

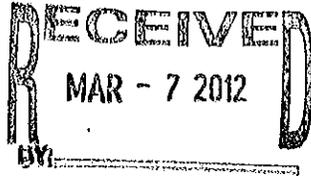
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	--	--	--

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 000	<p>INITIAL COMMENTS</p> <p>A Recertification/Abbreviated Survey/Partial Extended Survey investigating KY#00017725 was conducted 01/24/12 through 02/01/12.</p> <p>KY#00017725 was substantiated and Immediate Jeopardy was identified with deficiencies cited at F-282, F-323, and F-490 at a Scope and Severity (S/S) of a "J". The facility failed to provide adequate supervision for Resident #8 who had been assessed by the facility as being at risk for elopement and was placed on a secure locked unit. On 01/22/12, Resident #8 eloped from the facility without staff knowledge and went down the facility driveway to a sidewalk next to a busy street. The facility's failure to have an effective system in place to ensure adequate supervision and monitoring for residents who were at risk for wandering/elopement behaviors was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 01/27/12 and was determined to exist on 01/22/12.</p> <p>Deficiencies cited were 42 CFR 483.20 Resident Assessment, F-282 at a S/S of a "J", 42 CFR 483.25 Quality of Care, F-323 at a S/S of a "J", and 42 CFR 483.75 Administration, F-490 at a S/S of a "J". Substandard Quality of Care (SQC) was identified in the area of 42 CFR 483.25 Quality of Care, F-323. The highest Scope and Severity was a "J".</p> <p>An acceptable credible Allegation of Compliance, related to the Immediate Jeopardy, was received on 02/01/12. On 02/01/12, the Immediate Jeopardy was verified to be removed on 02/01/12 as alleged.</p>	F 000		
-------	---	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>C. Stale</i> <i>Cliff Stale</i>	TITLE Executive Director	(X8) DATE 3/5/12
---	-----------------------------	---------------------

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
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	--	--	--

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 282 SS=J	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's investigation, it was determined the facility failed to ensure services were provided in accordance with each resident's written Comprehensive Plan of Care for one (1) of twenty-eight (28) sampled residents (Resident #8).</p> <p>The facility identified Resident #8 as at risk for wandering/exit seeking behaviors. The facility placed Resident #8 on the Alzheimer's Care Unit (ACU) and detailed staff was to monitor the resident's movements, and redirect from situations as needed.</p> <p>On 01/22/12, between 3:00 PM and 3:20 PM, Resident #8 followed another resident's family off the locked ACU without staff knowledge, entered the West Wing Unit, proceeded through the lobby, and out the front main entrance. Although the resident passed a nursing station on the West Wing Unit, and passed a dietary staff member at 3:20 PM at the main front entrance. No staff recognized Resident #8 as a resident of the facility, allowing the resident to exit the facility unsupervised. The front main entrance door had a code alert system, (which required a code to be entered on the keypad in order to keep the</p>	F 282	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></p> <p>F 282 Services Provided in Accordance with Residents Care Plan</p> <p>This facility will ensure that services will be provided in accordance with each residents care plan.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident was returned to the care unit from outside on facility property and immediately assessed for physical injuries and psychosocial well being.. It was determined she had no injuries or negative effects. Resident was immediately placed on one-on-one for forty eight hours to continue monitoring effects of the incident. Resident's code alert was checked to</p>	2/24/12

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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 282	<p>Continued From page 2</p> <p>system from alarming when a resident with a code alert bracelet was exiting), however, Resident #8's code alert bracelet, which was on her/his ankle, did not activate the system to alarm when the resident exited through the main entrance door. Resident #8 exited the building, went down the facility driveway to a sidewalk which was next to a busy street, approximately one mile from a railroad track, without staff knowledge. At 3:34 PM, the House Supervisor received a call from an employee who left work early and noticed Resident #8 standing on the sidewalk.</p> <p>The facility was knowledgeable the staff gave visitors and families the codes to the locked unit keypad system without ensuring that staff was monitoring residents movements, based on their supervision policy, in order to prevent the resident from exiting the unit/building unsupervised.</p> <p>The facility's failure to have an effective system in place to ensure services were provided in accordance with each resident's written Plan of Care was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy (IJ) was identified on 01/27/12 and was determined to exist on 01/22/12.</p> <p>Observations, staff interviews, and in-service record reviews were conducted to verify removal of Immediate Jeopardy as alleged in the acceptable credible Allegation of Compliance (AOC) on 02/01/12. However, non-compliance continued to exist at a scope and severity of a "D" as the facility had not completed the development and implementation of the Plan of Correction (POC) to ensure the facility implemented plans of</p>	F 282	<p>ensure working order, family and physician notified of incident. The environment was immediately assessed, staff, families and residents interviewed and a determination established as to how she was able to get off of the secure unit. Care plan of resident #8 was reviewed and updated by the Assistant Director of Nursing. Resident #8's plan of care was discussed with supervisor, charge nurse and CNA's by Assistant Director of Nursing and Director of Nursing on 1/22/12. Each shift conveyed the plan of care to the upcoming shift.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents who have the potential for elopement have the potential to be affected. A head count of all residents was immediately completed once the resident was returned to the care unit. Exit doors were monitored by staff and fifteen minute checks were completed on all potential elopement residents until we were able to ensure that doors and wander systems were in working order. The environment was immediately assessed. Charge nurse, maintenance supervisor and an outside vendor all independently checked doors armed with code alert system.</p>	

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

PRINTED: 02/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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)	(X6) COMPLETION DATE
F 282	<p>Continued From page 3 care to ensure residents' safety.</p> <p>The findings include:</p> <p>Review of the facility's "Elopement Policy and Procedure Guide", dated 01/11, revealed residents on the secured unit will be deemed at risk for elopement and the documentation guidelines included a Care Plan that addressed the potential to wander or exit the living center and the measures taken to prevent wandering/elopement.</p> <p>Interview with the Director of Nursing (DON), on 01/26/12 at 1:30 PM and on 02/01/12 at 9:15 AM, revealed there was no policy related to Care Plans. She stated the Certified Nursing Assistants (CNAs) carried the Assignment Sheets in their pockets and used it as a reference for the care they were to provide and could also check resident's Comprehensive Care Plans if needed. However, she stated there was no actual audit of the Plans of Care to ensure they were followed.</p> <p>Although the ACU was a locked unit for residents who had been assessed as being at risk for exit seeking/elopement and required a keypad code to prevent residents from exiting the doors unsupervised, staff interviews revealed visitors and families were aware of the code. In addition, interviews with staff who worked on the ACU, revealed there was to be a staff member in the common area or at the nurse's station at all times to view the common area. However, on 01/22/13, CNA #4 left the common area without ensuring staff was monitoring the area. Resident #8 followed a family member off the unit without staffs knowledge.</p>	F 282	<p>Windows were also checked to ensure that they could not be opened to allow a resident to leave via a window. Staff, families and residents were interviewed and a determination was established as to how resident was able to get off of the secure unit. All staff were immediately in-serviced by the Administrator - 1/22/12 - on the policies which include the importance of quick response to door alarms, elopement risk residents and to assist resident families out of the doors instead of giving them the actual codes. This was rein-serviced again with the addition of explaining the change in the front door's extra lock on 1/27/12 by the Administrator, Director of Nurses, Assistant Director of Nursing and/or Director of Staff Development. All residents care plan interventions were reviewed and compared to actual daily implementation of the plan of care to ensure compliance by the Director of Nursing and/or Assistant Director of Nursing.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p>	

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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 282	<p>Continued From page 4</p> <p>Interview with the Staff Development Nurse, on 01/27/12 at 1:30 PM, revealed she stressed during orientation, staff was not to give out the codes to the doors, and was to escort families to the doors and open the doors for them.</p> <p>Interview, on 01/31/12 at 9:30 AM with the Alzheimer's Care Director, revealed there was always the potential for a resident to follow a visitor or family member out of the ACU, and the staff on the ACU had always been allowed to give the visitors codes.</p> <p>Interview with the Unit Manager/Licensed Practical Nurse (LPN) #9 of the ACU, on 01/25/12 at 1:00 PM and 01/31/12 at 10:15 AM, revealed she had informed staff on the ACU they needed to make sure someone was covering the common areas at all times, and the CNAs were to make sure the nurse was aware if they were leaving the common area to give a shower or be in a resident room providing care.</p> <p>Interview with LPN #12, on 01/31/12 at 2:40 PM, revealed she worked the ACU and Advanced Alzheimer's Care Unit (AACU) Units and a staff member should be in the common area or the nurse's station at all times on both units.</p> <p>Interview with Registered Nurse (RN) #5, on 01/25/12 at 3:45 PM and on 01/31/12 at 4:00 PM, revealed she was assigned to Resident #8 on 01/22/12 when the resident left the building. She stated, the resident had not demonstrated exit seeking behaviors prior to the incident on 01/22/12; however, she stated a staff member should always be in the common area or in the</p>	F 282	<p>Code was changed immediately - 1/22/12 - on the secure doors of the unit by the Maintenance Director. Code was also changed on the code alert at each exit door by the Maintenance Director on 1/22/12. Code will be changed at the beginning of each month in the future by the Maintenance Director and reported to the Administrator. Additional lock was added to the front door on 1/26/12. This was in addition to the previous implemented steps. A letter was sent on 1/23/12 to all listed responsible parties to remind them of the potential of a resident following them off of the secure unit and that the codes would be changing routinely in the future. A letter is also given to all new admissions concerning the potential of residents following them out the door and that locks are changed routinely. All staff were immediately in-serviced by the Administrator on 1/22/12 regarding the policies which include the importance of quick response to door alarms, elopement risk residents and to assist resident families out of the doors instead of giving them the actual codes. This was rein-serviced on 1/27/12 by the Administrator, Director of Nursing, Assistant Director of Nursing and/or Director of Staff Development. We continued in-servicing with all staff on 2/22/12 by the Director of Nursing and Staff</p>	

