07/29/15, 08/05/15, and 08/06/15. Review of the QAPI documentation, dated 07/23/15, revealed process and progress of audit systems were discussed.</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was</p>	{F 353}	<p>F353</p> <ol style="list-style-type: none"> 1. Resident #8 was reassessed for restorative services, including toileting program, by the Restorative Nurse on 8-31-2015. 2. All residents were assessed by the DNS, Restorative Nurse, Nurse Consultant and/or MDS Nurses for the need of restorative services. It was determined 92 residents are appropriate for restorative services. 	

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{F 353}	<p>Continued From page 56</p> <p>determined the facility failed to provide sufficient staffing to ensure restorative services related to toileting and transfer assistance were provided as written in the plan of care for one (1) of fifteen (15) sampled residents. (Resident #8)</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding staffing procedures.</p> <p>Review of the Comprehensive Care Plan for Resident #8 revealed a plan was developed on 05/02/11, with updated goals and a target date for 11/13/15. The problem stated the resident had an alteration in activities of daily living and required assistance with activities of daily living due to history of a stroke and right sided hemiparesis, expressive aphasia and neuropathy. The goal stated the resident would be clean and dressed appropriately on a daily basis and would continue to feed self meals with set up through the next review. The approaches directed the facility to provide restorative services as ordered for transfer training-sit to stand at hand rail or hemi-walker three (3) times a day, scheduled toileting program as ordered and provide assistance with toileting.</p> <p>Interview with Assistant Director of Nursing (ADON), on 08/10/15 at 9:00 AM, revealed she had identified Resident #8 had not received the daily restorative care the resident was care planned for and thought maybe the resident had experienced a decline in ability so she ordered; a therapy screen/evaluation, the resident's toileting program to be re-evaluated and for restorative to</p>	{F 353}	<p>3. Licensed nursing staff and certified nursing assistants received education by the Director of Clinical Education regarding restorative nursing staffing, such as if a call in occurs, the call in has to be covered; employees assigned to restorative duties will not be reassigned; if restorative shifts are not covered, the ED and/or DNS will be notified immediately. If a call-in has occurred, a plan has been implemented to replace the call-in. All assigned staff was educated on the call in process by the ED and DNS. An audit will be completed daily by the ED, DNS and/or Nursing Supervisor to ensure adequate staffing for restorative has occurred. This plan began on 8-31-2015 and is ongoing.</p> <p>4. Beginning on 9-3-2015, QAPI meetings will be held weekly for four weeks, then bi-weekly for 1 month, then monthly on going. QAPI committee will review results of daily audits to ensure adequate restorative staffing occurred. ED is responsible for QAPI meetings.</p> <p>5. Date of Compliance: 9-4-2015</p>	
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{F 353}	<p>Continued From page 57</p> <p>provide services daily. The ADON stated due to the CNA shortage and the facility using the RNAs as regular staff, the staff had not implemented the toileting and restorative care plan interventions as per their policy.</p> <p>On 08/11/15 at 11:55 AM, an interview with Restorative Nursing Assistant (RNA) #2, revealed at times the restorative aides were pulled to work as a Certified Nursing Assistant (CNA). RNA #2 stated the facility was short CNAs on 08/08/15 and she was not able to complete the restorative program requirements. RNA #2 stated there were three (3) restorative aides with three (3) different assignment loads of restorative care for residents in the building. When the facility had CNA shortages the facility used the restorative aides to cover for the staffing shortage, which meant staff would not be able to provide the restorative services according to facility policy.</p> <p>Interview with the Restorative Nurse, on 08/05/15 at 1:32 PM, revealed she stated she worked the weekend of 08/08/15 in a supervisory role and believed one of the restorative aides was also pulled to work the floor as a certified nursing aide; again preventing them from providing the required restorative services per policy requirements. She stated Resident #8 should have received three (3) fifteen (15) minute restorative nursing sessions each day shift to work on transferring with a handrail. She stated from 07/17/15 through 08/05/15 the resident missed twelve (12) days of restorative services due to staffing. She stated a resident could experience a decline if they did not receive the amount of ordered restorative services they should. She stated Resident #8 had not received restoratives services as ordered and per the</p>	{F 353}		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/01/2015
FORM APPROVED
OMB NO. 0938-0391

