

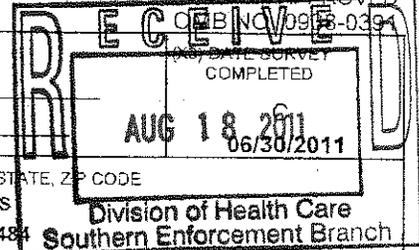
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Amended SoD

PRINTED: 07/19/2011

FORM APPROVED

0918-0394



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 105 HARMON HEIGHTS STANFORD, KY 40484
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F 000	INITIAL COMMENTS An abbreviated standard survey (KY16571, KY16572) was conducted on June 29-30, 2011. KY16572 was unsubstantiated with no related deficient practice identified. KY16571 was substantiated with deficient practice identified at 'D' level.	F 000	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. Golden Living Center of Stanford maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Golden Living Center of Stanford asserts that is in substantial compliance with regulations governing the operation of long term care facilities, and this Plan of Correction in its entirety, constitutes this provider's allegation of compliance and, thereby, we request resurvey to verify such as of August 03rd, 2011.	
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide goods and services necessary to avoid physical harm and mental anguish for one of three sampled residents (Resident #1). On 06/10/11, Resident #1 was transferred to a treatment center for a routine treatment which required the resident to be at the center from approximately 10:00 AM until 4:00 PM, however, the facility failed to provide a lunch or incontinence briefs for the resident while away from the facility. The findings include: A review of the facility's Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect,	F 224	Completion dates are provided for procedural processing purposes to comply with federal and state regulations, and correlate with the most recent contemplated or accomplished corrective action. These do not necessarily chronologically correspond to the date that Golden Living Center of Stanford is under the opinion that it was in compliance with the requirements of participation or that corrective action was necessary.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
William B. Watson, II, FACHE, Fellow of ACHCA

TITLE: Executive Director 18 August 2011 (X6) DATE

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

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F 224	<p>Continued From page 1</p> <p>Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property (revised 07/1/10), Reporting Alleged Violations (reviewed March 2007), and Social Services Policies and Procedures Manual Residents' Rights (revised October 2009) revealed all residents in the facility would be free from neglect. A review of the policy revealed neglect was defined as the failure to provide goods and services necessary to avoid physical harm and mental anguish. The policy review also revealed staff was required to take appropriate steps to prevent occurrences of neglect of residents.</p> <p>The facility admitted Resident #1 on 10/29/02, with diagnoses that included Paranoid Schizophrenia, Manic Disorder, Psychosis, Morbid Obesity, and Lymphoma. Further review of Resident #1's medical record, including documentation from the treatment center dated 03/9/11, 04/12/11, and 04/22/11, revealed the resident had a history of treatment at the center for Lymphoma. Based on documentation, Resident #1 would initiate "another set of (weekly) treatments" in May 2011.</p> <p>An observation and interview with Resident #1 on 6/29/11, at 3:05 PM, revealed the resident was in bed and consistently kept his/her eyes closed even during conversation. Resident #1 responded "yes" or "no" to the majority of questions asked, did not attempt to make meaningful conversation and, at times, did not appear to understand the questions.</p> <p>A review of Resident #1's Care Area Assessment (CAA) dated 03/2/11, and a review of the most recent Minimum Data Set (MDS) assessment</p>	F 224	<p>F224 It is the policy of this provider to provide goods and services necessary to avoid physical harm and mental anguish.</p> <p>The provider respectfully requests Informal Dispute Resolution for F 224.</p> <p><u>1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?</u></p> <p>Resident #1 has had no further visits to the cancer treatment center.</p> <p><u>2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken?</u></p> <p>Residents with the propensity to be affected by the alleged deficient practice have been identified as those transferred out of the facility to receive treatments at other providers scheduled for an extended period of time. Such residents with appointments meeting the criteria so identified would be provided with incontinent briefs, sack lunch or other equipment as appropriate.</p> <p><u>3. What action did the provider take to assure that the alleged deficient practice does not recur?</u></p> <p>The licensed staff responsible for initiating transfer paperwork were in-serviced with regard to the procedure to assure that when a resident is scheduled to be out of the facility for an extended period of time for treatment(s), they are supplied with a sack lunch and incontinence care items or other equipment, as appropriate. These items are treated as part of the transfer paperwork. The</p>	

