STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185192	A. BUILDING _____ B. WING _____	05/07/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - ST MATTHEWS	227 BROWNS LANE LOUISVILLE, KY 40207

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility's policy and investigation, it was determined the facility failed to have an effective system to ensure staff was knowledgeable of the care plan interventions and failed to ensure staff implemented those care plan interventions for one (1) of eight (8) sampled residents (Resident #1). The facility assessed Resident #1 to be at risk for elopement and developed a Comprehensive Care Plan for that potential risk. Resident #1's care plan included an intervention to redirect the resident away from the exit doors to prevent the resident from wandering from the secure facility. However, per interview, the staff was unaware of the intervention thus the staff did not follow the care plan directive and Resident #1 left the facility's premises without staff knowledge on 04/20/15, at approximately 12:55 PM. The resident was found at approximately 1:15 PM, off the facility's grounds, standing approximately two (2) feet from a busy two (2) lane street. The facility's failure to ensure staff was knowledgeable of the Comprehensive Care Plan interventions and implemented those interventions to ensure the resident's safety was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 04/27/15 and was determined to exist on 04/20/15. The facility provided an acceptable Allegation of Compliance (AOC) on 05/06/15 with the facility alleging removal of the Immediate Jeopardy on 05/02/15. The Immediate Jeopardy was verified to be removed on 05/02/15 as alleged, with the scope and severity lowered to a D while the facility implements and monitors the Plan of Correction (POC) for effectiveness of systemic changes and quality assurance. The findings include: The facility did not provide a policy for care plans. Review of the facility's policy regarding Elopement, not dated, revealed residents identified at risk for elopement would have an interdisciplinary elopement prevention care plan developed. The care plan would include individual risk factors and patterns. Review of the facility's investigation, dated 04/23/15, revealed Resident #1 successfully exited the building without staff knowledge on 04/20/15. The investigation continued to state the Social Service's Director (SSD) at approximately 1:15 PM saw the resident walking down the road in front of the facility. The SSD directed the resident back to the facility and notified other staff for assistance. The investigation stated the facility determined the resident was missing for less than twenty (20) minutes. Review of the clinical record for Resident #1 revealed the facility readmitted Resident #1 on 11/07/14, with [DIAGNOSES REDACTED]. The record revealed the resident wandered throughout the facility freely. The facility conducted an elopement risk evaluation upon readmission, on 11/07/14, with findings of wandering behaviors. The resident's picture was placed in the Elopement Binder and an Accutech was placed on the resident. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 02/14/15, revealed the facility assessed the resident to have a cognitive loss with a Brief Interview for Mental Status (BIMS) score of eleven (11) out of possible fifteen (15). The facility assessed the resident to have a self-care impairment requiring limited assistance with bed mobility and transfers. The facility assessed the resident to be independent (needing no staff assistance) with ambulation. A care plan was developed on 11/07/14 addressing the elopement risk with interventions directing staff to redirect the resident away from all doors. Interview with Certified Nursing Assistance (CNA) #2, on 04/23/15 at 11:45 AM, revealed she had worked with Resident #1 for the past couple of weeks. She stated the resident hardly ever sat, but rather walked all day throughout the facility. She stated Resident #1 would stand in front of the entry/exit doors to look out, but the resident never tried opening the doors. She stated she never redirected Resident #1 away from the doors when he/she was standing in front of them. Interviews with CNA #2 on 04/23/15 at 11:45 AM; CNA #3 on 04/24/15 at 8:00 AM; CNA #4 on 04/24/15 at 9:00 AM; CNA #5 on 04/24/15 at 9:15 AM; CNA #6 on 04/26/15 at 3:45 PM; CNA #7 on 04/26/15 at 4:30 PM; CNA #8 on 04/27/15 at 11:00 AM; CNA #9 on 04/27/15 at 11:15 AM; CNA #10 on 04/27/15 at 12:00 PM; and CNA #11 on 04/27/15 at 12:45 PM, revealed none of the CNAs were aware of the directive on the care plan to redirect Resident #1 from the exit/entry doors. Per interviews, all had knowledge of the resident standing at the doors to look out; however, staff had never redirected the resident away from the doors. Interview with the Activity Assistant, on 04/23/15 at 1:45 PM, revealed she saw Resident #1 every time she worked and he/she enjoyed walking throughout the facility. She stated she would see the resident standing in front of the entry/exit doors sometimes just looking out the window. She stated she never saw Resident #1 exit seeking and she never redirected the resident away from doors. She further stated she did not know the care plan stated to redirect the resident away from the doors. Interview with the North Wing Unit Manager Registered Nurse (RN) #4, on 04/24/15 at 8:35 AM, revealed Resident #1 would walk freely throughout the entire facility and he had never seen the resident exit seeking. RN #4 stated he did see Resident #1 looking out the window at the doors, but never redirected him/her away from doors. RN #4 further stated he was not aware the care plan directed staff to redirect the resident away from the doors. Interview with Licensed Practical Nurse (LPN) #5, on 05/07/15 at 10:15 AM, revealed Resident #1 walked freely through the facility and LPN #5 did witness Resident #1 standing in front of entry/exit doors looking out the widows, but she never saw him/her trying to exit the facility. LPN #5 stated she did not ever redirect Resident #1 away from doors because she never saw him/her trying to push open the doors. Interview with the MDS Coordinator, on 05/07/15 at 8:15 AM, revealed the elopement care plans were generated from a computer program. The MDS Coordinator could not verbalize the exact interventions for Resident #1 related to elopement. However, she did state potential interventions would be residents wearing Accutech tags for monitoring, and their picture being placed in the elopement logs at each of the nursing stations and throughout the facility. The MDS Coordinator further stated she could not remember if she put the intervention on the care plan or not and did not know the care plan stated to redirect