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SEP 23 2015

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 R-C 08/12/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 353}	Continued From page 58 facility policy due to the restorative aides being pulled to work as floor aides. Interview with the ADON, on 08/10/15 at 9:00 AM, revealed the facility had experienced a shortage of nursing assistants and had to use the restorative aides to cover for that shortage. She stated the shortage had been ongoing from April of 2015. Interview with LPN #12, on 08/10/15 at 8:35 AM, revealed the facility had been pulling the restorative nursing staff to work as Certified Nursing Assistants when they needed staff to cover the call ins. Interview with the Administrator, on 08/12/15 at 5:50 PM, revealed the facility was having difficulty providing restorative services due to staffing shortages, but they were working on hiring people to correct the issue.	{F 353}			
{F 490} SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of the facility's policies and the Plan of Correction for the 06/03/15 Recertification Survey, it was determined the facility's Administrator failed to	{F 490}	F490 1. The Executive Director received education by the Area Vice President on 8-31-2015 regarding implementing an effective system in place to ensure staff education regarding policies and procedures regarding the care planning process, providing adequate supervision to prevent resident falls and sufficient staffing to administer restorative care as ordered.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/12/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222
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{F 490}	<p>Continued From page 59</p> <p>have an effective system in place to ensure effective staff education regarding policies and procedures regarding the care planning process, providing adequate supervision to prevent resident falls, and sufficient staffing to administer restorative care as ordered. (Refer to F282, F323, F353, and F520).</p> <p>Resident #1 had a history of falls, unsteady gait, and walking with eyes closed. The resident was assessed to need staff assistance with transfers and walking. On 06/08/15, at 12:14 PM Physical Therapy assessed the resident to need the maximum assistance of two (2) persons for ambulation. However, Therapy staff failed to communicate the resident's need for maximum assist to nursing staff. On 06/08/15, at 5:10 PM, Resident #1 fell while walking in the hallway without any assistance of staff. Resident #1 sustained bilateral subdural hematomas to the forehead and a skull fracture to the back of the head and expired sixteen (16) hours later at the hospital. (Refer to F282 and F323)</p> <p>Resident #8 did not receive restorative services due to staffing issues and Restorative Aides were being pulled to the floor to provide direct care to residents. (Refer to F353)</p> <p>Repeat deficiencies at F282, F353, F490, F520 were cited previously on the 06/03/15 Recertification Survey at Immediate Jeopardy scope and severity of a "J", and F323 at a scope and severity of a "K". In addition, F282 was cited at a scope and severity of a "D".</p> <p>The facility's failure to have an effective system in place to ensure education of staff was provided regarding policies and procedures has caused or</p>	{F 490}	<ol style="list-style-type: none"> The Executive Director provided education to the Director of Nursing Services, Director of Clinical Education, MDS nurses, Restorative Nurse and/or Nursing Supervisors regarding staff education regarding policies and procedures regarding the care planning process, providing adequate supervision to prevent resident falls and sufficient staffing to administer restorative care as ordered. This occurred on 9-1-2015. The ED and/or DNS will discuss audit findings in interdisciplinary team (IDT) meeting weekly. The Area Vice President and/or Nurse Consultant will monitor audit findings weekly to ensure compliance with staff education, adequate supervision to prevent falls and sufficient staffing to administer restorative care as ordered. Completed 9-3-2015. The Area Vice President or Nurse Consultant to address any noted issues of implantation of the plan of correction immediately with assurance of review following implementation of action plan, if needed, to assure competency beginning 9-3-2015. 	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/12/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222
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{F 490}	Continued From page 60 Is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was determined to exist on 06/08/15. An acceptable Allegation of Compliance was received on 08/05/15 alleging removal of the Immediate Jeopardy on 08/01/15. The State Survey Agency (SSA) validated the removal of Immediate Jeopardy on 08/01/15 as alleged prior to exit on 08/12/15. The scope and severity was lowered to an "D" while the facility monitors the systemic changes and the Quality Assurance monitors the effectiveness of the plan of correction. The findings include: Review of the Administrator's Job Description, not dated, revealed the role consisted of leading and directing the overall operation of the facility in accordance with customer needs, government regulations and company policies, with the focus on maintaining excellent care for the residents while achieving the facility's business objectives. Essential job duties included overseeing regular rounds to monitor the delivery of nursing care, operation of support departments, maintaining a working knowledge to ensure compliance with all governmental regulations, and comply with, support and enforce company policies involving all safety and infection control procedures. 1. Reference F282 Review of the Plan of Correction for the 06/03/15 Recertification Survey revealed RNs and LPNs were retrained to follow care plans and the care planning process. Interview with the Director of Nursing, on	{F 490}	The Executive Director will address issues of Director of Nursing Services and other department managers of implementation of the plan of correction immediately with assurance of review following action plan, if needed, to assure competency beginning 9-3-2015. The Director of Nursing Services will address issues specific to nursing, such as catheter leg straps, restorative program and fall interventions, regarding competency beginning on 9-3-2015. 4. Beginning on 9-3-2015, QAPI meetings will be held weekly for four weeks, then bi-weekly for 1 month, then monthly on going. QAPI committee will review results of audits pertaining to F282, F323, F353 and F520. ED is responsible for QAPI meetings. 5. Date of Compliance: 9-4-2015	
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9/23/15
All licensed nursing staff and nursing assistants will receive education regarding seatbelt alarms, restorative services and fall interventions. Competency were conducted for leg strap audits by DCE. If an employee gets

Post-test were given to licensed nursing staff and CNA by ED, DNS & DCE.
OK 9/23/15

an answer incorrect, immediate education was provided by ED, DNS & DCE. All data is reviewed in IDT for trends related to missed answers by IDT members. This was complete on 9/22/15.

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

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT	STREET ADDRESS, CITY, STATE, ZIP CODE SERVICES 1101 LYNDON LANE LOUISVILLE, KY 40222
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{F 490}	<p>Continued From page 61</p> <p>07/14/15 at 3:40 PM and 08/12/15 at 5:18 PM, revealed she had identified the nursing staff, even though recently trained on the care planning process, still experienced a lack of knowledge and experience with developing, revising and implementing the care plan and had discussed this with the Administrator. She stated she was in the process of developing a plan to fix the issues and the identified concerns. She stated if resident care plans were not revised to include appropriate interventions related to the root cause of the fall and or not followed, residents were at risk for falls and injuries.</p> <p>Interview with the Administrator, on 07/10/15 at 3:30 PM and on 07/14/15 at 5:30 PM, revealed revealed her role was to ensure the care planning process was implemented. She stated the facility still needed to work on the care planning process. She stated the facility was still in the process of drilling down to determine the extent of the education needed in order to develop a plan to correct the issues identified. Per interview, the facility had recently recognized the nursing staff needed additional training in the care planning process and they were still in the process of improving the skills of their nursing staff.</p> <p>2. Reference F323 Review of the Plan of Correction revealed staff were retrained on fall issues and these would be reviewed during the morning meetings. Staff was trained on Incident/accident reports completion, interventions, to include one one supervision, completion of the SBAR including the Antecedent form.</p> <p>Interview with the Director of Nursing, on 08/12/15 at 5:20 PM, revealed communication</p>	{F 490}		

