

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

PRINTED: 03/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/16/2011
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	INITIAL COMMENTS	F 000	<p><b><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></b></p> <p><b>F 280 Care Plan Participation</b></p> <p>This facility will ensure that all residents have the opportunity to participate in their care plans and treatment.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident discharged 11-01-10.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>All residents have the potential to be affected. Nursing administration will audit 100% of residents on therapy caseload in past quarter to compare</p>	4/15/11
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, and interview, it was determined the facility failed to revise the nursing plan of care for one (1) of three (3) sampled residents (#1) regarding a recommended change in level of supervision during ambulation.</p>	F 280		

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

X 

TITLE

X Executive Director

(X6) DATE

X 4/15/11

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.

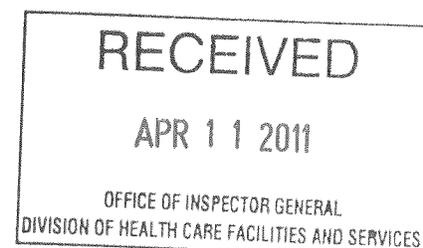
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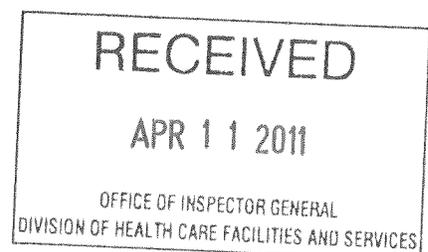
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F 280	Continued From page 1 The findings include:  Review of the facility policy "Clinical Guideline: Falls Management" dated 04/24/06 on 03/16/11 revealed residents are to be assessed for fall risk, evaluated by therapy staff as needed, and appropriate interventions are to be implemented.  Record review for Resident #1 on 03/15/11 revealed an admission date of 03/10/10 with diagnoses to include Alzheimer's Dementia, Cataracts, and Osteoarthritis. The facility assessed the resident as being severely cognitively impaired with a score of two (2) on the Minimum Data Set dated 09/20/10. The facility assessed Resident #1 as being at risk for falls upon admission. At that time a nursing care plan was written to provide interventions to be implemented to prevent falls. A physical therapy assessment completed on 10/12/10 revealed the resident could use a rolling walker with supervision but did not require physical assistance. Resident #1 sustained a second fall on 10/19/10 and was reassessed by physical therapy. The physical therapy assessment on 10/19/10 revealed Resident #1 required contact guard assistance with ambulation. Further record review of the nursing care plan did not reveal interventions reflecting the increased level of supervision recommended by physical therapy. Review of the certified nursing assistants' assignment sheet revealed a key for acronyms used for ambulation to be documented for each resident. This key did not include contact guard assistance as a choice. On 10/28/10 Resident #1 was discovered lying on his/her bedroom floor and was unresponsive. Resident #1 was transported to the hospital, was admitted, and subsequently expired on 11/01/10, Review of the	F 280	therapy recommendations to care plans for accuracy and update as needed.  CNA assignment sheets will be updated by nurse managers/supervisors as changes in functional status are identified.  <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b>  Institute formal written communication protocol from therapist to nursing related to changes in resident's functional status: <ul style="list-style-type: none"> <li>• Therapy will communicate changes in resident's functional status with written communication form given to DNS/ADNS during morning stand-up meeting or managers/supervisors at all other times.</li> <li>• Therapy will keep signed copy of communication to nursing in their office.</li> <li>• Care plans and assignment sheets will be updated by administrative nurses or nurse managers/supervisors as information is conveyed</li> </ul>	