the resident away from exit doors. Interview with the Assistant Director of Nursing Services (ADON), on 04/27/15 at 10:30 AM, revealed Resident #1 was assessed for an elopement risk due to wandering, impaired cognition and being ambulatory. She stated the resident would stand at the entry/exit doors and look out the window, but never tried to open the doors. The ADON stated she never redirected the resident away from doors due to the resident was not exit seeking and not trying to get out of the facility. She further stated she did not know the care plan intervention was to redirect the resident. The ADON stated it was her responsibility to review the care plans monthly; however, she missed that intervention. Interview with the Administrator, on 04/24/15 at 7:58 AM, revealed he relied on the Director of Nursing (DON) and the ADON to monitor the staff to ensure the care plans were followed. He stated they discussed concerns in the morning meetings and this included not following the care plans; however, he stated they had not discussed lately, not following the care plans or Resident #1. The facility provided an acceptable Allegation of Compliance (AOC) on 05/06/15 that alleged removal of the Immediate Jeopardy on 05/02/15. Review of the AOC revealed the facility implemented the following: 1. On 04/20/15, Resident #1 was returned back to the facility. Vital signs were conducted and a full head to toe body assessment was conducted by LPN #5 . No injuries or harm were detected. 2. On 04/20/15, One Hundred and Eleven (111) residents were accounted for via physical count compared to census data by the Interdisciplinary Team that consisted of three (3) Unit Manager, the ADON and DON. 3. On 04/20/15, an audit was completed on One Hundred and Eleven residents (111) by the ADON and Unit Managers using the Golden Living elopement assessment form to identify potential new residents who were at risk, no additional residents were added to list of current sixteen (16) residents. 4. On 04/20/15, the Interdisciplinary Team (IDT) reviewed the care plans of seventeen (17) residents identified at risk for elopement. Two (2)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185192	A. BUILDING _____ B. WING _____	05/07/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - ST MATTHEWS	227 BROWNS LANE LOUISVILLE, KY 40207

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) care plans were revised; one (1) resident (Resident #1) was placed on one (1) to one (1) supervision and the other was no longer considered an elopement risk, this reduced the count to sixteen (16). 5. Three (3) elopement drills were conducted by the ADON and residents were accounted for via visual observation/head count. On 04/21/15 at 2:45 PM, 04/29/15 at 8:30 PM and 04/29/15 at 11:30 PM. 6. On 04/20/15, the two (2) public entry/exit doors with the Accutech System were checked by the Maintenance Director Assistant and determined to be working correctly. A physical test using an Accutech bracelet was conducted on both doors and the bracelet alarmed during the fifteen (15) second egress test to alert staff. 7. On 04/20/15 all seventeen (17) residents wearing an Accutech device were checked by the Director of Nursing Services (DON) and devices were determined to be working correctly. A hand held device was used to determine proper functioning of each bracelet. 8. On 04/20/15 a lead technician from Applied Audio Video validated the Accutech System was working correctly. 9. On 04/20/15 the Administrator posted signs at each exit door to remind staff and visitors to check behind them before they leave to prevent residents from following them outside. 10. On 04/21/15 members of the Quality Assurance Performance Improvement (QAPI) committee including the Medical Director held a meeting to discuss the elopement that occurred on 04/20/15 and develop a plan to prevent reoccurrence. Elopement policy and procedures were reviewed and an addendum was added to the policy to include not giving the code to visitors or vendors. Discussion also included review of how the code alarm system worked and changing the code to the doors monthly or more often if needed. 11. On 04/20/15, 04/21/15, 04/29/15, 04/30/15, and 05/01/15, the DON and ADON completed re-education on Elopement Guidelines to 121 facility staff including not giving door codes to visitors and the disengagement of the alarm when the code was entered and care plan education. 12. On 04/27/15 the Administrator mailed a letter to all family members and/or responsible parties stating door codes would not be provided and staff members would assist visitors in and out the doors. One Hundred and fourteen (114) letters were mailed. 13. The Multi-Site Clinical Educator provided care plan training, on 04/29/15, 04/30/15 and 05/01/15, to forty-five (45) licensed staff that included a demonstration. Education included use of CNA Assignment Sheets, initiation of care plans, updating of care plans, reviewing/revising/resolving and following the plan of care. 14. Starting 05/01/15 the Unit Managers/ADON/DON began completing audits during the clinical start up meeting. Audits include care plans, progress notes, 24 hour report and new admissions. This would continue on an ongoing bases. 15. On 05/01/15 Unit Managers and Weekend House Supervisor began making documented rounds daily to observe residents for exit seeking behaviors and staff redirection of residents. 16. On 05/01/15 Social Services staff began audits of documentation of mood and behaviors in the care tracker report Monday through Friday and would report any issues identified from these audits to the IDT/Startup teams. 17. Beginning the week of 05/04/15, results of all audits would be reported in the QAPI committee meeting for review and changes as indicated. The QAPI meeting would be held weekly for four (4) weeks, the bi-weekly for four (4) weeks, then monthly thereafter. The committee would also review compliance with education related to care plan training and elopement. If the Medical Director was unavailable in person on a weekly basis, he would review progress by telephone with the Administrator and/or DON. Through observation, interview and record review the State Survey Agency validated the AOC on 05/07/15 as follows: 1. Review of the head to toe assessment conducted by LPN #5 for Resident #1 on 04/20/15 revealed no injuries were found. Interview with LPN #5, on 05/07/15 at 10:15 AM, revealed she completed the head to toe assessment with no injuries found. 