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

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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185185	(X2) MULTIPLE CONSTRUCTION A. BUILDING RECEIVED SEP 23 2015 B. WING	(X3) DATE SURVEY COMPLETED R 08/12/2015
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{F 490}	<p>Continued From page 62 amongst the interdisciplinary team was an identified concern. She stated she had identified supervision of staff was an issue and the facility needed to ensure care plan interventions were implemented by the staff to prevent falls.</p> <p>Interview with the Administrator, on 07/14/15 at 5:30 PM, revealed she assumed the role in April of 2015 and had identified the facility had opportunities for improvement. She stated the facility needed to work on developing the root cause after an incident occurred in order to prevent another occurrence.</p> <p>3. Reference 353 Review of the Plan of Correction revealed staffing would be reviewed daily to validate staffing for the center. If a call in occurred the DON would be notified immediately.</p> <p>Interview with the Administrator, on 08/12/15 at 5:50 PM, revealed the facility was having difficulty providing restorative services due to staffing shortages, but they were working on hiring people to correct the issue. She stated she had identified the facility staff still needed additional education and required supervision to ensure communication occurred and resident needs were met. She stated they were working on that presently.</p> <p>4. Reference F520 Review of the Plan of Correction revealed the QA Committee would meet monthly to review audits, logs, appropriate followup, discuss and develop plans to prevent reoccurrence.</p> <p>Interview with the Medical Director, on 08/12/15 at 1:45 PM, revealed he met weekly with the</p>	{F 490}		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
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{F 490}	Continued From page 63 facility QA committee members to discuss the information brought to the committee by its members. He stated he expressed his opinion at the meetings, but he had no say in rule changes at the facility. He stated his concern was the health of the individual resident and recently recommended to speed up the process of reporting a change in condition to immediately instead of a 24 hour turn around; and the facility was presently working on making that to happen. He stated the QA committee had identified a communication issue between the departments in the facility and were in the process of putting steps in place to improve that now. Interview, on 07/14/15 at 5:30 PM, with the Administrator revealed she stated the facility had identified educational needs in regards to the root cause analysis and care planning process. Further the facility was still in the process of providing additional education to correct these identified issues. Continued interview with the Administrator, revealed they had not identified an issue with communication between nursing and rehab and the root cause analysis. The facility took the following actions to remove the Immediate Jeopardy on 08/01/15 as follows: 1. On 06/08/15 Resident #1 was assessed by RN #2 the Nursing Supervisor and immediately sent to the hospital. 2. On 07/16/15, the Director of Rehabilitation and Executive Director (ED) reviewed the Therapy Evaluation policy and agreed the policy was followed and that communication would be enhanced by updating to include "Tell a Nurse" for the evaluation process. This was also discussed	{F 490}			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222
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{F 490}	<p>Continued From page 64</p> <p>on the phone with Kentucky Area Vice President of Golden Living on 07/16/15. The previous policy did not include communication upon evaluation. This was completed on 07/16/15.</p> <p>3. On 06/09/15 the facility started training supervisors on one to one (1:1) supervision staffing by the Administrator and Director of Nursing (DNS); seventy-seven (77) staff had been trained. Training completed 07/31/15. Any staff that had not been trained will not work until training had been completed. Starting on 06/09/15 Nurses and CNAs received training on the meaning of 1:1 by DNS. Seventy-seven (77) nurses and CNAs have received training as of 07/31/15. Attendance is checked by DNS, ADNS and Nursing Supervisors. If a CNA or Nurse was on leave or vacation, they were scheduled to have the education prior to shift upon return. Golden Living Camelot does not utilize Agency staffing.</p> <p>4. One on one competency audit interviews for the one on one (1:1) supervision training follow-up started 07/29/15 with Certified Nursing Assistant (CNA) and nursing staff, Registered Nurse (RN), and Licensed Practical Nurse (LPN). This was completed by Nursing Consultant, ED, and Nursing Supervisors. Forty-eight (48) interviews had been done. Going forward five (5) interviews would be done on varied shifts each day for two (2) weeks and then five (5) times per week for one month. Any deficits were retrained at the time of the interview with the CNA or Nurse.</p> <p>5. Rehabilitation Manager identified residents that had been evaluated by therapy in the last three (3) months or on therapy caseload as of 07/23/15</p>	{F 490}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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{F 490}	<p>Continued From page 65</p> <p>without any issues noted. Thirty-seven (37) residents had been evaluated. Thirty-seven (37) care plans were revised by nursing and therapy to include gait and transfer information. Those care plans had been reviewed and revised as indicated. On 07/17/15 CNA care cards were revised to assure consistent language was used throughout the building for CNA care.</p> <p>6. Training on Tell a Nurse program was done with ten (10) therapists starting 07/16/15 by the Director of Rehabilitation. Training with therapists was completed on 07/24/15. Starting on 07/16/15, DNS trained forty-three (43) of forty-four (44) nurses on the Tell a Nurse program. Training for nurses was completed on 07/30/15. The one remaining nurse would be trained prior to working a shift by the DNS, Assistant Director of Nursing Services (ADNS), or Nursing Supervisor.</p> <p>7. Checked the Tell A Nurse binders on each nursing unit for communication sheet, check care plan and care sheet to assure any changes were added to the care plan and the CNA care sheet. Audits were completed on 07/15/15 through 08/04/15 by DNS, ADNS, ED, Nursing Supervisor or Nurse Consultant subsequent to Tell A Nurse form to observe service and confirm it was consistent with Tell A Nurse information. On 07/23/15 the Nurse Consultant completed an audit of the Tell a Nurse process. Each binder was reviewed to assure communication sheets were in place, and care plans and care sheets were reviewed to assure accuracy. Three (3) care plans were updated or changed by the Nurse Consultant. Follow up was completed with the nurse. The modifications included more specific information to a care plan regarding transfers, and supervision to licensed nurse to assure</p>	{F 490}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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{F 490}	<p>Continued From page 66 update of CNA care sheet. On the two other cases it was assured that the care plan and CNA care sheets matched and both were updated.</p> <p>8. Starting 07/30/15 when a 1:1 was done, the Unit Manager brought the 1:1 supervision documentation to the clinical start up for a check of the documentation. The Administrator, DNS, or Nursing Supervisor would complete an audit of 1:1's at varied times daily to assure one to one supervision was being done according to protocol.</p> <p>9. Starting on 07/23/15 the DNS, ADNS, or Nurse Supervisor continue to check that changes were made to the care plans from therapy evaluations at the daily clinical start up. The nurse brought the binder to clinical start up, when a Tell a Nurse form had been completed. Therapy, Nursing Consultant/ DNS or ADNS checked the Tell A Nurse form and assured care plan updates and care sheet updates were completed using the Tell A Nurse Audit Form.</p> <p>10. An Ad Hoc Quality Assurance Process Improvement (QAPI) meeting was held on 07/23/15 to discuss and validate that the results of the therapy evaluations were updated to the care plans and the CNA care cards. This was conducted by the Administrator, DNS, ADNS, Social Worker, Therapist, and Medical Director and will continue weekly times four (4) weeks, then bi-weekly times four (4) weeks, then monthly thereafter. The monitoring and auditing of the Tell A Nurse program would be done by the DNS, ADNS, or Nurse Supervisor. Additional Ad Hoc QAPI held on 07/29/15 to update system of checks and validate current systems. Ad Hoc QAPI for entire system held on 07/29/15 including</p>	{F 490}		

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{F 490}	Continued From page 67 Competency Interview system. The State Survey Agency validated the removal of Immediate Jeopardy on 08/12/15 as follows: 1. Review of Resident #1 nurses note, dated 06/08/15, revealed Resident #1 was assessed by RN #2 the Nursing Supervisor and sent to emergency department post fall on 06/08/15 at 5:17 PM. 2. Review of "Evaluation-Plan of Care policy, undated, and "Tell A Nurse" form, undated, on 08/10/15, revealed the Therapy Evaluation policy and procedure was reviewed and updated to include the Tell A Nurse form by the Director of Rehabilitation, ED, and the Kentucky Area Vice President of Golden Living. Interview with the Rehabilitation Director, on 08/10/15 at 11:00 AM, and Administrator, on 08/10/15 at 8:45 AM, revealed the policy was reviewed and procedure updated to include the Tell A Nurse communication form and completed on 07/16/15. 3. Review of in-service records, dated 06/09/15, revealed seventy-seven (77) staff had been trained by the Administrator and Director of Nursing on one to one staffing. Training included the definition of 1:1 staffing, steps to provide 1:1 supervision, and the required documentation for 1:1 supervision. Interview with Nursing Supervisor #2, on 08/10/15 at 3:50 PM and Licensed Practical Charge Nurse #3 revealed they had received training on 1:1 resident care and could correctly define 1:1 and knew what to document regarding 1:1 supervision. 4. Review of one on one (1:1) Competency Interview audits and Daily Assignment Sheets,	{F 490}				