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
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 282	<p>Continued From page 5</p> <p>nurses' station where the common area could be viewed.</p> <p>Interview, on 01/31/12 at 10:00 AM with CNA #5, revealed she consistently worked the day shift on the ACU and she always let the nurse know when she was leaving the common area to go in a resident's room or the shower room because someone needed to visualize the common area at all times.</p> <p>Review of Resident #8's clinical record revealed the facility admitted the resident on 03/23/11 with diagnoses which included Senile Dementia with Disturbance of Mood and Behavior, and Delusions. Review of the Comprehensive Plan of Care, dated 04/02/11, revealed the resident was placed on the ACU for safety due to increasing confusion related to Dementia, was ambulatory, at risk for wandering/exit seeking behavior, and was unable to make safe and appropriate decisions. The Care Plan goal stated the resident would not wander out of the facility or into unsafe areas. The interventions included: monitoring the resident's movement about the unit; redirecting with programming; redirecting from situations, areas, as needed to keep resident safe and secure; and code alert bracelet.</p> <p>Review of the Care Area Assessment Summary (CAAS), dated 04/05/11, revealed the resident was admitted to the facility following an acute care stay at an area hospital secondary to mental status changes and was placed on the ACU as it was felt she/he would be in a safe environment. Further review revealed the resident had cognitive loss and communication difficulty suggested by a Brief Interview of Mental Status</p>	F 282	<p>Development to ensure understanding of the importance of following the care plans, their location, what information is on the care plan and how it is communicated to the staff. A post test was given to all staff to ensure understanding. Our policy concerning elopement was revised and our elopement book "Hikers Handbook" is now being kept in the front office, each nursing unit, Housekeeping/Laundry, Dietary and Therapy office. All residents are assessed for potential of elopement upon admission, quarterly and as needed.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Random alarm checks at front door and back door were completed to ensure appropriate staff responses on 1/24, 1/25 & 1/26/12 by the Administrator and Director of Nursing. These will be continued once a week for three months by the Administrator and/or Director of Nursing. Monthly elopement drills will be completed by the Director of Nursing and/or Assistant Director of Nursing. Ten TARS audited weekly to ensure compliance with code alert checks by Director of Nursing or Assistant</p>	

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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 282	<p>Continued From page 6</p> <p>(BIMS) score of four (4), which indicated the resident had severely impaired cognitive status. Documentation in the medical record revealed the resident had episodes of inattention, disorganized thinking, and presence of behaviors such as wandering episodes.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 11/23/11, revealed the facility assessed Resident #8 as severely impaired in cognitive skills for decision making and required supervision with ambulation.</p> <p>Review of the "Risk for Elopement" section of the Quarterly Interdisciplinary Resident Review, dated 11/23/11, revealed the resident was physically able to leave the building, was cognitively impaired, had impaired decision making skills, and had a history of wandering or elopement. Interview with the Assistant Director of Nursing (ADON), on 02/01/12 at 1:20 PM, revealed if the resident was able to leave the building on his/her own and was cognitively impaired, the resident was automatically considered a risk for elopement. She further stated, according to the completed Quarterly Interdisciplinary Resident Review, dated 11/23/11 which she completed, Resident #8 was considered to be at risk for elopement.</p> <p>Review of the facility's investigation, dated 01/22/12, revealed Resident #8 followed a family member out of the ACU and walked past a nursing station, to the front lobby and exited the front door. Further review revealed the resident walked down the driveway and was observed by a staff member who stopped her car and brought the resident back to the facility. Interview, on</p>	F 282	<p>Director of Nursing weekly for three months. Ten residents will be audited for implementation of their care plan weekly by Director of Nursing Services or Assistant Director of Nursing Services for three months to ensure that services provided are in accordance with each residents-written plan of care. Code alert log audited weekly by Administrator to ensure compliance with alarm checks. A list of all code alerts and their expiration dates will be maintained by the Assistant Director of Nursing and will be checked weekly by the Director of Nursing. Code alerts to be changed as they expire. Findings of audits/interviews will be brought to Quality Assessment & Assurance (QAA) monthly for three months. QAA members include Director of Nursing, Administrator, Medical Director, Social Worker, Dietician and other disciplines as needed. Action plans will be reviewed for progress or new developments and revised as needed with QAA.</p> <p>Compliance Date: 02/24/12</p>	2/24/12

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	--	--	--

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 282	<p>Continued From page 7</p> <p>01/25/12 at 5:30 PM, with CNA #1 revealed she had left work early on 01/22/12 and was pulling out of the facility parking lot when she observed Resident #8 standing on the sidewalk next to the facility's driveway. She stated she parked across the street from the facility's driveway and walked across the street to the resident and called House Supervisor/RN #4. Continued interview revealed she walked the resident back across the street and attempted to assist the resident into her truck; however, the resident declined. She stated she stayed with the resident until the House Supervisor/RN #4, CNA #9, and LPN #12 arrived, and the staff walked the resident back across the street to the facility.</p> <p>Interview with RN/Supervisor #4 on 01/25/12 at 3:20 PM, revealed she received a call on 01/22/12 at 3:34 PM from Certified Nursing Assistant (CNA) #1 who informed her Resident #8 was on the sidewalk by the street. RN/Supervisor #4 explained she called Licensed Practical Nurse (LPN) #12 and asked the LPN to meet her at the front door, and took CNA #6 with her. She stated Resident #8 was observed with CNA #1 across the street from the facility. She, LPN #12 and CNA #6 walked Resident #8 across the street and back to the facility. Continued interview revealed the resident's code alert bracelet, which was on her/his ankle, alarmed at the door as they were walking back in the front entrance.</p> <p>Interview with LPN #12, on 01/31/12 at 2:40 PM, revealed she was working on the Advanced Alzheimer's Care Unit AACU, which was connected to the ACU by another door, on 01/22/12 when she received a call from the House Supervisor/RN #4 asking for assistance.</p>	F 282		

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

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 02/01/2012
--	--	--	--

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)	(X6) COMPLETION DATE
F 282	<p>Continued From page 8</p> <p>She stated, she and House Supervisor/RN #4 went across the street where Resident #8 and CNA #1 were standing and assisted with walking the resident back into the facility.</p> <p>Further review of the investigation, revealed a head to toe assessment was completed and revealed no injuries. Review of the Progress Notes, dated 01/22/12 at 3:35 PM, revealed Resident #8 left the building and was found on the sidewalk in front of the building. The Note stated, the resident was alert and oriented to self which was baseline for this resident. Interview with RN #5, on 01/25/12 at 3:45 PM and on 01/31/12 at 4:00 PM, revealed she had written the Progress Note, was assigned to Resident #8 on 01/22/12 and had arrived on the unit at 2:45 PM when she observed the resident sitting in a chair in the common area. She stated she was completing finger stick blood sugars about 3:30 PM when Licensed Practical Nurse (LPN) #12, who was working the AACU, informed her she was leaving the unit because she had received a phone call stating a resident had left the unit; however, did not say which resident. RN #5 stated she was unaware Resident #8 left the unit, and staff brought the resident back to the unit at approximately 3:40 PM. Continued interview revealed she completed a head to toe assessment of the resident, and no visible injuries were noted. She stated upon return to the unit, the resident was wearing two (2) pairs of pants, a long sleeve top and a heavy red sweater, and was carrying a purse which was usual for this resident.</p> <p>According to the Investigation, Resident #8 was observed by a visitor who was sitting on a couch</p>	F 282		

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2012
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 282	<p>Continued From page 9</p> <p>on the West Wing to follow a family member out of the locked unit. Further review of the investigation, revealed Resident #8 passed a dietary employee when going through the front exit doors, but the employee did not recognize she/he was a resident. The resident was placed on one on one (1:1) for forty-eight (48) hours. The investigation was signed by House Supervisor/Registered Nurse (RN) Supervisor #4.</p> <p>Interview, on 01/27/12 at 3:15 PM with CNA #4, revealed she was assigned to Resident #8 on 01/22/12 at the time of the incident. She stated she arrived on the unit at 3:00 PM and observed the resident sitting by the wall next to the Advanced Alzheimer's Care Unit (AACU). She reported she was the only CNA assigned on the unit; however CNA #8/Restorative Aide was on the unit when she assisted another resident to the bathroom. She stated she usually told the nurse when she was leaving the common area to assist a resident; however, she had not notified the nurse this time because the restorative aide was on the floor. Continued interview revealed she had not asked the restorative aide to watch the common area for her, and the restorative aide had gone over to the AACU unit while CNA #4 was in the bathroom with the other resident. She verified some visitors knew the code to the double doors that led from the locked unit to the West Wing, and there was no code alert on that door. Interview further revealed she was aware Resident #8 had a Plan of Care related to wandering behaviors with an intervention to monitor the resident's movements.</p> <p>Observation of Resident #8 on 01/24/12 at 6:00 PM revealed the resident was ambulating down</p>	F 282			