2. Review of the census data from the physical count the facility conducted on 04/20/15 revealed One Hundred and Eleven (111) residents were accounted for. Interview with the ADON, on 05/07/15 at 10:45 AM, revealed she participated in the count using some of the staff on duty at the time; the Unit Manager and the House Supervisor. Interview with the Unit Manager, on 05/07/15 at 2:15 PM, revealed the census was verified and all residents were accounted for. 3. Review of the audit forms for One Hundred and Eleven (111) residents revealed sixteen (16) residents were at risk for elopement. Interview with the Unit Manager, on 05/07/15 at 2:15 PM, revealed the audit was completed using the Golden Living elopement risk questionnaire to determine if other residents were at risk for elopement. 4. Review of the two (2) care plans that were revised revealed Resident #1 was placed on one to one (1:1) supervision and the other resident was no longer considered an elopement risk. Observation, on 04/23/15 at 11:45 AM, revealed a CNA was walking throughout the facility with Resident #1. Interview with CNA #2, on 04/23/15 at 11:45 AM, revealed since the elopement a CNA was assigned to Resident #1 and that staff member was to stay with the resident throughout their entire shift. 5. Review of the elopement drills conducted revealed three (3) elopement drills were conducted. One on 04/21/15 at 2:45 PM and two (2) on 04/29/15 at 8:30 PM and 11:30 PM. The drill conducted on 04/21/15 at 2:45 PM was completed in five (5) minutes with One Hundred and Twelve (112) residents. Drill conducted on 04/29/15 at 8:30 PM was completed in twelve (12) minutes with One Hundred and Six (106) residents and the drill conducted at 11:30 PM that same day was completed in ten (10) minutes with One Hundred and Seven (107) residents. Admission, hospital stays, out of building to visit accounts for the census fluctuation. Post survey interviews, on 05/13/15 with CNA #17 at 11:46 AM; CNA #18 at 11:49 AM; CNA #19 at 11:53 AM; and CNA #20 at 11:57 AM, revealed they all participated in the elopement drills by conducting resident counts. 6. Review of the facility's Daily Maintenance Rounds revealed ten (10) doors including the Main and North/Rear entry/exit doors were all checked and operating correctly. Observation of the ten (10) doors being locked, the fifteen (15) second alarm working correctly, and the Accutech alarm system working correctly was conducted, on 04/23/15 at 10:20 AM, with the Assistance Maintenance Director. A hand held device was used to determine the Accutech system was working correctly. Interview with the Assistance Maintenance Director, on 04/23/15 at 9:42 AM, revealed he conducted checks of all ten (10) doors every morning Monday-Fridays and the nursing staff checked the doors on Saturday and Sundays. Interview with the House Supervisor, on 05/07/15 at 3:00 PM, revealed at the start of her shift, she checked all doors with the Accutech box and actually pushed on the doors to test the alarm. She documented these checks in the computer. 7. Review of the audit of the seventeen (17) residents with Accutech devices revealed all devices were determined to be working correctly. Interview with the DON, on 04/23/15 at 3:30 PM, revealed she completed the audits of the seventeen (17) residents with Accutech devices, for a total of eighteen (18) devices (one resident had two devices), tested good with no malfunction. She stated none of the devices indicated a low or dead battery and all worked correctly. 8. Review of a signed statement on letter head from a lead technician from Applied Audio Video stated he responded to a service request on 04/20/15 for a review of the Accutech system. The statement revealed he tested all equipment and found the system to be One Hundred (100%) percent functional. 9. Review of a sign posted at each of the exit doors revealed the facility reminded staff and visitors to check behind them before exiting the building to make sure residents don't follow them out the door. Interview with Family Member #1, on 04/25/15 at 7:45 PM, revealed she previously knew the code to enter and exit the facility and she would enter and exit the building on her own anytime she visited her loved one. Family member #1 stated she had never let any resident exit the building with him/her and she had never seen a resident entering in the code on the key pads to the doors. 10. Review of the QAPI meeting minutes including the sign in sheet, dated 04/21/15, revealed fourteen (14) staff members were present including the Medical Director. Review of the minutes revealed the committee discussed the elopement that occurred on 04/20/15 including a plan to prevent reoccurrence, elopement policy and procedures, how the code alarm system worked, and changing the door code monthly or more often. Interview with the Administrator, on 05/07/15 at 2:30 PM, revealed the meeting was held to address the elopement, 1:1 supervision of the resident, reassessing all the residents for elopement, alarm checks, elopement book, updating the care plans, signs posted, door codes changed monthly, and staff education. Post survey interview with the Medical Director, on 05/13/15 at 11:13 AM, revealed he was notified of the elopement on 04/20/15. 11. Review of training records including sign in sheets, dated 04/20/15, revealed ninety seven (97) staff were trained on safety of residents, door codes not to be given out, elopement policy and procedures, following missing person action and care plan education. Further review of training records, dated 04/21/15, 04/27/15, 04/29/15, 04/30/15, and 05/01/15, revealed the remaining twenty-four (24) staff received education on these days. Interviews, on 05/07/15 with CNA #13 at 1:05 PM, CNA #14 at 2:17 PM, CNA #15 at 2:58 PM, CNA #16 at 3:12 PM, RN #5 at 1:12 PM, Dietary Aide #19 at 2:07 PM, Dietary Aide #18 at 1:10 PM, Dietary Aide #13, at 1:31 PM, LPN #10 at 1:16 PM, Housekeeper #14 at 1:45 PM, and Housekeeper #11 at 2:27 PM revealed they all had received in-service training on Elopement Guidelines, not giving door codes to visitors, and disengagement of the alarm when code is entered. CNAs all stated they received care plan training which included following the plan of care. 12. Review of the letter, dated 04/27/15, that was mailed to all family members and/or responsible parties revealed all family members and/or responsible parties were notified the facility would no longer provide visitors with the access codes to the entrances and a staff member would be required to let them in and out of the doors. 13. Review of training records including sign in sheets dated 04/29/15, 4/30/15, 5/01/15 and 05/03/15 revealed forty five (45) licensed staff was trained on initiation of care plans, updating of care plans, reviewing/revising/resolving, following care plans, and CNA Assignment Sheets included a demonstration. Interview on 05/07/15 with RN #5 at 1:12 PM, LPN #10 at 1:16 PM, and RN #4 at 2:00 PM, revealed they all had received in-service training on care plans including updating,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185192	A. BUILDING _____ B. WING _____	**05/07/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - ST MATTHEWS	**227 BROWNS LANE LOUISVILLE, KY 40207**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) reviewing, revising, and following and a demonstration was also given on the Point Click Care system. 