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SEP 23 2015
DIRECTOR GENERAL

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/12/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222
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(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
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{F 490}	<p>Continued From page 68</p> <p>revealed forty eight (48) staff, including CNAs, RNs, and LPNs, on varied shifts had been interviewed regarding 1:1 supervision. Interviews began on 07/29/15 and were completed daily until 08/09/15 by Nursing Consultant, Administrator, and Nursing Supervisors. Interview with Administrator, on 08/10/15 at 8:45 AM, revealed she conducted 1:1 Competency interviews, and had done more than the required five each day during the first 2 weeks. She stated any staff person requiring retraining was done at the time of the interview. Interview with Certified Nursing Assistant #10, on 08/10/15 at 3:10 PM, revealed she received training on 1:1 supervision and had been interviewed after training to determine if she could recite what she was required to do. Interview with Licensed Practical Nurse #7, on 08/11/15 at 1:55 PM, stated she had received training regarding 1:1 supervision and had been interviewed afterwards to check if she knew her responsibility regarding 1:1 supervision. She stated she was to ensure the CNA's documented their 1:1 observations and that staff could not leave the resident unless provided relief. Interview with Registered Nurse #2, on 08/10/15 at 11:00 AM, revealed she had received training on 1:1 supervision and had been interviewed after the training to determine her knowledge of the 1:1 process. She stated her responsibility was to ensure documentation was completed by the CNA and that staff was not to leave the resident unless another staff member relieved them.</p> <p>5. Review of the facility's document titled Level of Assist from 05/01/15 to current, revealed thirty-seven (37) residents had been evaluated by therapy during that time. Record review of those thirty seven (37) resident care plans and CNA care cards, revealed gait and transfer information</p>	{F 490}		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 490}	<p>Continued From page 69</p> <p>was included on the care plans and CNA care cards. Interview with Rehabilitation Manager, on 08/10/15 at 11:00 AM, revealed she identified 37 residents had been evaluated by therapy in the last 3 months, and resident care plans were updated to include gait and transfer information. Interview with Director of Nursing, on 08/10/15 at 10:40 AM, revealed CNA care cards were revised on 07/17/15 to assure consistent language was used throughout the building.</p> <p>6. Review of in-service records, dated 07/16/15, revealed ten (10) therapists had been trained on Tell a Nurse program by the Director of Rehabilitation. Interview with the Director of Rehabilitation, on 08/10/15 at 11:00 AM, revealed she had trained 10 therapists on the Tell A Nurse program. Interview with the Occupational Therapist, on 08/10/15 at 11:10 AM, revealed she had received training by the Director of Rehabilitation regarding the Tell A Nurse program which included filling out the form and verbally providing a report to nursing staff of their assessment findings.</p> <p>Additional review of in-service record, dated 07/16/15, revealed forty-three (43) nurses had attended training on the Tell A Nurse program by the DNS. Interview with Licensed Practical Nurse #7, on 08/11/15 at 1:55 PM, revealed he/she had been trained on the Tell A Nurse program, including the location and purpose of the Tell a Nurse binder, and the process for updating care plans and CNA care sheet after therapy evaluation.</p> <p>7. Review completed on 08/10/15, of the Tell A Nurse Binder communication sheets, resident care plans, and CNA care sheets, revealed</p>	{F 490}		
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{F 490}	<p>Continued From page 70</p> <p>changes and updates from the Tell A Nurse form were updated on the resident care plan and CNA care sheets.</p> <p>Interview with the Administrator, on 08/10/15 at 8:45 AM, and Director of Nursing, on 08/10/15 at 10:40 AM, revealed they had conducted audits of the Tell A Nurse communication sheet, resident care plans, and CNA care sheets to confirm that information was consistent on all documents.</p> <p>Interview with Nurse Consultant, on 08/10/15 at 10:45 AM, and Nursing Supervisor #2, on 08/10/15 at 3:50 PM, revealed they completed audits of the Tell A Nurse process on 07/23/15, including reviewing the Tell A Nurse binders to assure communication sheets were in place, and care plans and care sheets were reviewed for accuracy. In addition, they revealed three (3) care plans were updated to include more specific information regarding transfers, and supervision to licensed nurse to assure update of CNA care sheet. Review of the three care plans, revealed care plans and CNA care sheets were updated with therapy's recommendations for assistance with transfers and walking.</p> <p>8. Observation of the clinical start up meeting, on 08/06/15 at 9:00 AM, revealed the Unit Manager of the Alzheimer's Care Unit (ACU) had one resident on 1:1 supervision. The 1:1 documentation was discussed and reviewed by the DON. Review of the 1:1 documentation for the resident, revealed 1:1 documentation was complete, and the ED, DNS, or Nursing Supervisor had completed a daily audit of the documentation. Review of Golden Living Center Camelot E.D. Stand-Up Meeting sheets from 07/31/15-08/05/15, revealed 1:1 documentation</p>	{F 490}		
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{F 490}	Continued From page 71 was reviewed daily during the clinical start up meeting. 9. Observation of the clinical start up meeting, on 08/08/15 at 9:00 AM, revealed the Tell A Nurse binders on each nursing unit were reviewed with no new Tell A Nurse forms completed the previous day. Review of the Tell A Nurse forms from 07/23/15, resident care plans, and CNA care sheets, revealed therapy evaluations from the Tell A Nurse form were updated on the resident care plan and CNA care sheets to reflect therapy recommendations. Interview with the DNS, on 08/12/15 at 5:20 PM, revealed she checked the Tell A Nurse form and assured care plans and CNA care sheets were updated using the Tell A Nurse Audit Form. 10. Review of the Ad Hoc Quality Assurance Process Improvement (QAPI) sign in sheets, and agendas dated 07/23/15 and 07/29/15, revealed the Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, Therapist and Medical Director were in attendance. Interview with the Administrator, on 08/12/15 at 5:50 PM, revealed the QAPI team met weekly if not more frequently. In addition, the QAPI team discussed the results of therapy evaluations and ensured care plans and CNA care cards were updated. Interview with the Director of Nursing, on 08/12/15 at 5:20 PM, revealed she was responsible for the monitoring and auditing of the Tell A Nurse program. She stated she reviewed the Tell A Nurse communication sheet in the daily clinical start up meeting and completed audits to ensure care plans and CNA care sheets were updated as needed.	{F 490}		
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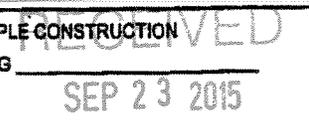
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{F 490}	Continued From page 72 Interview with the Medical Director, on 08/12/15 at 1:45 PM, revealed he met weekly with the facility QA committee members to discuss the information brought to the committee by its members. He stated the Tell A Nurse form and communication process was discussed and actions were developed at the meeting. He stated the 1:1 supervision process was also discussed along with audit findings.	{F 490}			
{F 520} SS=J	Review of the QAPI sign in sheets, revealed QAPI meetings were held on 07/23/15, 07/29/15, 08/05/15, and 08/06/15. Review of the QAPI documentation, dated 07/23/15, revealed process and progress of audit systems were discussed. 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	{F 520} F520	1. The QAPI committee failed to identify that the facility investigations were not determining the root cause of incidents or relevant interventions were implanted to prevent incidents and failed to identify a staffing shortage regarding provision of restorative services. 2. The Area Vice President and Nurse Consultant provided education to the QAPI committee regarding the importance of identifying root cause analysis of incidents, implementing appropriate interventions and adequate staffing to provide restorative services. Completed 9-2-2015.		