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

PRINTED: 02/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222
--	---

(X4) IO 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 282	<p>Continued From page 10</p> <p>the hallway on the locked Alzheimer's Care Unit (ACU) with a steady gait. She/he had a purse on her/his shoulder, and was accompanied by a staff member.</p> <p>Interview with LPN #12, on 01/31/12 at 2:40 PM revealed she sometimes worked the ACU. She verified a lot of the families knew the code to get out of the ACU and did not have to be escorted out of the unit by staff prior to the incident.</p> <p>Interview, on 01/31/12 at 9:30 AM with the Alzheimer's Care Director, revealed, it "stands to reason" if the CNA was to leave the common area to give a shower or provide care, they should inform the nurse to ensure residents were monitored per their Plans of Care. Continued interview revealed there was normally one nurse and one CNA on the ACU and there was an unspoken dependence on the staff to ensure the residents did not leave the unit. She stated the Care Plans were updated as needed for new interventions if residents were exit seeking.</p> <p>Interview with the Director of Nursing (DON), on 01/26/12 at 1:30 PM and on 02/01/12 at 9:15 AM, revealed the staff development nurse oriented new hires to the Missing Resident and Elopement Policy, and also to the door alarms and code alert bracelets. She was unsure if staff was told in orientation not to give out door codes to families and visitors; however, it was the facility's philosophy to not give out the codes. She stated she was aware some families were punching in codes to take families out the doors without staff assistance. She further stated, Resident #8's intervention on the Care Plan to monitor movement was referring to staff monitoring</p>	F 282		

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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 282	<p>Continued From page 11 residents for exits seeking behaviors and to re-direct from doors if needed to ensure they were safe.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 02/01/12 that alleged removal of the IJ effective 02/01/12, based on the following;</p> <p>1) The codes to exit the ACU were changed on 01/22/12 and will be changed on the first Monday of each month by the Maintenance Director, and reported to the Administrator upon completion.</p> <p>2) All staff in all departments was inserviced by the Administrator and Director of Nursing on 01/22/12 related to the unit exit door code change, and the code change to the front and back door secure care alarm. The inservice informed staff, they were not to give out door codes to families or visitors. Subsequent shifts, in all department were not allowed to work until they completed the inservice.</p> <p>3) The DON and the ADON reviewed all the current elopement assessments and Care Plans for all active residents to ensure all residents at risk for elopement had been identified and all Care Plans were up to date and listed appropriate interventions on 01/22/12.</p> <p>4) The elopement Hikers Handbook was reviewed by the DON to ensure all residents at risk for elopement were listed in the manual with their picture on 01/22/12.</p> <p>5) A letter to all families/responsible parties was issued by the Executive Director to provide</p>	F 282		

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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 282	<p>Continued From page 12</p> <p>education to watch for residents following them through the doors and informing them there was a code change for exiting the unit.</p> <p>6) On 01/22/12 and 01/23/12, a Quality Assurance Meeting was held to discuss the root cause of the incident and the steps taken to prevent further incidents to Resident #8 and other residents. Also, during the meeting, the incident, investigation, actions taken, and the effectiveness of the actions taken were discussed. The Medical Director was contacted by phone.</p> <p>7) On 01/24/12 and 01/25/12, the Executive Director, the DON, and the ADON conducted door alarm drills to evaluate the staff's response to alarms sounding.</p> <p>8) On 01/26/12, an additional interior key pad and external button to the main entrance was installed.</p> <p>9) On 01/27/12, inservice training was provided for all staff related to installation of the new key pad to the main entrance door and the responsibility of staff to search outside for a resident prior to disabling the secure care alarm. Also the staff was instructed to not give out secure care codes to anyone who was not employed at the facility. Staff who was not present for the inservice were contacted by phone.</p> <p>10) The ADON made additional Hiker Handbooks for all departments and units that included resident face sheet and pictures of each resident identified to be at risk for elopement. The DON, ADON, and the Director of Education conducted</p>	F 282		
-------	---	-------	--	--

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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 282	Continued From page 13 training on 01/31/12 in person in small groups, and by phone to all department staff to inform the staff of the additional elopement manuals, locations, and the need for staff to be familiar with residents identified to be at risk for elopement. Staff was not allowed to work until they had received the inservice.	F 282		
	<p>11) Monthly elopement drills are to be completed by the DON, ADON, or the Director of Clinical Education.</p> <p>12) The Quarterly Elopement Review will be done monthly for three months by the ADON and brought to the QA Meetings.</p> <p>13) New employees are to be trained on the elopement system upon hire by the Director of Clinical Education. The elopement Hikers Handbook will be reviewed during orientation of new staff. The revised elopement policy and procedure have been included in the new hire orientation material beginning 1/31/12.</p> <p>On 02/01/12, it was verified the immediacy of the IJ was removed and the facility implemented corrective actions as alleged in the AOC, effective 02/01/12 based on the following:</p> <p>Observation on 02/01/12 from 09:45 AM until 1:25 PM revealed there were Hikers Handbooks on all the nursing units including the East 1 Nurses Station, East 2 Nurses Station, Alzheimer's Nurses Station, Therapy Department, Dietary Department, Housekeeping Office, Laundry Department, and the Front Office.</p> <p>Interviews with staff including the Occupational</p>			

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

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 02/01/2012
--	---	--	---

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)	(X6) COMPLETION DATE
F 282	<p>Continued From page 14</p> <p>Therapist on 01/31/12 at 3:05 PM, the Physical Therapist on 01/31/12 at 3:20 PM, the Restorative Nurse on 01/31/12 at 3:40 PM, LPN #7 on 02/01/12 at 10:55 AM, LPN #8 on 02/01/12 at 11:05 AM, the MDS Coordinator on 02/01/12 at 11:15 AM, RN #3 on 02/01/12 at 10:10 AM, CNA #3 on 02/01/12 at 10:20 AM, LPN #5 on 02/01/12 at 10:30 AM, LPN #6 on 02/01/12 at 10:40 AM, Dietary Assistant #1 on 02/01/12 at 1:25 PM, Dietary Assistant #3 on 02/01/12 at 1:30 PM, and Dietary Assistant #4 on 02/01/12 at 1:35 PM revealed they were aware of the Hikers Handbook, and the elopement policy. They were also aware they were not to give out secure code alarms for the front and back doors at any time, they were not allowed to give out door codes for the AACU and the ACU doors at any time, staff was to open doors which required a code for families and visitors, and they were not to turn off a code alarm until the resident was found.</p> <p>Interview, on 02/01/12 at 9:45 AM, with the Staff Development Nurse, revealed she had assisted with the changes in the new elopement policy and the policy would be given to each new hire. She further stated most current staff had been inserviced on the new policy and if they had not received the inservice, they were not to clock in until they had been inserviced and signed that they had received the inservice.</p> <p>Interview with the Administrator and review of the new Elopement Policy, on 02/01/12 at 3:00 PM, revealed the Policy was updated 01/31/12 to include bullet points which stated; staff was not to give out the secure care alarm codes which were located at the front and back entrance, staff was not to give out door codes to the AACU and ACU,</p>	F 282		

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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 282	Continued From page 15 and there was to be a Hikers Handbook located on each nurses station and in each department. The facility remained out of compliance at a lower scope and severity of a "D", an isolated deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction. (POC).	F 282	F 323 Free of Accident and Hazards This facility will ensure that the environment remains free of accident hazards as is possible and each resident receive adequate supervision and assistance devices to prevent accidents.	2/24/12
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's investigation and the facility's policy, it was determined the facility failed to provide adequate supervision and monitoring to prevent accidents for one (1) of twenty-eight (28) sampled residents (Resident #8). The facility assessed and identified Resident #8 and forty-six (46) additional residents as at risk for wandering or elopement; however, the facility failed to ensure staff was knowledgeable of residents who the facility had identified as being at risk for elopement. In addition, the facility failed to ensure the code alert system and the door code system for the Alzheimer's Care Unit	F 323	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident was returned to the care unit from outside on facility property and immediately assessed for physical injuries and psychosocial well being. It was determined she had no injuries or negative effects. Resident was immediately placed on one-on-one for forty eight hours to continue monitoring for effects of the incident. Resident's code alert was checked to ensure working order, family and physician notified of incident. The environment was immediately assessed, staff, families and residents interviewed and a determination established as to how she was able to get off of the secure unit. Care plan reviewed by Assistant Director of Nursing. How will you identify other residents having the potential to be affected by	

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	--	--	--

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 16</p> <p>(ACU) was effective as an assistive device in protecting residents who were assessed to be an elopement risk.</p> <p>The facility did not ensure the Plan of Care was implemented related to monitoring the resident's movements and redirect from situations as needed to ensure supervision and monitoring to prevent elopement for Resident #8.</p> <p>On 01/22/12, between 3:00 PM and 3:20 PM, Resident #8 followed another resident's family off the locked unit without staff knowledge, entered the West Wing Unit, proceeded to walk through the lobby and out the front main entrance. Although the resident passed a nursing station on the West Unit, and at the facility's main entrance, passed a dietary staff member at 3:20 PM, the dietary staff member was unaware Resident #8 was a resident of the facility and let the resident exit the facility unsupervised. The front main entrance had a code alert system, (which required a code to be entered on the keypad in order to keep the system from alarming when a resident with a code alert bracelet was exiting). However, Resident #8's code alert bracelet did not activate the system to alarm as the resident exited through the main entrance door. Resident #8 exited the building, went down the facility driveway to a sidewalk next to a busy street, which was approximately one mile from a rail road track, without staff knowledge. The temperature outside was forty-eight (48) degrees and it was a cloudy day. At 3:34 PM, the House Supervisor received a call from an employee who left work early and saw Resident #8 standing on the sidewalk.</p>	F 323	<p>the same deficient practice and what corrective action will be taken?</p> <p>All residents who have the potential for elopement have the potential to be affected. A head count of all residents was immediately completed once the resident was returned to the care unit. Exit doors were monitored by staff and fifteen minute checks were completed on all potential elopement residents until we were able to ensure that doors and wander systems were in working order. The environment was immediately assessed. Charge nurse, maintenance supervisor and an outside vendor, independently checked all doors armed with code alert system. Windows were also checked to ensure that they could not be opened to allow a resident to leave via a window. Staff, families and residents were interviewed and a determination was established as to how resident was able to get off of the secure unit. All residents assessments and care plans was reviewed and changes were made as needed by Director of Nursing and Assistant Director of Nursing. All staff were immediately in-serviced by the Administrator on 1/22/12 regarding the policies which include the importance of quick response to door alarms, elopement risk residents and to assist resident families out of the doors instead of giving them the actual</p>	