14. Review of the Golden Clinical Startup Checklist dated 05/01/15, 05/02/15, 05/03/15, 05/04/15, 05/05/15, 05/06/15, and 05/07/15 revealed Unit Mangers and Weekend House Supervisors were conducting audits on care plans, progress notes, 24 hour reports and new admissions. Interview with Unit Manger RN #4, on 05/07/15 at 2:00 PM, revealed he had completed the clinical startup checklist every morning at the beginning of his shift and would report any issues found to the DON and ADON. RN #4 stated those audits would help him and other staff with keeping up with changing care plans, new admission care plans, and following the care of plan for residents. 15. Review of the observation sheets dated 05/01/15-05/06/15 revealed the sheets were completed by the Unit Mangers and Weekend House Supervisors. Review revealed no residents during that time frame were seen exiting seeking. Observation, on 05/06/15 at 2:35 PM and on 05/07/15 at 7:15 AM, 9:00 AM, 9:30 AM, and 10:55 AM revealed staff was walking throughout the facility monitoring the residents. Observation revealed no residents were exit seeking during those times. Interview with the House Supervisor, on 05/07/15 at 3:10 PM, revealed her role was to monitor the facility by walking rounds to monitor for exit seeking behaviors, document the observations and the observation sheet and review the behaviors in the morning meeting. 16. Review of the care tracker reports dated 05/01/15-05/06/15 revealed Social Services staff had conducted audits of documenting mood and behaviors in the care tracker system. Interview with the SSD, on 05/07/15 at 10:00 AM, revealed she audited the mood and behaviors in the care tracker system and she presented that information to the IDT/Startup teams each morning. The SSD stated if she found any issues she would follow up with staff and the resident involved. The SSD stated she entered that behavior and/or mood on the care plan and documented in the progress notes any and all updates. 17. QAPI Committee would meet beginning the week of 05/04/15 to review results of the audits. QAPI meeting to be held weekly for four (4) weeks, the bi-weekly for four (4) weeks, then monthly thereafter. The committee also to review compliance with education related to care plan training and elopement. Interview with the Administrator, on 05/07/15 at 3:00 PM, revealed the first QAPI meeting was scheduled for 05/08/15. The Administrator stated if the Medical Director was unavailable in person on a weekly basis, he would review progress by telephone with either him and/or the DON. Post survey interview with the Medical Director, on 05/13/15 at 11:13 AM, revealed he attended the QA meetings on 04/21/15 and 05/08/15. He further stated if he was not available for the meetings he would conference call with the Administrator.
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy and investigation, it was determined the facility failed to have an effective system to ensure adequate supervision of residents with known behaviors of wandering for one (1) of eight (8) sampled residents (Resident #1). Resident #1 was assessed by the facility to be an elopement risk and had an Accutech alarm applied. On 04/20/15, at approximately 12:55 PM, Resident #1 left the facility's premises without staff knowledge. The resident was found approximately 1:15 PM, off facility grounds, standing approximately two (2) feet from a busy two (2) lane road. The resident was directed by staff to return to the facility and was left unsupervised. The resident walked back to the facility and was assessed with [REDACTED].#1 had on a long sleeve flannel shirt, long pants and tennis shoes. The facility's failure to provide adequate supervision of residents with known wandering risk placed those residents in a situation that was likely to cause serious injury, harm, impairment or death. Immediate Jeopardy and Substandard Quality of Care was identified on 04/27/15 and was determined to exist on 04/20/15. The facility provided an acceptable Allegation of Compliance (AOC) on 05/06/15 with the facility alleging removal of the Immediate Jeopardy on 05/02/15. The Immediate Jeopardy was verified to be removed on 05/02/15 as alleged with the scope and severity lowered to a D while the facility monitors the Plan of Correction for effectiveness of systemic changes and quality assurance. The findings include: Review of the facility's policy regarding Elopement, not dated, revealed residents identified at risk for elopement would have an interdisciplinary elopement prevention care plan developed. The care plan would include individual risk factors and patterns. Review of the facility's investigation, dated 04/23/15, revealed Resident #1 successfully exited the building without staff knowledge on 04/20/15. The investigation continued to state the Social Service's Director (SSD) at approximately 1:15 PM saw the resident walking down the road in front of the facility. The SSD directed the resident back to the facility and notified other staff for assistance. The investigation stated the facility determined the resident was missing for less than twenty (20) minutes. Interview with the SSD, on 4/23/15 at 1:10 PM, revealed she found Resident #1 off of the facility grounds on 04/20/15 without staff present. She stated, on 04/20/15 at approximately 1:15 PM, she was driving back to the facility and turned left onto the two (2) lane road that runs in front of the facility. She stated after turning onto the road she happened to look out of her driver side window and saw a person who she realized was Resident #1. She stated the resident was approximately two feet from the road, walking on the side of the road with no sidewalk, walking away from the facility toward a busy main road. The SSD stated the resident was less than a mile from the facility and during that time of the day traffic was busy on the two (2) lane road. She stated she then slowed down and stopped in the middle of the road and rolled down her window and yelled for the resident to turn around and come back to the facility. She stated the resident then turned around and started walking back toward the facility. Per interview, she left the resident walking back towards the facility unsupervised. She continued to drive back to the facility, and when she turned into the employee parking lot of the facility and parked her car, she saw Resident #1 standing by the East Wing emergency door. The SSD also stated Resident #1 had on a long sleeve flannel