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F 224	<p>Continued From page 2</p> <p>dated 5/20/11, revealed facility staff assessed Resident #1 to have severe cognitive impairment, was incontinent of bowel and bladder, and required assistance with all activities of daily living.</p> <p>Interviews with the Director of the treatment center on 06/29/11, at 3:50 PM, revealed Resident #1 had arrived at the Cancer Center on 05/20/11, via non-emergency ambulance transport for treatment, without an accompanying staff attendant, provisions for a lunch meal, or incontinence briefs. The Director stated staff at the treatment center contacted the resident's facility on 05/20/11, and informed the DON the facility would need to provide staff to accompany Resident #1, provide a lunch meal for the resident, and send incontinence briefs with the resident during each weekly treatment. The Director stated the resident's facility had also failed to provide staff and needed provisions for Resident #1 during appointments with the treatment center in March and April 2011. Continued interview with the Director revealed he had spoken with staff of the facility about the identified concerns on numerous occasions, including on 05/20/11, but the problems continued.</p> <p>An interview conducted with RN #1 on 06/29/11, at 4:36 PM, confirmed the treatment center had called and spoken with her on numerous occasions regarding the facility's failure of sending staff and needed provisions with the resident during the appointments at the treatment center. RN #1 reportedly acknowledged the center's requests and indicated the facility would make necessary arrangements to ensure staff</p>	F 224	<p>F224 Continued -</p> <p>nurse assigned to the resident would assure the equipment is given to the transferring agency, EMS, Bus Service, etc.</p> <p><u>4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?</u></p> <p>The ADNS or her designee will follow up by phone weekly with other providers asking if the items that were needed to care for the residents needs were received. If the results of the follow up conversations indicate that the items above were not received, corrective action will be initiated and an action plan developed, as needed. The results of the conversations and corrective actions if any will be reported monthly to the QA&A committee. The committee will review and recommend any revisions to the process to assure continued compliance including the necessity for continued monitoring.</p> <p>EDC -08/03/2011</p>		

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F 224	<p>Continued From page 3</p> <p>accompanied the resident to the treatment center and that personal provisions would be provided for Resident #1.</p> <p>Interviews were conducted on 06/30/11, at 11:15 AM, with Licensed Practical Nurse (LPN) #1 and on 06/29/11, at 2:15 PM, with Certified Nursing Assistant (CNA) #1 and revealed both employees had provided care for Resident #1 on 06/10/11, prior to the resident's transfer to the treatment center. LPN #1 recalled seeing incontinence briefs lying on Resident #1's bed on the morning of 06/10/11, and stated kitchen staff sent the resident a lunch meal to the nurses' station for Resident #1, but stated she had not placed the lunch meal or the incontinence briefs on the stretcher with Resident #1, and had not given the items to the ambulance attendants. CNA #1 stated she heard LPN #1 make a comment that Resident #1's lunch was at the nurses' station, and recalled that she had placed incontinence briefs on Resident #1's bed, prior to the ambulance arriving, but had not placed the lunch or incontinence briefs on the stretcher with Resident #1 and had not given the items to the ambulance attendants.</p> <p>Interviews conducted on 06/29/11, at 2:05 PM and 4:50 PM, with the Director of Nursing (DON) confirmed the treatment center had contacted her on 06/20/11, regarding Resident #1's needs related to the weekly treatments. The DON stated at that time nursing staff was informed to "send staff and briefs" with Resident #1, but no specific arrangements or systems were put in place to ensure the resident arrived to the treatment center with the required provisions. During interview, the DON indicated kitchen staff</p>	F 224			

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F 224	<p>Continued From page 4</p> <p>was to provide Resident #1 a lunch and nursing staff was responsible "as usual" to send any personal items required, such as incontinence briefs, with the resident. Additionally, the DON stated Resident #1's State Appointed Guardian was contacted and had requested to accompany Resident #1 to the treatment center on 06/10/11, due to the facility being "unable to provide staff all the time" for Resident #1's sessions at the treatment center.</p> <p>Interviews were conducted on 06/29/11, at 4:00 PM, and 06/30/11, at 8:15 AM, with Resident #1's Guardian. The Guardian stated she had agreed to accompany Resident #1 to the treatment center on 06/10/11, when contacted by the facility. However, the Guardian stated no information was provided by the facility except directions to the treatment center and the time of the resident's appointment on 05/10/11. The Guardian recalled Resident #1 arrived at the treatment center via non-emergency ambulance transport on 6/10/11, and the facility staff had failed to provide the resident with any provisions. According to the Guardian, the treatment center staff asked the Guardian about food/briefs for the resident and the Guardian stated, "I didn't know what they were talking about." The Guardian stated she had offered to leave the center to obtain the needed supplies, but was informed Resident #1 couldn't be left alone due to the resident's history of removing intravenous (IV) fluids and behavioral problems while at the treatment center. The Guardian stated she contacted the facility at approximately 12:30 PM, and informed the Social Worker of the facility's failure to provide food and incontinence briefs for the resident, and stated the resident was</p>	F 224			

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F 224	Continued From page 5 "obviously wet" from urine. The Guardian stated she requested the facility to bring food and briefs to the center for Resident #1, but the facility neglected to provide the needed items. Resident #1 remained at the treatment center until approximately 4:00 PM on 05/10/11, with wet clothing and without having a substantial meal.	F 224			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to implement policies and procedures for investigating and reporting an incident of possible neglect for one of three sampled residents (Resident #1). The facility was made aware on 05/10/11, that resident #1 had been sent to an off-grounds treatment center on 05/10/11, from approximately 10:00 AM until 4:00 PM, without food and incontinence briefs as requested by the treatment center staff. The facility failed to initiate an investigation of the incident, and failed to report the incident as an act of possible negligence to appropriate agencies as required. The findings include: A review of the facility's policies, "Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect,	F 226			