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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)	(X6) COMPLETION DATE
F 323	<p>Continued From page 17</p> <p>The facility's failure to have an effective system in place to ensure adequate supervision and monitoring for residents who were at risk for wandering/elopement behaviors was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy (IJ) was identified on 01/27/12 and was determined to exist on 01/22/12. Substandard Quality of Care (SQC) was identified at 483.25; Quality of Care F-323.</p> <p>Observations, staff interviews, and in-service record reviews were conducted on 02/01/12 to verify removal of Immediate Jeopardy as alleged in the acceptable Allegation of Compliance (AOC) on 02/01/12. However, non compliance continued to exist at a scope and severity of a "D" as the facility had not completed the development and implementation of the Plan of Correction (POC) to ensure the facility established and maintained an effective system to ensure a safe environment, free from accidental hazards.</p> <p>The findings include:</p> <p>Review of the facility's "Elopement Policy and Procedure Guide", dated 01/11, revealed the purpose of the elopement policy was to identify residents at risk for elopement; minimize episodes of elopement; protect residents who were not capable of protecting themselves; provide techniques and equipment to minimize safety risks; and educate staff. The policy stated, each resident was to be assessed upon admission for the potential for elopement, using the Clinical Health Status Form, and all residents at risk for elopement would be assessed quarterly and as needed. Photographs of residents were to be taken on admission and placed in the</p>	F 323	<p>codes. This was rein-serviced again 1/27/12 which also included explaining the new lock on the front door by the Administrator, Director of Nursing, Assistant Director of Nursing and/or Director of Staff Development.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Code was changed immediately on 1/22/12 by the Maintenance Director on the secure doors of the unit. Code was also changed on the code alert at each exit door by the Maintenance Director on 1/22/12. Code will be changed at the beginning of each month in the future. Additional lock was added to the front door on 1/26/12, which was in addition to the previous implemented steps. A letter was sent the next day, after the elopement, to all listed responsible parties to remind them of the potential of a resident following them off of the secure unit and that the codes would be changing routinely in the future. A letter is also given to all new admissions concerning the potential of residents following them out the door and that locks are changed routinely. All staff were immediately in-serviced on the policies which include the importance of quick response to door alarms, elopement</p>	

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	--	--	--

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 18</p> <p>Medication Administration Record (MAR). Staff was to observe, every shift, that each resident's bracelet/alarm device was in place, and document on the Treatment Administration Record (TAR). Further review revealed all new employees would be inserviced on the elopement policy during orientation.</p> <p>Interview, on 01/26/12 at 1:30 PM with the Director of Nursing (DON), revealed the staff development nurse oriented new hires to the missing resident and elopement policy, and to the door alarms and code alert bracelets. She stated she was unsure if staff was taught not to give out door codes to families and visitors; however, it was the facility's philosophy to not give out the codes. She further stated she was aware families were punching in codes to take families out the doors without staff assistance. Continued interview revealed the code alert bracelets were checked by the nurses every shift and this was documented on the TAR. Also, maintenance checked the door alarms to ensure they were working properly Monday through Friday, and the Manager of the Day was to check the alarms on the weekends. She stated the Hikers Handbook was in the front office as a reference to recognize residents who were at risk for elopement; however, the book was not kept on the nursing units or in the other departments.</p> <p>Interview, on 01/25/12 at 1:00 PM and 01/31/12 at 10:15 AM with the Unit Manager/LPN #9 of the ACU, revealed the nurses were to test each code alert bracelet on the unit with a transmitter and document this on the Treatment Administration Record (TAR) each shift. She further stated there were pictures of the residents on the Medication</p>	F 323	<p>risk residents and to assist resident families out of the doors instead of giving them the actual codes. This was rein-serviced again on 1/27/12 by the Administrator, Director of Nursing, Assistant Director of Nursing and/or Director of Staff Development. An in-service to all staff was also provided on 2/22/12 by the Administrator, Director of Nursing and Director of Staff Development on Accidents and supervision. This in-service included definitions, an overview of resident safety in the facility including supervision and identifying risk factors for each resident. It also emphasized the importance of evaluating and analyzing hazards and risks, implementing interventions, providing adequate supervision, providing assistance devices, monitoring effectiveness, modifying interventions and following each residents comprehensive care plan. Our elopement policy was revised and our elopement book "Hikers Handbook" is now being kept in the front office, each nursing unit, Housekeeping/laundry, Dietary and therapy office. All residents are assessed for potential of elopement upon admission, quarterly and as needed. Environment is audited daily, thru non-clinical rounds by the department managers and weekend manager, for safety concerns and this is reported to management team and</p>	

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	--	--	--

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

Continued From page 19

Administration Record (MAR), and all residents on the ACU were at risk for elopement. Continued interview revealed she had informed staff on the ACU they needed to make sure someone was covering the common areas at all times, and the Certified Nursing Assistants (CNAs) were to make sure the nurse was aware if they were leaving the common area to give a shower or be in a resident's room providing care. She stated she had given out codes to the locked doors from the ACU to the West Wing and was aware family members opened the door to the ACU without assistance from staff at times.

Interview, on 01/25/12 at 3:30 PM, with CNA #9, revealed he usually worked the East Wing and gave families codes to get out the doors. He stated, he had just given a family member a code to get out the East Wing back door.

Interview, on 01/25/12 at 3:45 PM and on 01/31/12 at 4:00 PM with Registered Nurse (RN) #5, who worked the Alzheimer's Care Unit (ACU) consistently, revealed a staff member should always be in the common area or in the nurses' station where the common area could be viewed.

Interview, on 01/25/12 at 5:30 PM, with CNA #1 revealed she had found Resident #8 on the sidewalk unsupervised on 01/22/12. She stated, either the staff gave the visitors the code to get out the front doors or put the code in for them. She further stated, a code was not needed to get out the front doors unless there was a resident with a code alert bracelet, and then the secure code would need to be entered.

Interview, on 01/27/12 at 3:15 PM with CNA #4,

F 323

resolved. Any trend identifying any consistencies are presented to QAA for problem resolution. Fall risk assessments are completed on each resident upon admission, quarterly and as needed. All falls are reviewed in enhanced startup for evaluation with revisions and/or additional interventions put into place. Preventative maintenance plan in place to ensure the safest environment possible for residents.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

Random alarm checks at front door and back door were completed by the Administrator and Director of Nursing on 1/24, 1/25 & 1/26/12 to ensure appropriate staff responses. These will be continued once a week for three months by the Director of Nursing and/or Administrator. Monthly elopement drills will be completed by the Director of Nursing and/or Assistant Director of Nursing. Ten TARS audited weekly to ensure compliance with code alert checks by Director of Nursing and Assistant Director of Nursing. Code alert log audited weekly by Administrator to ensure compliance with alarm checks.

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 20</p> <p>who was assigned to Resident #8 on 01/22/12 when the resident left the building unsupervised, revealed some visitors knew the code to the double doors that led from the ACU locked unit to the West Wing and there was no code alert on that door.</p> <p>Interview, on 01/31/12 at 9:30 AM, with the Alzheimer's Care Director, revealed there was always the potential for a resident to follow a visitor or family member out of the ACU, and the staff on the ACU had always been allowed to give the visitors codes until after the incident when Resident #8 got off the unit. She stated it "stands to reason" if the CNA was to leave the common area to give a shower or provide care, they should communicate this to the nurse. She further stated there was normally one nurse and one CNA on the ACU.</p> <p>Interview, on 01/31/12 at 2:40 PM, with Licensed Practical Nurse (LPN) #12, revealed she sometimes worked the ACU and there was to be a staff member in the common area or the nurses station at all times on the ACU. Continued interview revealed a lot of the families knew the code to get out of the ACU unit and did not have to be escorted out of the unit by staff.</p> <p>Interview, on 01/31/12 at 10:00 AM with CNA #5, revealed she consistently worked the day shift on the ACU and the visitors knew the codes to open the doors from the ACU to the West Wing; however, since the incident on 01/22/12, staff was not to give out the code. She stated she always let the nurse know when she was leaving the common area to go in a resident's room or the shower room because someone needed to</p>	F 323	<p>A list of all code alerts and their expiration dates will be maintained by the Assistant Director of Nursing and checked weekly by the Director of Nursing. Code alerts to be changed as they expire. Non-clinical round trends and fall trends are reported in QAA. Findings of audits/interviews will be brought to Quality Assessment & Assurance (QAA) monthly for three months. Action plans will be reviewed for progress or new developments and revised as needed with QAA.</p> <p>Compliance Date: 02/24/12</p>	2/24/12
-------	---	-------	--	---------

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	--	--	--

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 21 visualize the common area at all times.</p> <p>Record review revealed the facility admitted Resident #8 on 03/23/11 with diagnoses which included Senile Dementia with Disturbance of Mood and Behavior and Delusions. Review of the Comprehensive Plan of Care, dated 04/02/11, revealed the resident was placed on the ACU for safety due to increasing confusion related to Dementia. Continued review revealed the resident was ambulatory and at risk for wandering/exit seeking behavior, and was unable to make safe and appropriate decisions. The goal stated the resident would not wander out of the facility or into unsafe areas. Interventions included: monitoring the resident's movement about the unit; redirecting with programming; redirecting from situations, areas, as needed to keep the resident safe and secure; and the use of the code alert bracelet. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 11/23/11, revealed the facility assessed the resident as being severely impaired in cognitive skills for decision making and requiring supervision with ambulation. Review of the Quarterly Interdisciplinary Resident Review, dated 11/23/11, section titled "Risk for Elopement" revealed the resident was physically able to leave the building, was cognitively impaired, had impaired decision making skills, and had a history of wandering or elopement. Interview, on 02/01/12 at 1:20 PM, with the Assistant Director of Nursing (ADON) revealed she completed the "Risk for Elopement" section of the Clinical Health Status Form on every resident upon admission. In addition, she completed the "Risk for Elopement" section of the Quarterly Interdisciplinary Resident Review Form on a</p>	F 323		