shirt, long pants and tennis shoes. Interview with Resident #1, on 04/23/15 at 2:35 PM, revealed he/she was going to the doctor's office where a friend worked; however, the resident stated he/she did not know where the office was located. Per interview, the resident walked out the front door, when someone opened the door, but the device at the door only blinked and the alert bracelet only blinked, and did not alarm. The resident stated he/she walked down the street to the doctor's office. Interview with the Administrator, on 04/24/15 at 7:50 AM, revealed she was made aware Resident #1 had eloped from the facility on 04/20/15 at approximately 1:20 PM. Interview with the North Wing Unit Manager Registered Nurse (RN) #4, on 04/24/15 at 8:35 AM, revealed that he did not see Resident #1 leave the facility on 04/20/15. He stated on 04/20/15 at approximately 12:50 PM he was sitting at the North Wing nurses' station and Resident #1 walked up to him and asked him if he would open his/her milk. RN #4 stated he opened the resident's milk and the resident turned and walked away from the nurses' station toward the North Dining Room. Interview with Licensed Practical Nurse (LPN) #9, on 04/26/15 at 3:15 PM, revealed she saw Resident #1 at approximately 12:50 PM on 04/20/15. LPN #9 stated she was in the North Dining Room, she saw Resident #1 come into the dining at approximately 12:50 PM and the resident asked for a peanut butter sandwich. She stated the resident stood and waited for dietary staff to give him/her the sandwich and he/she turned and walked out of the dining room. She stated approximately ten (10) minutes after Resident #1 left the dining room she saw him/her walking in the hallway toward the West Wing. She stated she recalled the resident wearing a long sleeve flannel shirt, long pants and tennis shoes. She stated she never saw Resident #1 outside the facility and did not hear an alarm sound. Interview with LPN #5, on 05/07/15 at 10:15 AM, revealed she was the nurse who was assigned to the North Unit where Resident #1 resided. She stated she assessed Resident #1 on 04/20/15 at 4:20 PM, after the elopement. She stated Resident #1's vital signs were normal and a full head to toe assessment was completed and no obvious injuries were found. She stated she also notified the Medical Director, the attending physician, and notified the resident's family. Review of the clinical record for Resident #1 revealed the facility readmitted the resident on 11/07/14, with [DIAGNOSES REDACTED]. The record revealed the resident wandered throughout the facility freely. The facility conducted an elopement risk evaluation upon readmission, on 11/07/14, with findings of wandering behaviors. The resident's picture was placed in the Elopement Binder and a Accutech Tag was placed on the resident. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 02/14/15, revealed the facility assessed the resident to have a cognitive loss with a Brief Interview for Mental Status (BIMS) score of eleven (11) out of possible fifteen (15). The facility assessed the resident to have a self-care impairment requiring limited assistance with bed mobility and transfers. The facility assessed the resident to be independent (needing no staff assistance) with ambulation. Review of the Comprehensive Care Plan, dated 11/07/14, revealed all staff was to redirect Resident #1 away from doors. Other interventions included: evaluate effect of cognitive impairment upon the resident's ability to understand changes in surroundings; involve resident in activities; take picture of resident and place in elopement book; and, placement of an Accutech. Interview with the MDS Coordinator, on 05/07/15 at 8:15 AM, revealed the elopement care plans were generated from a computer program. The MDS Coordinator could not verbalize the exact interventions for Resident #1 related to elopement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185192	A. BUILDING _____ B. WING _____	05/07/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - ST MATTHEWS	227 BROWNS LANE LOUISVILLE, KY 40207

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) However, she stated potential interventions would be residents wearing an Accutech tag for monitoring, and their picture being placed in the elopement logs at each of the nursing stations and throughout the facility. Per interview, the entire facility would be a safe environment for residents who wandered because all exit doors required a code and had an Accutech alarm system. Interview with the Assistant Director of Nursing (ADON), on 04/27/15 at 10:30 AM, revealed Resident #1 was assessed for an elopement risk due to wandering, impaired cognition and being ambulatory. She stated before the elopement the resident had never tried leaving the building nor did he/she have a history of exit seeking and would ambulate freely throughout the entire facility. She stated the resident would stand at the entry/exit doors and look out the window, but never tried to open the doors. The ADON stated she never redirected the resident away from doors due to the resident was not exit seeking and not trying to get out of the facility. Continued interview with LPN #5, on 05/07/15 at 10:15 AM, revealed Resident #1 walked freely through the facility and LPN #5 witnessed Resident #1 standing in front of entry/exit doors looking out the widows, but she never saw him/her trying to exit the facility. LPN #5 stated she did not ever redirect Resident #1 away from doors because she never saw him/her trying to push open the doors. Interview with Certified Nursing Assistance (CNA) #2, on 04/23/15 at 11:45 AM, revealed she had worked with Resident #1 for the past couple of weeks. She stated the resident hardly ever sat and he/she walked all day throughout the facility. She stated Resident #1 would stand in front of the entry/exit doors to look out, but the resident never tried opening the doors. She stated she never redirected Resident #1 away from door the doors when he/she was standing in front of it. Continued interview with the SSD, on 4/23/15 at 1:10 PM revealed she never saw Resident #1 trying to open or go out the entry/exit doors. She stated she had seen the resident standing and looking out the glass windows of the doors. The SSD stated she did not know that Resident #1's care plan intervention stated staff was to redirect the resident away from doors. Interview with the Activity Assistant, on 04/23/15 at 1:45 PM, revealed she saw Resident #1 every time she worked and he/she enjoyed walking throughout the facility. She stated she would see the resident standing in front of the entry/exit doors sometimes just looking out the window. She stated she had never seen Resident #1 exit seeking and she never redirected the resident away from doors. Further review of the