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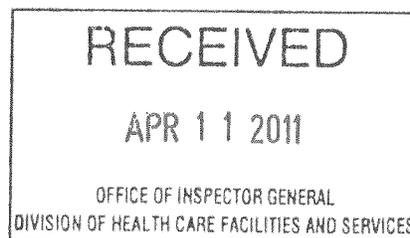
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F 280	<p>Continued From page 2</p> <p>hospital record for Resident #1 revealed a cat scan of Resident #1's head did not show a head injury and review of the death record revealed the cause of death was cardiac arrest.</p> <p>Interview with the Physical Therapist (PT) on 03/15/11 at 3:20pm revealed that Resident #1 had been reassessed on 10/19/11 following a fall. The PT stated the resident required Contact Guard assistance with ambulation. The PT defined Contact Guard assistance as needing a continuous hold on the resident during ambulation to prevent falls. The PT stated this information was relayed to the nursing staff verbally upon completion of the assessment. The PT also revealed there is no form of formal/written communication in place to notify nursing staff.</p> <p>Interview with the Occupation Therapist (OT) on 03/15/11 at 3:50pm revealed that Resident #1 had been assessed on 10/22/10 as requiring Contact Guard assistance. The OT stated that Resident #1 required constant contact to maintain balance while in a sitting position. The OT stated that the nursing staff had been notified verbally of the results of the assessment.</p> <p>Interview with the PT on 03/16/11 at 10:52am revealed that the PT was not able to remember which nursing staff member had been verbally notified of Resident #1's change in supervisory status. The PT was not sure if he informed a nursing staff member on 10/26/10 that Resident #1 had been reassessed and remained on Contact Guard supervision. The PT stated that a copy of the evaluation notes are placed on the residents clinical record, but they are not flagged and staff is not notified at the time the notes are inserted into the clinical record.</p>	F 280	<p>per communication form either in the morning meeting or directly to management nurses on the units.</p> <ul style="list-style-type: none"> <li>• Therapy will develop a key for the nursing staff to communicate types of assistance required. Key will be placed at nurse's stations and on aide assignment sheets.</li> <li>• DNS will in service IDT, nurse managers and supervisors on new communication protocol, care planning therapy recommendation s and updating CNA assignment sheets.</li> <li>• RPC (Rehab Program Coordinator) will inservice Aegis therapy staff on communication protocol with the nursing staff.</li> </ul> <p><b>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?</b></p> <p>10% of therapy caseload will be audited monthly by DNS or designee</p>		



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F 280	Continued From page 3  Interview with Licensed Practical Nurse (LPN) #1 on 03/16/11 at 10:57am revealed communication between the therapy department staff and the nursing staff for resident condition and status change is verbal and she stated she felt the means of communication could be improved. LPN #1 was not sure if she had been informed of the resident's change in level of supervision to contact guard but she thought it would have been documented on the twenty-four (24) hour nursing report. No evidence was provided that this information was on the twenty-four (24) hour report. This report information is not available to the nurse aide staff. LPN #1 stated a resident's change in ambulation status would be passed on to the nurse aides in a verbal "huddle" report between nurses and nurse aides. LPN #1 stated she thought the nursing aides were aware of Resident #1's ambulation status of contact guard but she could provide no documentation to prove this.  Interview with LPN #2 on 03/16/11 at 11:10am confirmed that verbal communication was the usual method of communication between the therapy and nursing department staff. He stated that he thought that Contact Guard was utilized with Resident #1. However, he also stated that use of a bed/chair alarm might have been useful for Resident #1 to alert staff when he/she was attempting to stand and ambulate.  Interview with CNA #2 on 03/16/11 at 11:50am revealed the nurse aides are informed of resident changes in the "huddle" and she thought she was informed of Resident #1's ambulation status but she was not aware of any documentation of this status. She also stated that she thought Resident	F 280	and compared to resident care plan for accuracy. Findings of audits will be brought to Quality Assessment & Assurance (QAA) monthly for three months and then quarterly for three quarters.  <b>Compliance Date: 04/15/11</b>		



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F 280	<p>Continued From page 4</p> <p>#1 always informed the staff when wishing to ambulate by using his/her call light or by 'yelling' but this had not occurred prior to Resident #1 being found on the floor on 10/28/10.</p> <p>Interview with the Director of Nursing (DON) on 03/16/11 at 12:00noon revealed residents in the facility may be on Contact Guard assistance with ambulation but admitted this is not on the nurse aide assignment sheet. She stated a resident may alert the staff of the desire to ambulate by utilizing his/her call light or by calling for help. However, she admitted that this might not occur and the resident might attempt to ambulate independently. She also admitted that Resident #1 might have benefitted from a bed/chair alarm as an intervention for safety from falls upon the recommendation for Contact Guard by the PT.</p>	F 280		