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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	Continued From page 22 quarterly basis for each resident in the facility. Continued interview revealed if the resident was able to leave the building on their own and was cognitively impaired, they were automatically considered a risk for elopement. She stated she had completed the Quarterly Interdisciplinary Resident Review, dated 11/23/11, and stated Resident #8 was considered at risk for elopement.	F 323		
	Review of the facility's investigation, dated 01/22/12, revealed Resident #8 followed a family member out of the ACU, walked to the front lobby and exited the front door. The resident walked down the driveway and was observed by a staff member less than one (1) block away. Further review of the investigation revealed the staff member stopped her car and brought the resident back to the facility. Interview, on 01/25/12 at 5:30 PM, with CNA #1 revealed she had left work early on 01/22/12 and was pulling out of the facility parking lot when she saw Resident #8 standing on the sidewalk next to the facility's driveway. She stated she quickly parked across the street from the facility's driveway, walked across the street to the resident and called House Supervisor/ RN #4. She further stated she walked the resident back across the street and attempted to assist the resident into her truck; however, the resident declined. Continued interview revealed she stayed with the resident until the House Supervisor/RN #4, CNA #9, and LPN #12 arrived. She stated the resident walked back across the street with the staff. Interview, on 01/25/12 at 3:20 PM, with RN/Supervisor #4, revealed she was called on 01/22/12 at 3:34 PM by Certified Nursing Assistant (CNA) #1 who reported Resident #8 was on the sidewalk by the			

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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 23</p> <p>street. The Nurse stated, she called Licensed Practical Nurse (LPN) #12 and asked the LPN to meet her at the front door, and took CNA #9 with her. Continued interview revealed Resident #8 was across the street from the facility with CNA #1, and she and the other staff walked Resident #8 across the street and back to the facility. She stated Resident #8's code alert bracelet, which was on her/his ankle, alarmed the door as they were walking back in the front entrance.</p> <p>Interview, on 01/25/12 at 3:30 PM, with CNA #9, verified he went to help House Supervisor/ RN #4 on 01/22/12, and noted Resident #8 was across the street from the facility with CNA #1.</p> <p>Interview, on 01/31/12 at 2:40 PM, with LPN #12, revealed she was working on the Advanced Alzheimer's Care Unit (ACU), on 01/22/12 when she received a call from the House Supervisor/ RN #4 asking for assistance. She stated she went with House Supervisor/RN #4 across the street where Resident #8 and CNA #1 were standing and assisted with walking the resident back into the facility.</p> <p>Continued review of the investigation, revealed a head to toe assessment of Resident #8 revealed no injuries. Review of the Progress Notes, dated 01/22/12 at 3:35 PM, revealed Resident #8 left the building and was found on the sidewalk in front of the building, and was alert and oriented to self which was baseline for this resident.</p> <p>Interview, on 01/25/12 at 3:45 PM and on 01/31/12 at 4:00 PM with RN #5, revealed she had written the Progress Note. She further stated she was assigned to Resident #8 on 01/22/12 and had arrived on the unit at 2:45 PM when she</p>	F 323		
-------	--	-------	--	--

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	--	--	--

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 24</p> <p>visualized the resident sitting in a chair in the common area. She stated she was completing blood sugar checks about 3:30 PM when Licensed Practical Nurse (LPN) #12, who was working the AACU, informed her she was leaving the unit because she had received a phone call from someone stating a resident had left the ACU, but did not say which resident. RN #5 was unaware Resident #8 left the unit, and stated staff brought the resident back to the unit at approximately 3:40 PM. Continued interview revealed she completed a head to toe assessment of the resident, who had no visible injuries. She stated the resident was wearing two (2) pairs of pants, a long sleeve top and a heavy red sweater, and was carrying a purse which was usual for this resident. She stated the resident had not demonstrated exit seeking behaviors prior to the incident on 01/22/12.</p> <p>Further review of the investigation revealed Resident #8 was observed following a family member out of the locked unit by a visitor who was sitting on the couch on the West Wing. Interview, on 01/25/12 at 6:10 PM, with Unsampled Resident D's private sitter, revealed on 01/22/12 she was on the West Wing when she noticed a woman with a child, who she could not identify, coming out of the ACU, followed by a lady with a red sweater, about 3:00 PM.</p> <p>Interview, on 01/31/12 at 3:20 PM, with the daughter of Unsampled Resident C, revealed she had visited her family member on the AACU on 01/22/12 and left the unit about 3:30 PM and went out to the West Wing through the ACU door. She stated she knew the code to get out because staff let the regular visitors know the codes. She</p>	F 323		

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	--	--	--

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 25</p> <p>further stated she went through the ACU door with her daughter, and was unaware of Resident #8 leaving the unit at that time.</p> <p>Continued review of the investigation, revealed Resident #8 passed a dietary employee when going through the front exit doors, but the employee did not recognize she/he was a resident. Interview, on 01/26/12 at 3:45 PM, with Dietary Assistant #1, revealed she was hired at the facility in 08/11. She stated on 01/22/12 at approximately 3:20 PM, she passed Resident #8 who was going out the front entrance main doors as she was coming in the doors after her break. She further stated she and this resident were the only ones passing through the doors at that time, and she did not realize Resident #8 was a resident of the facility. Continued interview revealed the resident's code alert bracelet did not alarm. She stated she "had no clue" Resident #8 was a resident of the facility because she/he looked like a visitor, wearing a jacket and carrying a purse and a bag. She stated she was not oriented to the ACU unit on orientation, nor was she oriented to any type of book which had photographs of residents who were at risk for elopement.</p> <p>The investigation further revealed, the resident was returned to the facility and was placed on one on one (1:1) for forty-eight (48) hours. The investigation was signed by House Supervisor/Registered Nurse (RN) Supervisor #4. Continued interview, on 01/25/12 at 3:20 PM, with RN/Supervisor #4, revealed when she arrived on duty 01/22/12 she went to every door and checked with a transmitter to ensure the doors and the code alerts were working properly, as she</p>	F 323		

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	--	--	--

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)	(X6) COMPLETION DATE
F 323	<p>Continued From page 26</p> <p>did every weekend when she was the House Supervisor. Continued interview revealed she notified Administrative Staff and stayed at the front doors to monitor the door and to take statements from staff and visitors after the incident. She further stated, on 01/22/12 after the incident, she helped give inservices to staff to ensure they were aware they could not give out door codes to visitors and families. She further stated she was aware families knew the codes to the doors in the past.</p> <p>During interview, on 01/31/12 at 11:00 AM, the Manager of the Day, revealed he worked the day shift on 01/22/12. He verified that he checked all the doors and alarms that morning when he arrived. He further stated he usually sat in the front office window where he could see the front door entrance; however, he had left the office to get water temperatures on the units at 3:00 PM which took about one and a half hours and was not at the front office window at the time of the incident.</p> <p>Interview, on 01/27/12 at 3:15 PM with CNA #4, revealed she was assigned to Resident #8 on 01/22/12 at the time of the incident. She stated she remembered giving Resident #8 ice cream when snacks came to the unit. CNA #4 reported she was the only CNA assigned on the unit; however CNA #8/Restorative Aide was on the unit when another resident was noted to come out in the common area requiring assistance. Continued interview revealed she took that resident to the bathroom and when she came back out to the common area she was informed Resident #8 was gone. She stated she usually told the nurse when she was leaving the common</p>	F 323		

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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 27</p> <p>area to assist a resident with incontinence care or a shower; however, she had not notified the nurse this time because CNA #8/Restorative Aide was on the floor. Continued interview revealed she had not asked CNA #8/Restorative Aide to watch the floor for her, and the restorative aide had left the unit while she was in the bathroom with the other resident.</p> <p>Interview, on 01/25/12 at 1:30 PM, with Restorative Aide/CNA #8, revealed he was doing restorative on the ACU until shortly after 3:00 PM on 01/22/12 and he saw Resident #8 go to her/his room and then come back out into the common area and sit down by the double locked doors which led to the West Wing. He confirmed shortly after 3:00 PM he left the ACU.</p> <p>Interview, on 01/26/12 at 4:05 PM, with the Dietary Manager, revealed she was unaware of any book which had photographs of residents who were at risk for elopement and she did not take dietary staff to the units to learn which residents were at risk for elopement on hire unless the facility received a new resident who looked like a visitor. She did not remember orienting new staff to Resident #8.</p> <p>Interview, on 01/27/12 at 1:30 PM, with the Staff Development Nurse, revealed new orientees received inservices related to elopement, keypad codes to doors, code alert bracelets, missing residents, and elopement risk assessments. She stated she told new employees about the "Hikers Handbook" which was a book with the Face Sheet and photographs of residents in the facility who were at risk for elopement, and was kept in the front office. Continued interview revealed she</p>	F 323		

