

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

PRINTED: 02/21/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2012
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NAME OF PROVIDER OR SUPPLIER THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229
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F 000	INITIAL COMMENTS An abbreviated survey was initiated and concluded on 02/08/12 to investigate KY17581, KY17700 and KY17831. The Division of Health Care substantiated the allegations for KY17581, KY17700 and KY17831 as verified by the evidence. Federal and State deficiencies were cited.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	Plan of Correction Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	

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

TITLE

(X8) DATE

[Signature] Administrator *[Signature]* 02/08/12

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.

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OFFICE OF INSPECTOR GENERAL

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F 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to thoroughly investigate three (3) of five (5) sampled residents' (Resident #1, 2, and 3) complaints of missing personal property for possible misappropriation of property. Resident #1 reported a ring missing. Resident #2 reported a ring missing. Resident #3 reported a missing camera.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Investigation and Reporting of Alleged Misappropriation of Resident Property, dated 07/01/10, revealed an investigation shall include interviews with employees, visitors, and residents. The documentation of the investigation shall be kept in a secure file. Federal law requires facilities to have evidence of investigations of alleged violations.</p> <p>Review of the facility's incident report investigation, dated 12/23/11, revealed Resident #1's family reported the resident had a missing ring. A Certified Nurse Aide (CNA) reported</p>	F 225	<p>F225</p> <p>1. The missing items were found and returned to residents #1 and #2. The investigation was re-opened for resident #3 on 2/8/12 and a thorough investigation has been completed. However, the missing item still has not been located. The facility offered to reimburse the resident for the missing item. The resident went shopping for the missing item on 02/27/12. The facility replaced the missing item on 02/28/12.</p> <p>2. The Investigative Team which consists of the Administrator, DON, and Social Services Director or Social Worker will review all allegations of abuse and neglect over the past 3 months (December 2011 – present) and re-open investigations that have not been completed thoroughly. If the allegations involve misappropriation of resident property and the missing item(s) have been found, the investigation will not be re-opened. The facility also sent out a notice to all residents and family members on 02/28/12, advising them to notify us immediately of missing items. This notice also contained instructions on how to label items being kept at the facility and suggestions on how to store valuables.</p>	
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F 225	<p>Continued From page 2</p> <p>seeing the the ring on 12/19/11. The facility searched the resident's room. There was no documentation located regarding interviews with staff or residents. On 12/28/11, the facility offered to reimburse the resident for the lost ring.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 12/21/09 with diagnoses of Dementia, Alzheimer's Type Dementia, Depression and Anxiety. The facility completed a quarterly Minimum Data Set (MDS) assessment on 11/22/11 which indicated the resident was cognitively impaired.</p> <p>Interview with the Social Services Director (SSD), on 02/08/12 at 11:00 AM, revealed Resident #1's ring had been found under a chair cushion where the resident often sits. The laundry department was searched by the Director of Housekeeping. No other areas of the facility were searched. The facility's list of staff who cared for Resident #1 between 12/19/11 and 12/23/11 were not interviewed. The SSD also stated the facility did not have any guidelines on how to conduct an investigation and she had no training on doing an investigation.</p> <p>2. Continued review of the facility's incident investigations, revealed the facility was notified Resident #2 was missing a ring on 01/14/12 at 6:50 AM. An aide looked in the resident's drawer at the resident's request, however the ring was not located. The resident had just returned from an emergency room visit following a fall sustained on 01/13/12. The aide reported the missing ring to the Registered Nurse (RN). The RN was at the</p>	F 225	<p>3. On 03/15/12, Detective Spegal of the Jeffersontown Police Department will in-service the investigative team on completing thorough investigations. The investigative team consists of the Administrator, Director of Nursing and Social Services Director. On 03/13/12, the HR Director will in-service the entire Leadership Team on conducting thorough workplace investigations per Good Samaritan policy and procedure. The leadership team consists of the Administrator, all Directors, Unit Managers, MDS Coordinators, Restorative Nurse, Nursing Weekend Supervisor, and HIM Manager. All training will be completed by 3/22/12.</p> <p>4. The Administrator and Social Services Director will audit 100% of all investigations involving alleged abuse and neglect weekly x 3 months, then monthly x 9 months when investigations are necessary to ensure that the investigations are thoroughly completed according to policy and procedure. The results of the audits will be submitted to the QA Committee for further review and recommendations.</p> <p>5. All corrective measures will be completed by 3/23/12.</p>	