facility's investigation revealed a visitor had put in the code to the exit door and allowed the resident to leave the facility; however, this could not be validated by the State Survey Agency during their investigation. Continued interview with LPN #5, on 05/07/15 at 10:15 AM, revealed she was aware that entering the code in the key pads at the entry/exit doors would disarm the system. She stated she had previously let residents out of the facility with family members and she would have to disarm the system for that reason. Continued interview with the ADON, on 04/27/15 at 10:30 AM, revealed she was aware that the code to the Accutech system disarmed the alarm. She stated that when she escorted residents out of the building to leave with visitors she would enter in the code at the key pad so the resident could leave the facility. She also stated she never thought a resident would elopement with a visitor or vendor. However, continued interview with CNA #2 on 04/23/15 at 11:45 AM, the SSD on 4/23/15 at 1:10 PM, the Activity Assistant on 04/23/15 at 1:45 PM, RN #4 on 04/24/15 at 8:35 AM, LPN #7 on 04/24/15 at 9:00 AM, LPN #6 on 04/24/15 at 10:25 AM, LPN #9 on 04/26/15 at 3:15 PM, and the MDS Coordinator on 05/07/15 at 8:15 AM, all revealed they did not know the Accutech system would disarm when the code was entered into the key pad at the entry/exit doors. Interview with the Maintenance Director, on 04/24/15 at 10:05 AM, revealed he did not know until after this elopement occurred that the Accutech system would disarm when the code was entered into the key pad at the entry/exit doors. He stated he was unaware until the technician came to the facility on [DATE] to check the Accutech system and made him aware at that time. Interview with the Administrator, on 04/24/15 at 7:50 AM, revealed she was unaware before the elopement that the Accutech system would disarm when the code was entered into the key pad at the entry/exit doors. She stated that the facility failed to ensure the safety for Resident #1 by not adequately supervising the resident by not knowing that he/she had exited the building. The facility provided an acceptable Allegation of Compliance (AOC) on 05/06/15 that alleged removal of the Immediate Jeopardy on 05/02/15. Review of the AOC revealed the facility implemented the following: 1. On 04/20/15, Resident #1 was returned back to the facility. Vital signs were conducted and a full head to toe body assessment was conducted by LPN #5 . No injuries or harm were detected. 2. On 04/20/15, One Hundred and Eleven (111) residents were accounted for via physical count compared to census data by the Interdisciplinary Team that consisted of three (3) Unit Manager, the ADON and DON. 3. On 04/20/15, an audit was completed on One Hundred and Eleven residents (111) by the ADON and Unit Managers using the Golden Living elopement assessment form to identify potential new residents who were at risk, no additional residents were added to list of current sixteen (16) residents. 4. On 04/20/15, the Interdisciplinary Team (IDT) reviewed the care plans of seventeen (17) residents identified at risk for elopement. Two (2) care plans were revised; one (1) resident (Resident #1) was placed on one (1) to one (1) supervision and the other was no longer considered an elopement risk, this reduced the count to sixteen (16). 5. Three (3) elopement drills were conducted by the ADON and residents were accounted for via visual observation/head count. On 04/21/15 at 2:45 PM, 04/29/15 at 8:30 PM and 04/29/15 at 11:30 PM. 6. On 04/20/15, the two (2) public entry/exit doors with the Accutech System were checked by the Maintenance Director Assistant and determined to be working correctly. A physical test using an Accutech bracelet was conducted on both doors and the bracelet alarmed during the fifteen (15) second egress test to alert staff. 7. On 04/20/15 all seventeen (17) residents wearing an Accutech device were checked by the Director of Nursing Services (DON) and devices were determined to be working correctly. A hand held device was used to determine proper functioning of each bracelet. 8. On 04/20/15 a lead technician from Applied Audio Video validated the Accutech System was working correctly. 9. On 04/20/15 the Administrator posted signs at each exit door to remind staff and visitors to check behind them before they leave to prevent residents from following them outside. 10. On 04/21/15 members of the Quality Assurance Performance Improvement (QAPI) committee including the Medical Director held a meeting to discuss the elopement that occurred on 04/20/15 and develop a plan to prevent reoccurrence. Elopement policy and procedures were reviewed and an addendum was added to the policy to include not giving the code to visitors or vendors. Discussion also included review of how the code alarm system worked and changing the code to the doors monthly or more often if needed. 11. On 04/20/15, 04/21/15, 04/29/15, 04/30/15, and 05/01/15, the DON and ADON completed re-education on Elopement Guidelines to 121 facility staff including not giving door codes to visitors and the disengagement of the alarm when the code was entered and care plan education. 12. On 04/27/15 the Administrator mailed a letter to all family members and/or responsible parties stating door codes would not be provided and staff members would assist visitors in and out the doors. One Hundred and fourteen (114) letters were mailed. 13. The Multi-Site Clinical Educator provided care plan training, on 04/29/15, 04/30/15 and 05/01/15, to forty-five (45) licensed staff that included a demonstration. Education included use of CNA Assignment Sheets, initiation of care plans, updating of care plans, reviewing/revising/resolving and following the plan of care. 14. Starting 05/01/15 the Unit Managers/ADON/DON began completing audits during the clinical start up meeting. Audits include care plans, progress notes, 24 hour report and new admissions. This would continue on an ongoing bases. 15. On 05/01/15 Unit Managers and Weekend House Supervisor began making documented rounds daily to observe residents for exit seeking behaviors and staff redirection of residents. 16. On 05/01/15 Social Services staff began audits of documentation of mood and behaviors in the care tracker report Monday through Friday and would report any issues identified from these audits to the IDT/Startup teams. 