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{F 520}	Continued From page 73 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies and the facility's Plan of Correction for the 06/03/15 Recertification Survey, it was determined the facility failed to maintain an effective Quality of Assurance/Performance Improvement Committee (QA) to investigate and develop plans of action in response to identified problems. The QA committee failed to identify that the facility investigations were not determining the root cause of incidents or relevant interventions were implemented to prevent incidents and failed to identify a staffing shortage regarding provision of restorative services. (Refer to F282, F323, F353, and F490) Resident #1 had a history of falls, unsteady gait, and walking with eyes closed. The resident was assessed to need staff assistance with transfers and walking. On 06/08/15, at 12:14 PM Physical Therapy assessed the resident to need the maximum assistance of two (2) persons for ambulation. However, Therapy staff failed to communicate the resident's need for maximum assist to nursing staff. On 06/08/15, at 5:10 PM, Resident #1 fell while walking in the hallway without any assistance of staff. Resident #1 sustained bilateral subdural hematomas to the forehead and a skull fracture to the back of the head and expired sixteen (16) hours later at the	{F 520}	<ol style="list-style-type: none"> The Area Vice President and/or Nurse Consultant will monitor QAPI meetings and discuss findings with ED and/or DNS weekly for four weeks, biweekly for 2 weeks and monthly on-going to ensure the QAPI committee is addressing root cause analysis of incidents, appropriate interventions and adequate staffing for restorative services. Completed 9-3-2015. The QAPI committee will discuss audits related to the use of catheter leg steps, falls that have occurred for the previous week and all falls for the month to ensure root cause analysis has been identified and appropriate interventions are in place. QAPI committee will address issues regarding restorative services, including staffing, resident participation and admissions and discharges to the program. This process began 9-3-2015 and is ongoing. Beginning on 9-3-2015, QAPI meetings will be held weekly for four weeks, then bi-weekly for 1 month, then monthly on going. QAPI committee will review results of audits and ensure compliance with plan of correction pertaining to F282, F323, F353 and F520. ED is responsible for QAPI meetings. Date of Compliance: 9-4-2015 9/23/15 			

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		A. BUILDING _____ OFFICE OF INSPECTOR GENERAL B. WING _____	

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{F 520}	<p>Continued From page 74 hospital. (Refer to F282 and F323)</p> <p>Resident #8 did not receive restorative services due to staffing issues and Restorative Aides were being pulled to the floor to provide direct care to residents. (Refer to F353)</p> <p>Repeat deficiencies at F353, F490, F520 were cited previously on the 06/03/15 Recertification Survey at Immediate Jeopardy scope and severity of a "J", and F323 at a scope and severity of a "K". In addition, F282 was cited at a scope and severity of a "D".</p> <p>The facility's failure to have an effective system in place to ensure the QA Committee ensured the root causes of incidents and relevant interventions were implemented and adequate staffing to ensure restorative services were provided has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was determined to exist on 06/08/15.</p> <p>An acceptable Allegation of Compliance was received on 08/05/15 alleging removal of the Immediate Jeopardy on 08/01/15. The State Survey Agency (SSA) validated the removal of Immediate Jeopardy on 08/01/15 as alleged prior to exit on 08/12/15. The scope and severity was lowered to an "D" while the facility monitors the systemic changes and the Quality Assurance monitors the effectiveness of the plan of correction.</p> <p>The findings include:</p> <p>Review of the facility Quality Assurance (QA) policy, not dated, revealed the committee would conduct performance improvement projects to</p>	{F 520}		
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{F 520}	<p>Continued From page 75</p> <p>examine and improve care or services in areas that were identified as needing attention. This involved gathering information systematically to clarify issues or problems and intervening for improvements.</p> <p>1. Reference F282 Review of the Plan of Correction for the 06/03/15 recertification survey revealed the facility would audit care plans quarterly and daily in conjunction with new orders. The QA Committee would assess for systemic issues with follow-up assigned.</p> <p>Review of the facility audits revealed they were completed; however, they did not identify staff not following the care plans. Review of the QA minutes provided by the facility revealed staff not following care plans had not been identified nor action plans developed and monitored.</p> <p>Interview with the Director of Nursing, on 07/14/15 at 3:40 PM and 08/12/15 at 5:18 PM, revealed she had identified the nursing staff, even though recently trained on the care planning process, still experienced a lack of knowledge and experience with developing, revising and implementing the care plan and had discussed this with the Administrator.</p> <p>2. Reference F323 Review of the Plan of Correction revealed care plans for falls would be reviewed and revised as appropriate by the nursing staff. Changes would be made to the CNA care sheets as needed.</p> <p>Review of the QA minutes revealed the committee had reviewed the falls however, did</p>	{F 520}		
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{F 520}	<p>Continued From page 76 not aggregate data to identify root causes of falls and develop plans of actions or monitor for effectiveness.</p> <p>Review of the Quality Assurance Meeting Minutes revealed QA meetings were held with the Director of Nursing, Medical Director and three (3) other facility staff participants on 06/23/15, 07/02/15, and 07/09/15; however no action plans were developed or evidence provided to validate the facility had identified opportunities for improvement related to the root cause analysis and the care planning process. In addition, interviews with the QA participants revealed the committee members did not provide direction for staff to implement quality of care changes related to resident falls.</p> <p>Interview with the Director of the Alzheimer's Care Unit on, 08/12/15 at 5:00 PM, revealed she participated in the QA committee meetings. She stated she presented information to the committee regarding Resident #1; however, no identified issues were determined with the root cause analysis process at the QA meeting. She stated no action plan was developed or opportunities for improvement identified in the quality of care provided for Resident #1.</p> <p>Interview with the Director of Social Services, on 08/12/15 at 4:45 PM, revealed no opportunities for improvement with the root cause analysis process had been identified in the QA meeting that she could recall. She stated the QA committee discussed incidents, but not the process or if the investigation determined the actual root cause.</p> <p>Interview with the Director of Nursing, on</p>	{F 520}		
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{F 520}	<p>Continued From page 77</p> <p>07/14/15 at 3:40 PM and 08/12/15 at 5:18 PM, revealed she attended QA meetings after she returned from vacation; however, the committee had not identified issues with the root cause analysis process or that relevant interventions to prevent incidents were not developed and implemented. She stated as far as she could remember there were no action plans developed from the committee to address these areas of concern. She stated she had a lot of work ahead of her to correct them.</p> <p>Interview with the Medical Director, on 08/12/15 at 1:45 PM, He stated the committee members had not identified issues with the facility's root cause analysis process or that there were additional care planning issues related to incidents and accidents.</p> <p>Interview with the Administrator, on 07/14/15 at 5:30 PM, revealed she assumed the role in April of 2015 and had identified the facility had opportunities for improvement. She stated the facility needed to work on developing the root cause after an incident occurred in order to put the relevant care plan interventions in place to prevent another occurrence. She stated during the QA meeting resident incidents were discussed; however no opportunities for improvement were identified and no action plans were developed for the members to implement and should have been.</p> <p>3. Reference 353 Review of the Plan of Correction revealed additional staff had been added to the Alzheimer's Care Unit and weekly audits of staffing would be completed.</p>	{F 520}			