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F 225	<p>Continued From page 3</p> <p>end of her shift and reported the missing ring to the oncoming nurse, Licensed Practical Nurse (LPN) #1. When another aide reported the missing ring to LPN #1 later that day, the LPN thought the missing ring had been reported and searched for and no further action was taken. The facility initiated an incident report on the missing ring on 01/16/12, two days after the ring was reported missing. The incident report indicated the ring was last seen on 01/15/12 even though the resident reported the ring missing on 01/14/12 at 6:50 AM. A search of the resident's room, on 01/16/12, revealed the ring was not located. The facility documented no abuse was suspected. On 01/19/12, the facility called the hospital, five days after the ring was reported missing, to inquire if a ring had been found.</p> <p>Interview with Resident #2, on 02/08/12 at 1:00 PM, revealed the resident had no memory of losing a ring. The resident was confused as to time and place.</p> <p>Review of the clinical record for Resident #2, revealed the facility admitted the resident on 09/22/10 with a diagnosis of Alzheimer's Disease. The facility completed a quarterly MDS assessment for the resident which revealed the resident had a Basic Interview for Mental Status (BIM) score of seven (7) and was ambulatory.</p> <p>Interview with the Social Services Director (SSD), on 02/08/12 at 2:00 PM, revealed the facility was unable to provide further documentation. She revealed Resident #2 did report a missing ring to the facility. She stated she was not sure of the date. She stated she asked housekeeping to search the room, however, the ring was not</p>	F 225		
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F 225	<p>Continued From page 4</p> <p>located. She reported the ring was later found by the family at the hospital and she felt the facility handled everything fine and no abuse was suspected. She stated she was provided a list of staff having provided care for the resident, however, she stated she did not complete any interviews with residents or staff.</p> <p>3. Additional review of the facility's investigations revealed Resident #3 had a missing camera and the facility was notified by the Ombudsman on 02/01/12 that the camera was missing. The resident's room was searched on 02/01/12 by an aide, however, the camera was not located. There was no documentation provided regarding an investigation. The facility documented misappropriation was not suspected.</p> <p>Interview with Resident #3, on 02/08/12 at 2:30 PM, revealed the resident was missing a camera since a few days prior to reporting on 02/01/12 and had not received word from the facility regarding the camera. The resident stated a trip on a bus to church had recently been taken and wondered if the camera might have gone missing there. The resident stated the facility took a report and looked through the room, however, the camera was not located.</p> <p>Interview with the SSD, on 02/08/12 at 2:00 PM, revealed Resident #3 had reported missing a camera, however, a search of the room had failed to locate the camera. She stated the facility planned to replace the camera and no further action was required. She had not interviewed staff or residents regarding the camera. She was aware the resident had taken a bus to church recently and had not contacted the bus company</p>	F 225			



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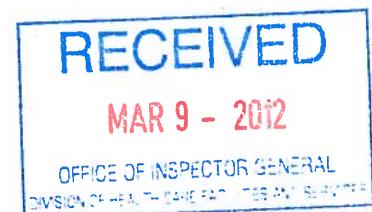
F 225	<p>Continued From page 5 or the church regarding the missing camera since replacement of the camera was planned.</p> <p>Interview with Resident #4 and Resident #5, on 02/08/12 at 3:00 PM, revealed they were very active in the facility's Resident Council. They stated they had not experienced any lost property and would report it to the facility if they had any concerns. They stated they were not aware of what action the facility would take to recover property but assumed the facility would search the building.</p> <p>Interview with the SSD, on 02/08/12 at 4:00 PM, and on 02/08/12 at 2:00 PM, revealed she was not sure what the facility's policy on misappropriation of property said. She stated the facility completed an incident report and the resident's room was searched for the missing property. She stated the staff member who completed the search documented the search and the results. She revealed she sent a report to the appropriate state agencies stating abuse was not suspected. She stated missing items were rarely found outside of a resident's room and searches of other areas were not indicated. She revealed the laundry might be contacted so they could be on the look-out but no search was requested. She indicated missing items were replaced by the facility so there was no concern and she had never thought about interviewing staff or residents to determine if misappropriation of property had occurred.</p> <p>Interview with the Administrator, on 02/08/12 at 4:45 PM, revealed the facility needed to educate staff on managing allegations of misappropriation of property and provide oversight to all</p>	F 225		
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F 225	Continued From page 6 investigations.	F 225	F226	
F 226 SS=E	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, record review and review of the facility's policy, it was determined the facility failed to implement the facility's policy on Investigating Misappropriation of Property for three (3) of five (5) sampled residents (Resident #1, 2 and 3). The facility failed to implement a policy to investigate missing rings belonging to Resident #1 and Resident #2. In addition, the facility failed to implement a policy to investigate a missing camera belonging to Resident #3. The findings include: Review of the facility policy for Investigation and Reporting of Alleged Misappropriation of Resident Property, dated 07/01/10, revealed an investigation shall include interviews with employees, visitors, and residents. The documentation of the investigation shall be kept in a secure file. Federal law requires facilities to have evidence of investigations of alleged violations. Review of the facility's incident report investigations, dated 12/23/11, revealed Resident #1's family reported the resident had a missing	F 226	1. The missing items were found and returned to residents #1 and #2. The investigation was re-opened for resident #3 on 2/8/12 and a thorough investigation has been completed according to our policy and procedure. However, the missing item still has not been located. The facility offered to reimburse the resident for the missing item. The resident went shopping for the missing item on 02/27/12. The facility replaced the missing item on 02/28/12. 2. The Investigative Team which consists of the Administrator, DON, and Social Services Director or Social Worker will review all allegations of abuse and neglect over the past 3 months (December 2011 – present) and re-open investigations that have not been completed thoroughly. If the allegations involve misappropriation of resident property and the missing item(s) have been found, the investigation will not be re-opened. The facility also sent out a notice to all residents and family members on 02/28/12, advising them to notify us immediately of missing items. This notice also contained instructions on how to label items being kept at the facility and suggestions on how to store valuables.	