17. Beginning the week of 05/04/15, results of all audits would be reported in the QAPI committee meeting for review and changes as indicated. The QAPI meeting would be held weekly for four (4) weeks, the bi-weekly for four (4) weeks, then monthly thereafter. The committee would also review compliance with education related to care plan training and elopement. If the Medical Director was unavailable in person on a weekly basis, he would review progress by telephone with the Administrator and/or DON. Through observation, interview and record review the State Survey Agency validated the AOC on 05/07/15 as follows: 1. Review of the head to toe assessment conducted by LPN #5 for Resident #1 on 04/20/15 revealed no injuries were found. Interview with LPN #5, on 05/07/15 at 10:15 AM, revealed she completed the head to toe assessment with no injuries found. 2. Review of the census data from the physical count the facility conducted on 04/20/15 revealed One Hundred and Eleven (111) residents were accounted for. Interview with the ADON, on 05/07/15 at 10:45 AM, revealed she participated in the count using some of the staff on duty at the time; the Unit Manager and the House Supervisor. Interview with the Unit Manager, on 05/07/15 at 2:15 PM, revealed the census was verified and all residents were accounted for. 3. Review of the audit forms for One Hundred and Eleven (111) residents revealed sixteen (16) residents were at risk for elopement. Interview with the Unit Manager, on 05/07/15 at 2:15 PM, revealed the audit was completed using the Golden Living elopement risk questionnaire to determine if other residents were at risk for elopement. 4. Review of the two (2) care plans that were revised revealed Resident #1 was placed on one to one (1:1) supervision and the other resident was no longer considered an elopement risk. Observation, on 04/23/15 at 11:45 AM, revealed a CNA was walking throughout the facility with Resident #1. Interview with CNA #2, on 04/23/15 at 11:45 AM, revealed since the elopement a CNA was assigned to Resident #1 and that staff member was to stay with the resident throughout their entire shift. 5. Review of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185192	A. BUILDING _____ B. WING _____	05/07/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - ST MATTHEWS	227 BROWNS LANE LOUISVILLE, KY 40207

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) elopement drills conducted revealed three (3) elopement drills were conducted. One on 04/21/15 at 2:45 PM and two (2) on 04/29/15 at 8:30 PM and 11:30 PM. The drill conducted on 04/21/15 at 2:45 PM was completed in five (5) minutes with One Hundred and Twelve (112) residents. Drill conducted on 04/29/15 at 8:30 PM was completed in twelve (12) minutes with One Hundred and Six (106) residents and the drill conducted at 11:30 PM that same day was completed in ten (10) minutes with One Hundred and Seven (107) residents. Admission, hospital stays, out of building to visit accounts for the census fluctuation. Post survey interviews, on 05/13/15 with CNA #17 at 11:46 AM; CNA #18 at 11:49 AM; CNA #19 at 11:53 AM; and CNA #20 at 11:57 AM, revealed they all participated in the elopement drills by conducting resident counts. 6. Review of the facility's Daily Maintenance Rounds revealed ten (10) doors including the Main and North/Rear entry/exit doors were all checked and operating correctly. Observation of the ten (10) doors being locked, the fifteen (15) second alarm working correctly, and the Accutech alarm system working correctly was conducted, on 04/23/15 at 10:20 AM, with the Assistance Maintenance Director. A hand held device was used to determine the Accutech system was working correctly. Interview with the Assistance Maintenance Director, on 04/23/15 at 9:42 AM, revealed he conducted checks of all ten (10) doors every morning Monday-Fridays and the nursing staff checked the doors on Saturday and Sundays. Interview with the House Supervisor, on 05/07/15 at 3:00 PM, revealed at the start of her shift, she checked all doors with the Accutech box and actually pushed on the doors to test the alarm. She documented these checks in the computer. 7. Review of the audit of the seventeen (17) residents with Accutech devices revealed all devices were determined to be working correctly. Interview with the DON, on 04/23/15 at 3:30 PM, revealed she completed the audits of the seventeen (17) residents with Accutech devices, for a total of eighteen (18) devices (one resident had two devices), tested good with no malfunction. She stated none of the devices indicated a low or dead battery and all worked correctly. 8. Review of a signed statement on letter head from a lead technician from Applied Audio Video stated he responded to a service request on 04/20/15 for a review of the Accutech system. The statement revealed he tested all equipment and found the system to be One Hundred (100%) percent functional. 9. Review of a sign posted at each of the exit doors revealed the facility reminded staff and visitors to check behind them before exiting the building to make sure residents don't follow them out the door. Interview with Family Member #1, on 04/25/15 at 7:45 PM, revealed she previously knew the code to enter and exit the facility and she would enter and exit the building on her own anytime she visited her loved one. Family member #1 stated she had never let any resident exit the building with him/her and she had never seen a resident entering in the code on the key pads to the doors. 10. Review of the QAPI meeting minutes including the sign in sheet, dated 04/21/15, revealed fourteen (14) staff members were present including the Medical Director. Review of the minutes revealed the committee discussed the elopement that occurred on 04/20/15 including a plan to prevent reoccurrence, elopement policy and procedures, how the code alarm system worked, and changing the door code monthly or more often. Interview with the Administrator, on 05/07/15 at 2:30 PM, revealed the meeting was held to address the elopement, 1:1 supervision of the resident, reassessing all the residents for elopement, alarm checks, elopement book, updating the care plans, signs posted, door codes changed monthly, and staff education. Post survey interview with the Medical Director, on 05/13/15 at 11:13 AM, revealed he was notified of the elopement on 04/20/15. 11. Review of training records including sign in sheets, dated 04/20/15, revealed ninety seven (97) staff were trained on safety of residents, door codes not to be given out, elopement policy and procedures, following missing person action and care plan education. Further review of training records, dated 04/21/15, 04/27/15, 04/29/15, 04/30/15, and 05/01/15, revealed the remaining twenty-four (24) staff received education on these days. Interviews, on 05/07/15 with CNA #13 at 1:05 PM, CNA #14 at 2:17 PM, CNA #15 at 2:58 PM, CNA #16 at 3:12 PM, RN #5 at 1:12 PM, Dietary Aide #19 at 2:07 PM, Dietary Aide #18 at 1:10 PM, Dietary Aide #13, at 1:31 PM, LPN #10 at 1:16 PM, Housekeeper #14 at 1:45 PM, and Housekeeper #11 at 2:27 PM revealed they all had received in-service training on Elopement Guidelines, not giving door codes to visitors, and disengagement of the alarm when code is entered. CNAs all stated they received care plan training which included following the plan of care. 12. Review of the letter, dated 04/27/15, that was mailed to all family members and/or responsible parties revealed all family members and/or responsible parties were notified the facility would no longer provide visitors with the access codes to the entrances and a staff member would be required to let them in and out of the doors. 