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F 226	<p>Continued From page 6</p> <p>Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property" (revised on 7/1/10), "Reporting Alleged Violations" (reviewed March 2007), and "Social Services Policies and Procedures Manual Residents' Rights" (revised October 2009) revealed all alleged violations that involved abuse/neglect would be thoroughly investigated and reported immediately to the Facility Administrator and state agencies in accordance with existing state law. Furthermore, a review of the policies revealed the social services staff was bound by accepted standards of practice to intervene when abuse/neglect was suspected.</p> <p>Interviews conducted on 06/29/11, at 4:00 PM, and 8/30/11, at 8:15 AM, with Resident #1's State Appointed Guardian revealed resident #1 had arrived for administration of a weekly treatment at a treatment facility on 06/10/11, at approximately 10:00 AM, and did not have provisions for a noon meal or incontinence briefs. The Guardian stated resident #1 became "obviously wet" with urine, and received only crackers and a few snacks found at the treatment center for lunch. The Guardian stated she called the facility on 06/10/2011, at approximately 12:30 PM, and spoke with the facility's Social Worker (SW), informed the SW that resident #1 had been sent to the treatment center without food or incontinence briefs, was "obviously wet," and needed to be fed. The Guardian also stated she contacted the facility and requested for facility staff to bring incontinence briefs and a "sack lunch" to the treatment center for the resident, however, according to the Guardian, the food and briefs were never brought to the center. The Guardian stated the resident remained at the</p>	F 226	<p>F226 It is the policy of this provider to develop and implement written policies and procedures prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property and to report timely to the State agency.</p> <p>The provider respectfully requests Informal Dispute Resolution for F 226.</p> <p><u>1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?</u></p> <p>Resident #1 has had no further visits to the cancer treatment center.</p> <p><u>2. How will the provider identify other resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken?</u></p> <p>Residents with the propensity to be affected by the alleged deficient practice have been identified as those transferred out of the facility to receive treatments at other providers scheduled for an extended period of time. Such residents with appointments meeting the criteria so identified would be provided with incontinent briefs, sack lunch or other equipment as appropriate.</p> <p><u>3. What action did the provider take to assure that the alleged deficient practice does not recur?</u></p> <p>Staff were in-serviced regarding the definition of mistreatment, abuse, neglect and misappropriation of resident property and reporting of same to the State Agency and initiation of an investigation. A return demonstration was required of a random</p>	

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F 226	Continued From page 7 center, wet and without a substantial meal, until approximately 4:00 PM. Interviews with the SW on 6/29/11, at 10:30 AM, and on 06/30/11, at 11:00 AM, revealed the SW had been trained by the facility on abuse/neglect investigation and reporting requirements, and routinely conducted and/or participated in the facility's investigations of allegations of abuse/neglect. The SW stated Resident #1's Guardian had contacted her on 06/10/11, and made a complaint that alleged the facility failed to provide food for resident #1 and the resident had remained wet, from urine, for a minimum of at least four hours because the facility had failed to provide the treatment center with incontinence briefs during the resident's treatment at the treatment center. Interview with the SW revealed she failed to initiate an investigation into the allegation and failed to report the allegation to the Administrator or state agencies as required. During the interview on 6/29/11, at 10:30 AM, the SW stated, "I told somebody, but I can't remember who it was, and assumed they would take care of it." The SW stated she had taken no further action regarding the allegation made by Resident #1's Guardian. Interviews conducted with the DON on 06/29/11, at 2:05 PM and 4:50 PM, and on 06/30/11, at 11:00 AM, revealed the DON became aware of the incident on 06/14/11, when Adult Protective Services (APS) arrived at the facility to investigate the incident as an act of caretaker neglect. The DON stated at that time the facility initiated an investigation into the incident but failed to notify the state agency of the allegation until 6/24/11, at 3:35 PM. When asked why the incident had not	F 226	sampling of the staff. When incorrect responses F226 continued are received from randomly sampled staff, a corrective one on one in-service will be conducted. The DCE or her/his designee will continue monitoring by random sampling of staff for correct response. <u>4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?</u> The results of the sampling will be forwarded to the DCE who will compile the results of the in-service/return demonstration and report them to the QA&A committee. The committee will review and recommend any revisions to the process to assure continued compliance including the necessity for continued monitoring. EDC - 08/03/2011	

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F 226	Continued From page 8 been reported as required, the DON responded, "I really didn't think much of it to be honest; either it was sent or it wasn't (referring to the food and briefs), no injury occurred from it, and [Resident #1] was clean when [he/she] left here that morning." An interview with the Administrator on 06/30/11, at 11:15 AM, revealed she initially became aware of the incident on 6/14/11, four days after the incident, when Adult Protective Services (APS) arrived at the facility to conduct an investigation. The Administrator reportedly was not at the facility, but had been contacted by facility staff and informed of the allegation/investigation by APS. The Administrator denied prior knowledge of the incident and stated she had not been notified on 06/10/11, by the SW or any facility staff, of the allegation made by Resident's #1 Guardian. Refer to F224.	F 226			