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F 226	Continued From page 7 ring. The facility searched the resident's room. There was no documentation located regarding interviews with staff or residents. Continued review of the facility's incident investigations revealed Resident #2 was missing a ring on 01/14/12 at 6:50 AM. LPN #1 thought the missing ring had been reported and searched for and no further action was taken. The facility initiated an incident report on the missing ring on 01/16/12, two days after the ring was reported missing. Even though the resident reported the ring missing on 01/14/12 at 6:50 AM. There was no evidence of interviews with staff or residents or other activity to determine when the ring was last seen and what events may have occurred. On 01/19/12, the facility called the hospital, five days after the ring was reported missing, to inquire if a ring had been found. In addition, Resident #3 was missing a camera and the facility was notified by the Ombudsman on 02/01/12 that the camera was missing. The resident's room was searched on 02/01/12 by an aide, however, the camera was not located. The facility documented misappropriation was not suspected. The facility did not provide any evidence of interviews with staff or residents to determine if misappropriation had occurred. Interview with the Social Services Director (SSD) on 02/08/12 at 11:00 AM, revealed the facility did not have any guidelines on how to conduct an investigation and she had no training on doing an investigation. Continued interview at 2:00 PM revealed she was not sure what the facility's policy on misappropriation of property said. Additional interview at 4:00 PM, revealed she had never thought about interviewing staff or residents to determine if misappropriation had occurred nor was she aware the policy required	F 226	3. On 03/15/12, Detective Spegal of the Jeffersontown Police Department will in-service the investigative team on completing thorough investigations. The investigative team consists of the Administrator, Director of Nursing and Social Services Director. On 03/13/12, the HR Director will begin in-servicing the entire Leadership Team on conducting thorough workplace investigations per Good Samaritan policy and procedure. The leadership team consists of the Administrator, all Directors, Unit Managers, MDS Coordinators, Restorative Nurse, Nursing Weekend Supervisor, and HIM Manager. The Social Services Director, Department Directors, and the Staff Development Coordinator will in-service all staff on reporting and following our abuse and neglect policy and procedure. During the training, the Social Services Director, Department Directors and the Staff Development Coordinator will inform all staff involved in investigations that they will be interviewed and/or asked to write statements of what occurred. If their statements do not contain all pertinent information, they will be asked further questions. All training will be completed by 3/22/12.		



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F 226	Continued From page 8 an investigation. Interview with the Administrator, on 02/08/12 at 4:45 PM, revealed the staff required additional education on the facility's misappropriation of property policy and required more oversight during investigations.	F 226	<p>4. The Administrator and Social Services Director will audit 100% of all investigations involving alleged abuse and neglect weekly x 3 months, then monthly x 9 months when investigations are necessary to ensure that all witnesses have been interviewed and the investigations are thoroughly completed according to policy and procedure. The results of the audits will be submitted to the QA Committee for recommendations. If compliance is established as indicated by a 100% audit rate after monitoring weekly x 3 months, the QA committee will recommend that we continue monitoring monthly x 9 months and give further recommendations as to whether we continue monitoring after such time has expired. If compliance is not established as indicated by an audit percentage of less than 100%, the QA committee will recommend further weekly review until 100% compliance is established, then monthly x 9 months. The QA committee will not recommend ceasing monitoring after the 9 month period unless 100% compliance has been maintained throughout the entire 9 month timeframe.</p> <p>5. All corrective measures will be completed by 3/23/12.</p>	
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