13. Review of training records including sign in sheets dated 04/29/15, 4/30/15, 5/01/15 and 05/03/15 revealed forty five (45) licensed staff was trained on initiation of care plans, updating of care plans, reviewing/revising/resolving, following care plans, and CNA Assignment Sheets included a demonstration. Interview on 05/07/15 with RN #5 at 1:12 PM, LPN #10 at 1:16 PM, and RN #4 at 2:00 PM, revealed they all had received in-service training on care plans including updating, reviewing, revising, and following and a demonstration was also given on the Point Click Care system. 14. Review of the Golden Clinical Startup Checklist dated 05/01/15, 05/02/15, 05/03/15, 05/04/15, 05/05/15, 05/06/15, and 05/07/15 revealed Unit Mangers and Weekend House Supervisors were conducting audits on care plans, progress notes, 24 hour reports and new admissions. Interview with Unit Manger RN #4, on 05/07/15 at 2:00 PM, revealed he had completed the clinical startup checklist every morning at the beginning of his shift and would report any issues found to the DON and ADON. RN #4 stated those audits would help him and other staff with keeping up with changing care plans, new admission care plans, and following the care of plan for residents. 15. Review of the observation sheets dated 05/01/15-05/06/15 revealed the sheets were completed by the Unit Mangers and Weekend House Supervisors. Review revealed no residents during that time frame were seen exiting seeking. Observation, on 05/06/15 at 2:35 PM and on 05/07/15 at 7:15 AM, 9:00 AM, 9:30 AM, and 10:55 AM revealed staff was walking throughout the facility monitoring the residents. Observation revealed no residents were exit seeking during those times. Interview with the House Supervisor, on 05/07/15 at 3:10 PM, revealed her role was to monitor the facility by walking rounds to monitor for exit seeking behaviors, document the observations and the observation sheet and review the behaviors in the morning meeting.
F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and policy review, it was determined the facility failed to follow their Infection Control Program for two (2) of twelve (12) sampled residents (Residents #6 and #7). RN #1 failed to remove gloves and wash hands when moving from dirty to clean while performing dressing changes. The findings include: Review of the Hand Washing/Hand Hygiene Policy, revised August 2014, revealed the facility considered hand hygiene the primary means to prevent the spread of infections. All personnel should follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. The use of alcohol-based hand rub containing at least 62 % alcohol or alternatives; soap and water for the following situations: before and after direct contact with residents, after contact with a residents intact skin, after contact with blood or bodily fluids, after handling used dressings, and after removing gloves. 1. Review of Resident #6's clinical record revealed the facility admitted the resident on 04/18/13 with [DIAGNOSES REDACTED]. Review of Resident #6's Minimum Data Set (MDS), Quarterly Assessment, dated 02/28/15, revealed the facility assessed Resident #6 with a Brief Interview for Mental Status (BIMS) score of thirteen (13) which meant Resident #6 was interviewable. Observation of Resident #6's dressing change completed by Registered Nurse (RN) #1, on 04/23/15 at 1:01 PM, revealed RN #1 washed her hands, donned clean gloves and removed Resident #6's dirty dressing. RN #1 then removed her gloves and donned new gloves without washing her hands. RN #1 then applied Risamine (medication) Ointment with the right gloved hand and placed a clean dressing onto the wound. RN #1 then removed her gloves and washed her hands. 2. Review of Residents #7's clinical record revealed the facility admitted the resident on 07/31/14 with [DIAGNOSES REDACTED]. Review of Resident #7's MDS Quarterly Assessment, dated 01/30/15, revealed the facility assessed Resident #7 with a BIMS score of fifteen (15), which meant Resident #7 was interviewable. Observation of Resident #7's dressing change completed by RN #1, on 04/23/15 at 2:00 PM, revealed RN #1 washed her hands and donned gloves. RN #1 then obtained a towel; washed Resident #7's back and then with the same towel, washed and dried the resident's bed. RN #1 then removed her gloves and donned new gloves without washing her hands. RN #1 then cleaned the resident's wound to his/her left buttock area. With the same gloved hands, RN #1 then began to cut Hydrogel with scissors and placed the Hydrogel onto the wound. RN #1 then applied three (3) Abdominal Pads to Resident #7's left buttock. Interview with RN #1, on 04/23/15 at 2:55 PM, revealed when moving from dirty to clean during a dressing change she was to remove her gloves and don new gloves. RN #1 stated the facility had educated her on washing her hands after removing her gloves, but felt she may have been nervous. RN #1 stated she did not recognize she used a towel to clean Resident #7's back and then cleaned Resident #7's bed. RN #1 stated she should have cleaned off Resident #7's bed with a separate towel to prevent cross contamination. RN #1 stated the facility wanted the staff to wash their hands to prevent infection. Interview with RN #3, on 04/23/15 at 5:50 PM, revealed he was educated by the facility to wash his hands every time he removed his gloves. RN #3 stated they wash their hands to prevent infections. Staff needed to wash their hands when moving from dirty to clean during a dressing change. Interview with the Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185192	A. BUILDING _____ B. WING _____	**05/07/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - ST MATTHEWS	**227 BROWNS LANE LOUISVILLE, KY 40207**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) Nursing (DON), on 04/23/15 at 6:12 PM, revealed she had completed audits and watched nurses complete wound care, (though she did not have evidence of the audits) and had not observed any problems with the wound care treatments. The DON stated she did not monitor RN #1 during any of her dressing changes. The DON stated she expected the staff to wash their hands when moving from dirty to clean during wound care. The DON stated she wanted her staff to wash their hands to prevent them from spreading anything to the residents.