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{F 520}	<p>Continued From page 78</p> <p>Review of the QA minutes revealed weekly meetings had occurred; however, had not identified a staffing shortage for restorative programs due to the nursing assistants being pulled to cover call-ins.</p> <p>Interview with the Administrator, on 07/14/15 at 5:30 PM, revealed the committee had not discussed the lack of restorative services being provided due to staffing in order to develop a plan of action until staff could be hired.</p> <p>4. Reference 490 Review of the Plan of Correction revealed the Administrator was to ensure education was started and no employee would work until education was received and monitored progress daily in the clinical morning startup meeting.</p> <p>Review of the QA minutes revealed education audits were reviewed; however, there were no issues identified.</p> <p>Interview with the Director of Nursing (DON), on 07/14/15 at 3:40 PM, revealed after assuming the role of DON and assessing the nursing staff skills related to the care planning process she stated she had concerns with the facility's ability to implement the care plan. She stated she was in the process of developing a plan to fix the issues and the identified concerns. She stated if resident care plans were not followed the appropriate interventions related to the fall, residents were at risk for falls and injuries.</p> <p>Interview, on 07/14/15 at 5:30 PM, with the Administrator revealed she stated the facility had identified educational needs in regards to the root cause analysis and care planning process.</p>	{F 520}			

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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 520}	<p>Continued From page 79</p> <p>Further the facility was still in the process of providing additional education to correct these identified issues. Continued interview with the Administrator, revealed they had not identified an issue with communication between nursing and rehab and the root cause analysis.</p> <p>Interview with the Medical Director, on 08/12/15 at 1:45 PM, revealed he met weekly with the facility QA committee members to discuss the information brought to the committee by its members. He stated the QA committee had identified a communication issue between the departments in the facility and were in the process of putting steps in place to improve that now.</p> <p>The facility took the following actions to remove the Immediate Jeopardy on 08/01/15 as follows:</p> <ol style="list-style-type: none"> 1. On 06/08/15 Resident #1 was assessed by RN #2 the Nursing Supervisor and immediately sent to the hospital. 2. On 07/16/15, the Director of Rehabilitation and Executive Director (ED) reviewed the Therapy Evaluation policy and agreed the policy was followed and that communication would be enhanced by updating to include "Tell a Nurse" for the evaluation process. This was also discussed on the phone with Kentucky Area Vice President of Golden Living on 07/16/15. The previous policy did not include communication upon evaluation. This was completed on 07/16/15. 3. On 06/09/15 the facility started training supervisors on one to one (1:1) supervision staffing by the Administrator and Director of Nursing (DNS); seventy-seven (77) staff had 	{F 520}		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ RECEIVED B. WING _____ SEP 23 2015		(X3) DATE SURVEY COMPLETED R 08/12/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 520}	Continued From page 80 been trained. Training completed 07/31/15. Any staff that had not been trained will not work until training had been completed. Starting on 06/09/15 Nurses and CNAs received training on the meaning of 1:1 by DNS. Seventy-seven (77) nurses and CNAs have received training as of 07/31/15. Attendance is checked by DNS, ADNS and Nursing Supervisors. If a CNA or Nurse was on leave or vacation, they were scheduled to have the education prior to shift upon return. Golden Living Camelot does not utilize Agency staffing. 4. One on one competency audit interviews for the one on one (1:1) supervision training follow-up started 07/29/15 with Certified Nursing Assistant (CNA) and nursing staff, Registered Nurse (RN), and Licensed Practical Nurse (LPN). This was completed by Nursing Consultant, ED, and Nursing Supervisors. Forty-eight (48) interviews had been done. Going forward five (5) interviews would be done on varied shifts each day for two (2) weeks and then five (5) times per week for one month. Any deficits were retrained at the time of the interview with the CNA or Nurse. 5. Rehabilitation Manager identified residents that had been evaluated by therapy in the last three (3) months or on therapy caseload as of 07/23/15 without any issues noted. Thirty-seven (37) residents had been evaluated. Thirty-seven (37) care plans were revised by nursing and therapy to include gait and transfer information. Those care plans had been reviewed and revised as indicated. On 07/17/15 CNA care cards were revised to assure consistent language was used throughout the building for CNA care.	{F 520}			

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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ SEP 23 2015 B. WING _____		(X3) DATE SURVEY COMPLETED R 08/12/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 520}	Continued From page 81 6. Training on Tell a Nurse program was done with ten (10) therapists starting 07/16/15 by the Director of Rehabilitation. Training with therapists was completed on 07/24/15. Starting on 07/16/15, DNS trained forty-three (43) of forty-four (44) nurses on the Tell a Nurse program. Training for nurses was completed on 07/30/15. The one remaining nurse would be trained prior to working a shift by the DNS, Assistant Director of Nursing Services (ADNS), or Nursing Supervisor. 7. Checked the Tell A Nurse binders on each nursing unit for communication sheet, check care plan and care sheet to assure any changes were added to the care plan and the CNA care sheet. Audits were completed on 07/15/15 through 08/04/15 by DNS, ADNS, ED, Nursing Supervisor or Nurse Consultant subsequent to Tell A Nurse form to observe service and confirm it was consistent with Tell A Nurse information. On 07/23/15 the Nurse Consultant completed an audit of the Tell a Nurse process. Each binder was reviewed to assure communication sheets were in place, and care plans and care sheets were reviewed to assure accuracy. Three (3) care plans were updated or changed by the Nurse Consultant. Follow up was completed with the nurse. The modifications included more specific information to a care plan regarding transfers, and supervision to licensed nurse to assure update of CNA care sheet. On the two other cases it was assured that the care plan and CNA care sheets matched and both were updated. 8. Starting 07/30/15 when a 1:1 was done, the Unit Manager brought the 1:1 supervision documentation to the clinical start up for a check of the documentation. The Administrator, DNS, or Nursing Supervisor would complete an audit of	{F 520}			