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

PRINTED: 02/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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 28</p> <p>did not show the book to staff during orientation and there was no other Hikers Handbooks except for the one in the front office. Continued interview revealed she toured new staff to the ACU either before or after hire; however, she did not make a point of introducing each resident to the staff. She further stated she stressed during orientation, staff was not to give out the codes to the doors, and was to escort families to the doors and open the doors for them.</p> <p>Continued interview, on 01/31/12 at 9:30 AM, with the Alzheimer's Care Director, revealed she was in charge of the programming or activities on the unit, and was in charge of visiting homes and facilities to ensure new admissions were appropriate for the ACU. When asked how she ensured residents did not leave the unit unsupervised, she stated there was an unspoken dependence on the staff, and the Care Plans were updated as needed for new interventions if residents were exit seeking.</p> <p>Further interview, on 01/25/12 at 1:00 PM and 01/31/12 at 10:15 AM with Unit Manager/LPN #9 of the ACU, revealed Resident #8 had no history of leaving the unit without an escort. She was unaware of any residents following the visitors out the doors. However, she stated, on 01/22/12 Resident #8 followed Unsampled Resident C's family out the doors from the ACU to the West Wing, and was witnessed by another family member who was sitting on the West Wing.</p> <p>Observation of Resident #8 on 01/24/12 at 6:00 PM revealed the resident was ambulating down the hallway on the locked Alzheimer's Care Unit (ACU) with a purse on her/his shoulder, and was</p>	F 323		

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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 29 accompanied by a staff member.</p> <p>Interview, on 01/26/12 at 1:30 PM with the Director of Nursing (DON), revealed there was no policy related to Care Plans and there was no reference source used related to care plans. She stated the CNA's carried the Assignment Sheets in their pockets and used it as a reference for the care they were to provide. She stated Resident #8's intervention on the Care Plan to monitor movement was referring to staff monitoring residents for exits seeking behaviors and to re-direct from doors if needed to ensure they were safe.</p> <p>Interview, on 01/26/12 at 4:10 PM, with the Administrator, revealed he came in on 01/22/12 when he was notified of Resident #8 getting out of the building. He stated Maintenance, House Supervisor/ RN #4, and also an outside vendor checked all the door alarms to ensure the doors and alarms were working properly. He stated there were no problems found with the doors and alarms, and felt like the front entrance door code alarmed as Resident #8 went through the door since she/he had a code alert bracelet on when she/he was found, and the code alert alarmed the door when staff brought the resident back in the building through the same front entrance. Further interview revealed he felt like an employee may have turned off the alarm as Resident #8 was going through and did not recognize she/he as a resident. He further stated a family member of another resident may have turned off the code when it alarmed as Resident #8 went through the door. He stated a code would not have been needed to open the front door until 9:00 PM; however, the code alert system should have</p>	F 323		

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	--	--	--

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 30</p> <p>alarmed if a resident wearing a code alert bracelet passed through without punching in the code to the secure code alarms. Continued interview revealed the Hikers Book was in the front office and was mainly used for the police as needed if there was a missing resident and there were no Hikers Handbooks on the other nursing units or in the other departments. He further stated he felt there was a breakdown in the system and staff may not have known to go outside and check the premises for a missing resident when the alarm went off, and staff did not recognize Resident #8 as a resident on the ACU.</p> <p>The facility provided an Acceptable Credible Allegation of Compliance (AOC) on 02/01/12 that alleged removal of the IJ effective 02/01/12, based on the following;</p> <p>1) The codes to exit the ACU were changed on 01/22/12 and will be changed on the first Monday of each month by the Maintenance Director, and reported to the Administrator upon completion.</p> <p>2) All staff in all departments was inserviced by the Administrator and Director of Nursing on 01/22/12 related to the unit exit door code change and the code change to the front and back door secure care alarm. The inservice informed staff they were not to give out door codes to families or visitors. Subsequent shifts, in all departments were not allowed to work until they completed the inservice.</p> <p>3) The DON and the ADON reviewed all the current elopement assessments and Care Plans for all active residents to ensure all residents at</p>	F 323		

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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 31</p> <p>risk for elopement had been identified and all Care Plans were up to date and listed appropriate interventions on 01/22/12.</p> <p>4) The elopement Hikers Handbook was reviewed by the DON to ensure all residents at risk for elopement were listed in the manual with their picture on 01/22/12.</p> <p>5) A letter to all families/responsible parties was issued by the Executive Director to provide education to watch for residents following them through the doors and informing them there was a code change for exiting the unit.</p> <p>6) On 01/22/12 and 01/23/12 a Quality Assurance Meeting was held to discuss the root cause of the incident and the steps to be taken to prevent further incidents to Resident #8 and other residents. Also, during the meeting, the incident, investigation, actions taken, and the effectiveness of the actions taken were discussed. The Medical Director was contacted by phone.</p> <p>7) On 01/24/12 and 01/25/12 the Executive Director, the DON and the ADON conducted door alarm drills to evaluate the staff response to alarms sounding.</p> <p>8) On 01/26/12 an additional interior key pad and external button to the main entrance was installed.</p> <p>9) On 01/27/12 inservice training was provided related to installation of the new key pad to the main entrance door and response of staff to search outside for a resident prior to disabling the secure care alarm. Also the staff was instructed</p>	F 323		

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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)	(X6) COMPLETION DATE
F 323	<p>Continued From page 32</p> <p>to not give out secure care codes to anyone who was not employed at the facility. Staff who was not present for the inservice were contacted by phone.</p> <p>10) The ADON made additional Hiker Handbooks for all departments and units that included resident face sheets and pictures of each resident identified to be at risk for elopement. The DON, ADON and the Director of Education conducted training on 01/31/12 in small groups and by phone to all department staff to inform the staff of the additional elopement manuals, locations, and the need for staff to be familiar with residents identified at risk for elopement. Staff was not allowed to work until they had received the inservice.</p> <p>11) Monthly elopement drills are to be completed by the DON, ADON or the Director of Clinical Education.</p> <p>12) The Quarterly Elopement Review will be done monthly for three months by the ADON and brought to the QA Meetings.</p> <p>13) New employees are to be trained on the elopement system upon hire by the Director of Clinical Education. The elopement Hikers Handbook will be reviewed during orientation of new staff. The revised elopement policy and procedure have been included in the new hire orientation material beginning 1/31/12.</p> <p>On 02/01/12 it was verified the immediacy of the IJ was removed and the facility implemented corrective actions as alleged in the AOC, effective 02/01/12 based on the following:</p>	F 323		

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	--	--	--

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)	(X6) COMPLETION DATE
F 323	<p>Continued From page 33</p> <p>Observation, on 02/01/12 from 09:45 AM until 1:25 PM, revealed there were Hikers Handbooks on all the nursing units including the East 1 Nurses Station, East 2 Nurses Station, Alzheimer's Nurses Station, Therapy Department, Dietary Department, Housekeeping Office, Laundry Department, and the Front Office.</p> <p>Interviews with staff including the Occupational Therapist, on 01/31/12 at 3:05 PM, the Physical Therapist on 01/31/12 at 3:20 PM, the Restorative Nurse on 01/31/12 at 3:40 PM, LPN #7 on 02/01/12 at 10:55 AM, LPN #8 on 02/01/12 at 11:05 AM, the MDS Coordinator on 02/01/12 at 11:15 AM, RN #3 on 02/01/12 at 10:10 AM, CNA #3 on 02/01/12 at 10:20 AM, LPN #5 on 02/01/12 at 10:30 AM, LPN #6 on 02/01/12 at 10:40 AM, Dietary Assistant #1 on 02/01/12 at 1:25 PM, Dietary Assistant #3 on 02/01/12 at 1:30 PM, and Dietary Assistant #4 on 02/01/12 at 1:35 PM revealed they were aware of the Hikers Handbook and the elopement policy. They were also aware they were not to give out secure code alarms for the front and back doors at any time, they were not allowed to give out door codes for the AACU and the ACU doors at any time, staff were to open doors which required a code for families and visitors, and they were not to turn off a code alarm until the resident was found.</p> <p>Interview, on 02/01/12 at 9:45 AM, with the Staff Development Nurse, revealed she had assisted with the changes in the new elopement policy and the policy would be given to each new hire. She further stated most current staff had been inserviced on the new policy and if they had not received the inservice, they were not to clock in</p>	F 323		

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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	Continued From page 34 until they had been inserviced and signed that they had received the inservice. Interview with the Administrator and review of the new Elopement Policy, on 02/01/12 at 3:00 PM, revealed the Policy was updated 01/31/12 to include bullet points which stated; staff was not to give out the secure care alarm codes which were located at the front and back entrance, staff was not to give out door codes to the AACU and ACU, and there was to be a Hikers Handbook located on each nurses station and in each department.	F 323	F 490 Administration This facility will 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.	2/24/12
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 interview, record review, facility policy review, and review of the facility's investigation, it was determined the facility's Administration failed to ensure the facility was administered in a manner which enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and	F 490	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident was returned to the care unit from outside on facility property and immediately assessed for physical injuries and psychosocial well being. It was determined she had no injuries or negative effects. Resident was immediately placed on one-on-one for forty eight hours to continue monitoring for effects of the incident. Resident's code alert was checked to ensure working order, family and physician notified of incident. The environment was immediately assessed, staff, families and residents interviewed and a determination established as to how she was able to get off of the secure unit. Care plan reviewed by the Assistant Director of Nursing.	

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	--	--	--

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)	(X6) COMPLETION DATE
F 490	<p>Continued From page 35 psychological well-being of each resident.</p> <p>The facility failed to have an effective system to ensure supervision to prevent accidents related to residents who were identified at risk for elopement/wandering. The facility Administration failed to have an effective system to ensure staff was knowledgeable of residents who the facility had identified as being at risk for elopement. The facility Administration failed to have an effective system to ensure the secure alarm code alert system and the door code system to the Alzheimer's Care Unit (ACU) was effective in protecting residents who were assessed to be an elopement risk. The facility failed to have an effective system to ensure the Comprehensive Plan of Care was implemented to ensure continuous supervision and monitoring to prevent elopement. (Refer to F-282 and F-323).</p> <p>On 01/22/12, between 3:00 PM and 3:20 PM, Resident #8 who the facility identified as a risk for elopement, exited the locked Alzheimer's Care Unit (ACU), traveled through the building and exited out the front door without staff identifying the resident and the code alert system alarming. The resident was found on a sidewalk next to a busy street, which was approximately one mile from a rail road track.</p> <p>Based on the above findings it was determined the facility's failure to have an effective system in place to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy (IJ) was identified on 01/27/12 and determined to exist on 01/22/12.</p>	F 490	<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents who have the potential for elopement have the potential to be affected. A head count of all residents was immediately completed once the resident was returned to the care unit. Exit doors were monitored by staff and fifteen minute checks were completed on all potential elopement residents until we were able to ensure that doors and wander systems were in working order. The environment was immediately assessed. Charge nurse, maintenance supervisor and an outside vendor, independently, checked all doors armed with code alert system. Windows were also checked to ensure that they could not be opened to allow a resident to leave via a window. Staff, families and residents were interviewed and a determination was established as to how resident was able to get off of the secure unit. All residents assessments and care plans were reviewed and changes were made as needed by the Assistant Director of Nursing and/or Director of Nursing. All staff were immediately in-serviced by the Administrator on 1/22/12 regarding the policies which include the importance of quick response to</p>	

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

PRINTED: 02/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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)	(X6) COMPLETION DATE
F 490	<p>Continued From page 36</p> <p>Observations, staff interviews, and in-service record reviews were conducted to verify removal of Immediate Jeopardy as alleged in the acceptable Allegation of Compliance (AOC) on 02/01/12. However, non compliance continued to exist at a scope and severity of a "D" as the facility had not completed the development and implementation of the Plan of Correction (POC) to ensure the facility established and maintained an effective system to ensure a safe environment, free from accidental hazards.</p> <p>The findings include:</p> <p>Review of the facility's "Elopement Policy and Procedure Guide", dated 01/11, revealed the purpose of the elopement policy was to identify residents at risk for elopement; minimize episodes of elopement; protect residents who were not capable of protecting themselves; provide techniques and equipment to minimize safety risks; and educate staff. The Policy stated, all new employees would be inserviced on the elopement policy during orientation.</p> <p>Review of the "Risk for Elopement" Quarterly Interdisciplinary Resident Review, dated 11/23/11, revealed Resident #1 was assessed by the facility and determined to be at risk for elopement. The Comprehensive Plan of Care, dated 04/02/11, revealed Resident #1 was placed on the ACU for safety due to increasing confusion related to Dementia. Continued review revealed the resident was ambulatory, at risk for wandering/exit seeking behavior, and was unable to make safe and appropriate decisions.</p>	F 490	<p>door alarms, elopement risk residents and to assist resident families out of the doors instead of giving them the actual codes. This was rein-serviced again 1/27/12 which also included explaining the new lock on the front door by the Administrator, Director of Nursing, Assistant Director of Nursing and/or Director of Staff Development.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Director of Operations will complete training with Administrator on elopement prevention on 2/23/12. Code was changed immediately by the maintenance supervisor on the secure doors of the unit 01/22/12. Code was also changed on the code alert at each exit door on 1/22/12. Code will be changed at the beginning of each month in the future. Additional lock was added to the front door, in addition to previously listed steps/interventions. A letter was sent the next day, after the elopement, to all listed responsible parties to remind them of the potential of a resident following them off of the secure unit and that the codes would be changing routinely in the future. A letter is also given to all new admissions concerning the potential of</p>	

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	--	--	--

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 490	<p>Continued From page 37</p> <p>However, interviews on 01/25/12 at 1:00 PM and 01/31/12 at 10:15 AM with the ACU Unit Manager/Licensed Practical Nurse (LPN) #9, 01/31/12 at 9:30 AM with the Alzheimer's Care Director, 01/25/12 at 3:30 PM with Certified Nursing Assistant (CNA) #9, 01/25/12 at 5:30 PM with CNA #1, and 01/26/12 at 4:00 PM with Dietary Assistant #5, revealed they gave the families the codes to the locked unit without ensuring that residents from the building were not exiting unsupervised, and also gave out the codes to the other main entrances. Additional staff interviews revealed the facility had not trained all staff to recognize those residents who were assessed to be at risk for wandering and elopement.</p> <p>Interview, with Dietary Assistant #1, on 01/26/12 at 3:45 PM, revealed she as hired at the facility in 08/11. She stated on 01/22/12 at approximately 3:20 PM, she passed Resident #8 who was going out the front entrance main doors as she was coming in the doors. She further stated she and this resident were the only ones passing through the doors at that time, and she did not recognize Resident #8 to be a resident of the facility. Further interview revealed the resident's code alert bracelet did not alarm. She stated she did not realize Resident #8 was a resident of the facility because she/he looked like a visitor, wearing a jacket and carrying a purse and a bag. She further stated she was not oriented to the ACU unit on orientation, nor was she oriented to any type of book which had photographs of residents who were at risk for elopement.</p> <p>Interview, on 01/27/12 at 1:30 PM, with the Staff Development Nurse, revealed she told new</p>	F 490	<p>residents following them out the door and that locks are changed routinely. All staff were immediately in-serviced on 1/22/12 by the Administrator regarding the policies which include the importance of quick response to door alarms, elopement risk residents and to assist resident families out of the doors instead of giving them the actual codes. This was rein-serviced again on 1/27/12 by the Administrator, Director of Nursing, Assistant Director of Nursing and/or Director of Staff Development. An in-service to all staff was also provided on 2/22/12 by the Administrator, Director of Nursing and Director of Staff Development on Accidents and supervision. This in-service included definitions, an overview of resident safety in the facility including supervision and identifying risk factors for each resident. It also emphasized the importance of evaluating and analyzing hazards and risks, implementing interventions, providing adequate supervision, providing assistance devices, monitoring effectiveness, modifying interventions and following each residents comprehensive care plan. Our elopement policy was revised and our elopement book "Hikers Handbook" is now being kept in the front office, each nursing unit, Housekeeping/laundry, Dietary and therapy office. All residents are</p>	

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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)	(X6) COMPLETION DATE
F 490	<p>Continued From page 38</p> <p>employees about the "Hikers Handbook" which was a book with the Face Sheet and photographs of residents in the facility who were at risk for elopement, and was kept in the front office. Further interview revealed she did not show the book to staff during orientation and there was no other Hikers Handbooks except for the one in the front office. She stated she toured new staff to the ACU and Advanced Alzheimer's Care Unit (AACU) either before or after hire; however, she did not make a point of introducing each resident to the staff.</p> <p>Review of the facility's investigation, dated 01/22/12, revealed Resident #8 exited the ACU on 01/22/12, between 3:00 PM and 3:20 PM, by following another resident's family off the locked unit without staff knowledge, entered the West Wing Unit, proceeded to walk through the lobby, and out the front main entrance. The resident proceeded to the facility's main entrance and passed a dietary staff member at 3:20 PM. The dietary staff member was unaware Resident #8 was a resident of the facility and let the resident exit the facility unsupervised. Resident #8's code alert bracelet did not activate the system to alarm as the resident exited through the main entrance door. Resident #8 exited the building and went down the facility driveway to a sidewalk next to a busy street. (Refer to F-323)</p> <p>Interview, on 01/26/12 at 4:10 PM, with the Administrator revealed he felt like an employee may have turned off the alarm as Resident #8 was going through and did not recognize she/he as a resident or a family member of another resident may have turned off the alarm. He stated he was aware families knew the codes to</p>	F 490	<p>assessed for potential of elopement upon admission, quarterly and as needed. Environment is audited daily, thru non-clinical rounds by the department managers and our weekend manager, for safety concerns and this is reported to management team and resolved. Any trend identifying any consistencies are presented to QAA for problem resolution. Fall risk assessments are completed on each resident upon admission, quarterly and as needed. All falls are reviewed in enhanced startup for evaluation with revisions and/or additional interventions put into place. Preventative maintenance plan in place to ensure the safest environment possible for residents.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Executive Director to complete elopement training on Golden University on 2/23/12. All staff to complete over the next quarter. Random alarm checks at front door and back door were completed 1/24, 1/25 & 1/26/12 to ensure appropriate staff responses by director of Nursing and/or Administrator. Monthly elopement drills will be completed by</p>	

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	--	--	--

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 490	<p>Continued From page 39</p> <p>get out the doors in the past; however, did not know of any resident following a family member out of the ACU until this incident. Continued interview revealed the Hikers Book was in the front office and there were no Hikers Handbooks on the other nursing units or in the other departments for the employees to review. He further stated he felt there was a breakdown in the system and staff may not have known to go outside and check the premises for a missing resident when the alarm went off, and staff did not recognize Resident #8 to be a resident on the ACU. He indicated the staff failed to follow the Plan of Care by failing to monitor the movements of Resident #8, as evidenced by the resident leaving the building unsupervised and without staff knowledge.</p> <p>The facility provided an Acceptable Credible Allegation of Compliance (AOC) on 02/01/12 that alleged removal of the IJ effective 02/01/12, based on the following;</p> <p>1) The codes to exit the ACU were changed on 01/22/12 and will be changed on the first Monday of each month by the Maintenance Director, and reported to the Administrator upon completion.</p> <p>2) All staff in all departments was inserviced by the Administrator and Director of Nursing on 01/22/12 related to the unit exit door code change and the code change to the front and back door secure care alarm. The inservice informed staff they were not to give out door codes to families or visitors. Subsequent shifts, in all departments were not allowed to work until they completed the inservice.</p>	F 490	<p>director of Nursing and/or Assistant director of Nursing. Ten TARS audited weekly to ensure compliance with code alert checks by Director of Nursing and/or Assistant Director of Nursing. Code alert log audited weekly by Administrator to ensure compliance with alarm checks. A list of all code alerts and their expiration dates will be maintained by Assistant Director of Nursing and will be audited weekly by director of Nursing. Code alerts to be changed as they expire. Non-clinical round trends and fall trends are reported in QAA. Findings of audits/interviews will be brought to Quality Assessment & Assurance (QAA) monthly for three months. Action plans will be reviewed for progress or new developments and revised as needed with QAA.</p> <p>Compliance Date: 02/24/12</p>	2/24/12