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		B. WING _____		

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SEP 23 2015

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222
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{F 520}	<p>Continued From page 82</p> <p>1:1's at varied times daily to assure one to one supervision was being done according to protocol.</p> <p>9. Starting on 07/23/15 the DNS, ADNS, or Nurse Supervisor continue to check that changes were made to the care plans from therapy evaluations at the daily clinical start up. The nurse brought the binder to clinical start up, when a Tell a Nurse form had been completed. Therapy, Nursing Consultant/ DNS or ADNS checked the Tell A Nurse form and assured care plan updates and care sheet updates were completed using the Tell A Nurse Audit Form.</p> <p>10. An Ad Hoc Quality Assurance Process Improvement (QAPI) meeting was held on 07/23/15 to discuss and validate that the results of the therapy evaluations were updated to the care plans and the CNA care cards. This was conducted by the Administrator, DNS, ADNS, Social Worker, Therapist, and Medical Director and will continue weekly times four (4) weeks, then bi-weekly times four (4) weeks, then monthly thereafter. The monitoring and auditing of the Tell A Nurse program would be done by the DNS, ADNS, or Nurse/Supervisor. Additional Ad Hoc QAPI held on 07/29/15 to update system of checks and validate current systems. Ad Hoc QAPI for entire system held on 07/29/15 including Competency Interview system.</p> <p>The State Survey Agency validated the removal of Immediate Jeopardy on 08/12/15 as follows:</p> <p>1. Review of Resident #1 nurses note, dated 06/08/15, revealed Resident #1 was assessed by RN #2 the Nursing Supervisor and sent to emergency department post fall on 06/08/15 at</p>	{F 520}		
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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/12/2015
	NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222
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{F 520}	Continued From page 83 5:17 PM. 2. Review of "Evaluation-Plan of Care policy, undated, and "Tell A Nurse" form, undated, on 08/10/15, revealed the Therapy Evaluation policy and procedure was reviewed and updated to include the Tell A Nurse form by the Director of Rehabilitation, ED, and the Kentucky Area Vice President of Golden Living. Interview with the Rehabilitation Director, on 08/10/15 at 11:00 AM, and Administrator, on 08/10/15 at 8:45 AM, revealed the policy was reviewed and procedure updated to include the Tell A Nurse communication form and completed on 07/16/15. 3. Review of in-service records, dated 06/09/15, revealed seventy-seven (77) staff had been trained by the Administrator and Director of Nursing on one to one staffing. Training included the definition of 1:1 staffing, steps to provide 1:1 supervision, and the required documentation for 1:1 supervision. Interview with Nursing Supervisor #2, on 08/10/15 at 3:50 PM and Licensed Practical Charge Nurse #3 revealed they had received training on 1:1 resident care and could correctly define 1:1 and knew what to document regarding 1:1 supervision. 4. Review of one on one (1:1) Competency Interview audits and Daily Assignment Sheets, revealed forty eight (48) staff, including CNAs, RNs, and LPNs, on varied shifts had been interviewed regarding 1:1 supervision. Interviews began on 07/29/15 and were completed daily until 08/09/15 by Nursing Consultant, Administrator, and Nursing Supervisors. Interview with Administrator, on 08/10/15 at 8:45 AM, revealed she conducted 1:1 Competency Interviews, and had done more than the required five each day	{F 520}		
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222
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{F 520}	Continued From page 84 during the first 2 weeks. She stated any staff person requiring retraining was done at the time of the interview. Interview with Certified Nursing Assistant #10, on 08/10/15 at 3:10 PM, revealed she received training on 1:1 supervision and had been interviewed after training to determine if she could recite what she was required to do. Interview with Licensed Practical Nurse #7, on 08/11/15 at 1:55 PM, stated she had received training regarding 1:1 supervision and had been interviewed afterwards to check if she knew her responsibility regarding 1:1 supervision. She stated she was to ensure the CNA's documented their 1:1 observations and that staff could not leave the resident unless provided relief. Interview with Registered Nurse #2, on 08/10/15 at 11:00 AM, revealed she had received training on 1:1 supervision and had been interviewed after the training to determine her knowledge of the 1:1 process. She stated her responsibility was to ensure documentation was completed by the CNA and that staff was not to leave the resident unless another staff member relieved them. 5. Review of the facility's document titled Level of Assist from 05/01/15 to current, revealed thirty-seven (37) residents had been evaluated by therapy during that time. Record review of those thirty seven (37) resident care plans and CNA care cards, revealed gait and transfer information was included on the care plans and CNA care cards. Interview with Rehabilitation Manager, on 08/10/15 at 11:00 AM, revealed she identified 37 residents had been evaluated by therapy in the last 3 months, and resident care plans were updated to include gait and transfer information. Interview with Director of Nursing, on 08/10/15 at 10:40 AM, revealed CNA care cards were revised on 07/17/15 to assure consistent language was	{F 520}		
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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ RECEIVED B. WING _____ SEP 23 2015	(X3) DATE SURVEY COMPLETED R 08/12/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222	
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{F 520}	Continued From page 85 used throughout the building. 6. Review of in-service records, dated 07/16/15, revealed ten (10) therapists had been trained on Tell a Nurse program by the Director of Rehabilitation. Interview with the Director of Rehabilitation, on 08/10/15 at 11:00 AM, revealed she had trained 10 therapists on the Tell A Nurse program. Interview with the Occupational Therapist, on 08/10/15 at 11:10 AM, revealed she had received training by the Director of Rehabilitation regarding the Tell A Nurse program which included filling out the form and verbally providing a report to nursing staff of their assessment findings. Additional review of in-service record, dated 07/16/15, revealed forty-three (43) nurses had attended training on the Tell A Nurse program by the DNS. Interview with Licensed Practical Nurse #7, on 08/11/15 at 1:55 PM, revealed he/she had been trained on the Tell A Nurse program, including the location and purpose of the Tell a Nurse binder, and the process for updating care plans and CNA care sheet after therapy evaluation. 7. Review completed on 08/10/15, of the Tell A Nurse Binder communication sheets, resident care plans, and CNA care sheets, revealed changes and updates from the Tell A Nurse form were updated on the resident care plan and CNA care sheets. Interview with the Administrator, on 08/10/15 at 8:45 AM, and Director of Nursing, on 08/10/15 at 10:40 AM, revealed they had conducted audits of the Tell A Nurse communication sheet, resident care plans, and CNA care sheets to confirm that	{F 520}		

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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ RECEIVED B. WING _____ SEP 23 2015		(X3) DATE SURVEY COMPLETED R 08/12/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE INSPECTOR GENERAL LOUISVILLE, KY 40222 SERVICES		
(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 520}	Continued From page 86 information was consistent on all documents. Interview with Nurse Consultant, on 08/10/15 at 10:45 AM, and Nursing Supervisor #2, on 08/10/15 at 3:50 PM, revealed they completed audits of the Tell A Nurse process on 07/23/15, including reviewing the Tell A Nurse binders to assure communication sheets were in place, and care plans and care sheets were reviewed for accuracy. In addition, they revealed three (3) care plans were updated to include more specific information regarding transfers, and supervision to licensed nurse to assure update of CNA care sheet. Review of the three care plans, revealed care plans and CNA care sheets were updated with therapy's recommendations for assistance with transfers and walking. 8. Observation of the clinical start up meeting, on 08/06/15 at 9:00 AM, revealed the Unit Manager of the Alzheimer's Care Unit (ACU) had one resident on 1:1 supervision. The 1:1 documentation was discussed and reviewed by the DON. Review of the 1:1 documentation for the resident, revealed 1:1 documentation was complete, and the ED, DNS, or Nursing Supervisor had completed a daily audit of the documentation. Review of Golden Living Center Camelot E.D. Stand-Up Meeting sheets from 07/31/15-08/05/15, revealed 1:1 documentation was reviewed daily during the clinical start up meeting. 9. Observation of the clinical start up meeting, on 08/06/15 at 9:00 AM, revealed the Tell A Nurse binders on each nursing unit were reviewed with no new Tell A Nurse forms completed the previous day. Review of the Tell A Nurse forms from 07/23/15, resident care plans, and CNA care	{F 520}			

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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 520}	<p>Continued From page 87</p> <p>sheets, revealed therapy evaluations from the Tell A Nurse form were updated on the resident care plan and CNA care sheets to reflect therapy recommendations. Interview with the DNS, on 08/12/15 at 5:20 PM, revealed she checked the Tell A Nurse form and assured care plans and CNA care sheets were updated using the Tell A Nurse Audit Form.</p> <p>10. Review of the Ad Hoc Quality Assurance Process Improvement (QAPI) sign in sheets, and agendas dated 07/23/15 and 07/29/15, revealed the Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, Therapist and Medical Director were in attendance. Interview with the Administrator, on 08/12/15 at 5:50 PM, revealed the QAPI team met weekly if not more frequently. In addition, the QAPI team discussed the results of therapy evaluations and ensured care plans and CNA care cards were updated.</p> <p>Interview with the Director of Nursing, on 08/12/15 at 5:20 PM, revealed she was responsible for the monitoring and auditing of the Tell A Nurse program. She stated she reviewed the Tell A Nurse communication sheet in the daily clinical start up meeting and completed audits to ensure care plans and CNA care sheets were updated as needed.</p> <p>Interview with the Medical Director, on 08/12/15 at 1:45 PM, revealed he met weekly with the facility QA committee members to discuss the information brought to the committee by its members. He stated the Tell A Nurse form and communication process was discussed and actions were developed at the meeting. He stated the 1:1 supervision process was also discussed along with audit findings.</p>	{F 520}				

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SEP 23 2015
OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/12/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT	STREET ADDRESS, CITY, STATE, ZIP CODE SERVICES 1101 LYNDON LANE LOUISVILLE, KY 40222
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{F 520}	Continued From page 88 Review of the QAPI sign in sheets, revealed QAPI meetings were held on 07/23/15, 07/29/15, 08/05/15, and 08/06/15. Review of the QAPI documentation, dated 07/23/15, revealed process and progress of audit systems were discussed.	{F 520}		

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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 08/12/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(K 000)	INITIAL COMMENTS	(K 000)		
K 025 SS=E	<p>Based upon an onsite revisit on 08/07/15 and implementation of the acceptable POC, the facility was deemed not in compliance on 07/14/15, as alleged.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect nine (9) of eleven (11) smoke compartments, residents, staff and visitors. The facility has one-hundred and forty-five (145) certified beds and the census was one-hundred and thirty-seven (137) on the day of the survey.</p> <p>The findings include: Observation, on 08/07/15 at 10:13 AM, with the</p>	K025	<ol style="list-style-type: none"> 1. No resident was affected by the deficient practice. 2. All staff, visitors and 129 residents have the potential to be affected. Contractors have been hired to complete the attic work to comply with 19.3.7.3 "The smoke barrier (s) will be constructed in accordance with section 8.3 and shall have a Fire Resistance Rating of not less than ½ hour". This work is scheduled to begin 9-17-2015 and be completed by 10-2-2015. 3. The Regional Director of Maintenance and the Maintenance Director checked the building for smoke barriers that may not comply with 19.3.7.3. All eleven smoke barriers were identified as not being in compliance. On 9-10-2015, the Regional Director of Maintenance educated the Maintenance Director and the Assistant Maintenance Director on smoke barriers and fire resistance ratio. The building will be inspected quarterly by the Maintenance Director and/or Assistant Maintenance Director after any contract work is completed by a contract vendor. 	

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

TITLE

(X6) DATE

Kimberly Shellhart RN

DNS

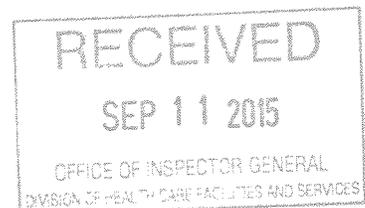
9/11/15

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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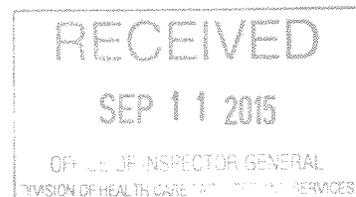
STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 08/12/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	<p>Continued From page 1</p> <p>Maintenance Director revealed exposed wood framing used to construct the smoke barrier located in the attic between Room #129 and Room #130 was covered with gypsum board on only one (1) side.</p> <p>Interview, on 08/07/15 at 10:14 AM, with the Maintenance Director revealed he was not aware of the requirements for the construction of smoke barriers and all of the other smoke barriers were constructed the same.</p> <p>The census of one-hundred thirty-seven (137) was verified by the Administrator on 08/12/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/12/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition).19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor.</p> <p>Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.</p> <p>Reference: NFPA 101 (2000 Edition) 8.3.6.1</p>	K 025	<p>4. On 9-3-2015, the Maintenance Director presented the findings to the QAPI committee. The QAPI committee will receive updates from the Maintenance Director weekly until the work is completed.</p> <p>5. Date of Compliance: 10-3-2015</p> <p><i>9/25/15 KD per Phone mzg</i></p>	



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

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K 025	Continued From page 2 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025		



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