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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 490	<p>Continued From page 40</p> <p>3) The DON and the ADON reviewed all the current elopement assessments and Care Plans for all active residents to ensure all residents at risk for elopement had been identified and all Care Plans were up to date and listed appropriate interventions on 01/22/12.</p> <p>4) The elopement Hikers Handbook was reviewed by the DON to ensure all residents at risk for elopement were listed in the manual with their picture on 01/22/12.</p> <p>5) A letter to all families/responsible parties was issued by the Executive Director to provide education to watch for residents following them through the doors and informing them there was a code change for exiting the unit.</p> <p>6) On 01/22/12 and 01/23/12 a Quality Assurance Meeting was held to discuss the root cause of the incident and the steps to be taken to prevent further incidents to Resident #8 and other residents. Also, during the meeting, the incident, investigation, actions taken, and the effectiveness of the actions taken were discussed. The Medical Director was contacted by phone.</p> <p>7) On 01/24/12 and 01/25/12 the Executive Director, the DON and the ADON conducted door alarm drills to evaluate the staff response to alarms sounding.</p> <p>8) On 01/26/12 an additional interior key pad and external button to the main entrance was installed.</p> <p>9) On 01/27/12 inservice training was provided related to installation of the new key pad to the</p>	F 490		

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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 490	<p>Continued From page 41</p> <p>main entrance door and response of staff to search outside for a resident prior to disabling the secure care alarm. Also the staff was instructed to not give out secure care codes to anyone who was not employed at the facility. Staff who was not present for the inservice were contacted by phone.</p> <p>10) The ADON made additional Hiker Handbooks for all departments and units that included resident face sheets and pictures of each resident identified to be at risk for elopement. The DON, ADON and the Director of Education conducted training on 01/31/12 in small groups and by phone to all department staff to inform the staff of the additional elopement manuals, locations, and the need for staff to be familiar with residents identified at risk for elopement. Staff was not allowed to work until they had received the inservice.</p> <p>11) Monthly elopement drills are to be completed by the DON, ADON or the Director of Clinical Education.</p> <p>12) The Quarterly Elopement Review will be done monthly for three months by the ADON and brought to the QA Meetings.</p> <p>13) New employees are to be trained on the elopement system upon hire by the Director of Clinical Education. The elopement Hikers Handbook will be reviewed during orientation of new staff. The revised elopement policy and procedure have been included in the new hire orientation material beginning 1/31/12.</p> <p>On 02/01/12 it was verified the immediacy of the</p>	F 490		

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	--	--	--

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 490	<p>Continued From page 42</p> <p>IJ was removed and the facility implemented corrective actions as alleged in the AOC, effective 02/01/12 based on the following:</p> <p>Observation, on 02/01/12 from 09:45 AM until 1:25 PM, revealed there were Hikers Handbooks on all the nursing units including the East 1 Nurses Station, East 2 Nurses Station, Alzheimer's Nurses Station, Therapy Department, Dietary Department, Housekeeping Office, Laundry Department, and the Front Office.</p> <p>Interviews with staff including the Occupational Therapist, on 01/31/12 at 3:05 PM, the Physical Therapist on 01/31/12 at 3:20 PM, the Restorative Nurse on 01/31/12 at 3:40 PM, LPN #7 on 02/01/12 at 10:55 AM, LPN #8 on 02/01/12 at 11:05 AM, the MDS Coordinator on 02/01/12 at 11:15 AM, RN #3 on 02/01/12 at 10:10 AM, CNA #3 on 02/01/12 at 10:20 AM, LPN #5 on 02/01/12 at 10:30 AM, LPN #6 on 02/01/12 at 10:40 AM, Dietary Assistant #1 on 02/01/12 at 1:25 PM, Dietary Assistant #3 on 02/01/12 at 1:30 PM, and Dietary Assistant #4 on 02/01/12 at 1:35 PM revealed they were aware of the Hikers Handbook and the elopement policy. They were also aware they were not to give out secure code alarms for the front and back doors at any time, they were not allowed to give out door codes for the AACU and the ACU doors at any time, staff were to open doors which required a code for families and visitors, and they were not to turn off a code alarm until the resident was found.</p> <p>Interview, on 02/01/12 at 9:45 AM, with the Staff Development Nurse, revealed she had assisted with the changes in the new elopement policy and the policy would be given to each new hire. She</p>	F 490		

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2012
--	---	--	---

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)	(X6) COMPLETION DATE
F 490	<p>Continued From page 43</p> <p>further stated most current staff had been inserviced on the new policy and if they had not received the inservice, they were not to clock in until they had been inserviced and signed that they had received the inservice.</p> <p>Interview with the Administrator and review of the new Elopement Policy, on 02/01/12 at 3:00 PM, revealed the Policy was updated 01/31/12 to include bullet points which stated; staff was not to give out the secure care alarm codes which were located at the front and back entrance, staff was not to give out door codes to the AACU and ACU, and there was to be a Hikers Handbook located on each nurses station and in each department.</p> <p>The facility remained out of compliance at a lower scope and severity of a "D", an isolated deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (POC).</p>	F 490		

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

ELEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/25/2012
---	---	---	---

NAME OF PROVIDER OR SUPPLIER OLDEN 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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1983</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) Story, Type III (211) Unprotected</p> <p>SMOKE COMPARTMENTS: Ten (10) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM originally installed in 1983 upgraded in 2008.</p> <p>FULLY SPRINKLED, SUPERVISED (Dry SYSTEM) original in 1983</p> <p>EMERGENCY POWER: Type II Natural Gas Generator. Original in 1983. Type II Diesel installed in 2008.</p> <p>A life safety code survey was initiated and concluded on 01/25/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred forty-five (145)</p>	K 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">FEB 27 2012</p> <p>BY: _____</p>	
-------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jeff Dale</i> Executive Director	TITLE 2/21/12 (X6) DATE 2/24/12
--	---

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
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186185	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/25/2012
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	Continued From page 1 beds and the census was one hundred forty-four (144) the day of the survey.	K 000	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></p> <p>K 062 NFPA 101 Life Safety Code Standard</p> <p>This facility will ensure that our sprinkler system is maintained in a continuously operating manner.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Identified sprinkler heads have been checked to ensure that they will operate as designed. Identified sprinkler heads have been ordered and will be replaced upon receiving.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p>	
K 062 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "E" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: -----Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained as required. The deficiency has the potential to affect three (3) of ten (10) smoke compartments, sixteen residents, staff and visitors. The facility is licensed for one hundred forty-five (145) beds and the census the day of the survey was one hundred forty-four (144).</p> <p>The findings include:</p> <p>Observation during the Life Safety Code survey tour, on 1/25/12, between 9:30 AM and 1:30 PM, with the Maintenance Director revealed paint loaded sprinkler heads at Assistant Director of nursing office (1), West Wing Hall (2) heads, West Wing B Hall two (2) heads identified as corroded. Also two (2) heads paint loaded at family style kitchen in the ACU Unit. Not maintaining sprinkler heads can decrease their ability to react as intended.</p>	K 062		

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

PRINTED: 02/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186165	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/25/2012
--	--	---	--

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 GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 062	Continued From page 2 Interview with the Maintenance Director, on 1/25/12 at 1:30 PM revealed that he was told by the sprinkler company technician that the heads would be ok. Reference: NFPA 25 (1998 Edition). 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	All sprinkler heads have been checked to ensure that they will operate as designed. Any sprinkler head identified with paint, corrosion, foreign material or damaged have been ordered and will be replaced upon receiving. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All sprinkler heads will be audited weekly to ensure that they work properly by the Administrator.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of egress were maintained free and clear of obstructions according to NFPA standards. The deficiency has the potential to affect one (1) of ten (10) smoke compartments, thirteen (13) residents, staff, and visitors. The facility is licensed for one hundred forty-five (145) beds; the census on the day of the survey was one	K 072	All sprinkler heads will be audited weekly to ensure that they work properly by the Administrator. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Findings of audits will be brought to QAA. Action plans will be reviewed for progress or new developments and revised as needed with QAA. Additional focus will be placed on areas as needed. Compliance Date: 02/24/12	

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

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/25/2012	
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 072	<p>Continued From page 3 hundred forty-four (144).</p> <p>The findings include:</p> <p>Observation during the Life Safety Code survey tour, on 1/25/12 between 9:30 AM and 1:30 PM, with the Maintenance Director revealed china cabinet, chair, and plants in corridor at west wing nursing station. Means of egress must be kept clear at all times in case of fire or other emergency.</p> <p>Interview with the Maintenance Director, and Administrator on 1/25/12 at 1:30 PM, in the Administrator's office confirmed the items were stored in the corridor and said the items would be removed from the corridor to an appropriate location.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p>	K 072	<p>K 072 NFPA 101 Life Safety Code</p> <p>This facility will ensure that the means of egress are continuously maintained free of obstructions to ensure access to, egress from and visibility of exits.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The identified furniture and plants have been moved to an appropriate area.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All corridors have been checked to ensure that nothing is stored in the corridor which would impede use in case of an emergency.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>All corridors will be audited weekly for three months by the administrator to ensure that they are clear. Staff will be in-serviced by the Administrator, director of Nursing and/or Director of Staff Development concerning the</p>	

necessity of ensuring that corridors are maintained clear and that furniture cannot be placed there.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

Findings of audits will be brought to Q.A.A. Action plans will be reviewed for progress or new developments and revised as needed with IDT. Additional focus will be placed on areas as needed.

Compliance Date: 02/24/12
