

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374
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F000000	<p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00143695, completed on 2-6-2014.</p> <p>Complaint IN00143695 -- Not corrected.</p> <p>Survey dates: March 26 and 27, 2014</p> <p>Facility number: 000077 Provider number: 155157 AIM number: 100266490</p> <p>Survey team: Penny Marlatt, RN-TC</p> <p>Census bed type: SNF/NF: 90 Total: 90</p> <p>Census payor type: Medicare: 11 Medicaid: 74 Other: 5 Total: 90</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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	Quality review completed on March 29, 2014, by Janelyn Kulik, RN.			
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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure staff members followed each resident's plan of care during transfers which resulted in 2 assisted falls with no injuries for 2 of 2 assisted falls reviewed in a sample of 3. (Resident #F and Resident #G)</p> <p>Findings include:</p> <p>1. Resident #G's clinical record was reviewed on 3-27-14 at 9:50 a.m. Her diagnoses included, but were not limited to, anemia, breast cancer with metastasis (spread) to the bone, chronic obstructive pulmonary disease (COPD), anxiety and depression.</p> <p>In review of Resident #G's most recent Minimum Data Set (MDS) Assessment, a Significant Change MDS, dated 2-12-14, it indicated she had significant cognitive impairment, did not ambulate, required extensive assistance with bed mobility of 2 or more persons and required extensive assistance with transfers of one</p>	F000282	<p>Tag F282</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Both residents #F and #G care plans have been reviewed to ensure that the care plan and CNA assignment sheets match. All Nursing Staff are being educated on following residents plan of care during transfers.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>All Nursing Staff are being educated on following residents plan of care during transfers.</p>	04/18/2014
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	<p>person. Her most recent fall risk assessment, dated 2-13-14, indicated she was at high risk for falls.</p> <p>In review of Resident #G's plan of care, it indicated the resident was at risk for falls related to the "use of medication and incontinence and need for assist with transfers." The goal of no falls with injury through the next review period was indicated. Interventions listed to address the fall risk were indicated to include, "Gait belt with transfers assist of 2 staff." The plan of care indicated two separate entries for this concern of falls. Both entries indicated a date of initiation for this concern of fall risk to be 2-28-14. For the intervention listed, one entry indicated the initiation date of 10-10-13; the second entry indicated the initiation date of 3-19-14 with a revision date of 3-21-14.</p> <p>In review of the "CNA Assignment Sheet" for Resident #G, provided by the Executive Director (ED) on 3-27-14 at 11:20 a.m., it indicated she required 2 persons to assist her with transfers; it indicated with toileting she required 2 persons and a gait belt to assist her. In an interview with the ED on 3-27-14 at 11:20 a.m., he indicated the CNA Assignment</p>		<p>New staff will have education All Nursing Staff are being educated on following residents plan of care during transfers.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>All Nursing Staff are being educated on following residents plan of care during transfers.</p> <p>New staff will have education All Nursing Staff are being educated on following residents plan of care during transfers</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>The DNS/Designee will question C.N.A's regarding where do you obtain the information on how to transfer a patients 5 times a week for 4 weeks, then 3 times a week for 4 weeks</p>		

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	<p>Sheets are updated daily and the previous ones are not kept on file. He indicated this was a current CNA Assignment Sheet for Resident #G.</p> <p>In review of a document entitled, "Verification of Investigation," dated 3-21-14, it indicated, "[Name of CNA #1] was attempting to transfer res [resident] from bed to wc [wheelchair] when res stopped helping with transfer and had to be lowered to floor by staff." It indicated she was needing to be toileted. The document indicated CNA#1 failed to use a gait belt. It indicated the resident sustained no injuries. It indicated the date of occurrence as 3-15-14 at 7:20 p.m.</p> <p>On 3-27-14 at 2:00 p.m., the ED provided a copy of a document entitled, "Personnel Conference" for CNA #1, dated 3-27-14 and signed by RN #3. This document indicated the CNA Assignment Sheet for Resident #G indicated she was to have 2 persons to assist her with transfers, as well as the use of a gait belt with transfers. It indicated CNA #1 failed to follow the plan of care via the CNA Assignment Sheet and utilized only 1 person to transfer and failed to use a gait belt with the transfer for Resident #G. This</p>		<p>then weekly for 4 months or ongoing if indicated.</p> <p>Results of audits will be reviewed at the monthly QAA meetings for 6 months then audits will be conducted randomly then reviewed during monthly QAA. The Facility will evaluate the audits for trends or patterns and action plans will be implemented if indicated.</p>		

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	<p>document indicated the conference was conducted by telephone with CNA #1.</p> <p>In an interview with the ED on 3-27-14 at 11:20 a.m., he indicated CNA #1 worked at the facility "on a casual [not routinely scheduled] basis." At this time, the ED provided a copy of CNA #1's time card summary which indicated she has worked for the facility a total of 15.47 hours for 2014, with 7.53 of those hours in the month of March, 2014. The time card summary indicated on 3-15-14, CNA #1 clocked in at 7:00 p.m. and clocked out at 9:32 p.m. It indicated she had not clocked in at the facility since that date. He indicated CNA #1 had not been counseled at this time regarding the assisted fall of Resident #G which occurred on 3-15-14.</p> <p>CNA #1 was unable to be reached by phone or in person for an interview.</p> <p>2. Resident #F's clinical record was reviewed on 3-27-14 at 9:25 a.m. His diagnoses included, but were not limited to, syncope (fainting) with collapse, transient ischemic attacks (TIA's), macular degeneration, glaucoma, diabetes and generalized pain.</p>						

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	<p>In review of Resident #F's Admission Minimum Data Set (MDS) Assessment, dated 2-1-14, indicated he had moderate cognitive impairment, did not ambulate and required extensive assistance with bed mobility and transfers of 2 or more persons. The most recent fall risk assessment, dated 1-25-14, indicated he was at high risk for falls.</p> <p>In review of Resident #F's plan of care, it indicated the resident was at risk for falls related to falls in the last 3 months. The goal for this concern was indicated as, "No fall related injuries." Interventions listed to address the fall risk were indicated to include, "Gait belt with transfers x2 staff [2 staff members]." The date for the plan of care indicated for this concern of fall risk to be 1-29-14. For the intervention listed, it indicated the date of initiation as 1-29-14 with a revision date of 1-30-14.</p> <p>In review of the "CNA Assignment Sheet" for Resident #F, provided by the Executive Director (ED) on 3-27-14 at 11:20 a.m., it indicated he required 2 persons and a gait belt to assist him with transfers. In an interview with the ED on 3-27-14 at 11:20 a.m., he indicated the CNA</p>			

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	<p>Assignment Sheets are updated daily and the previous ones are not kept on file. He indicated this was a current CNA Assignment Sheet for Resident #F.</p> <p>In review of a document entitled, "Verification of Investigation," dated 3-21-14, it indicated, "Resident was being transferred to w/c [wheelchair] when he lost his balance regardless of CNA assist with gait belt. CNA was able to ease Resident to the floor, as he slid down at front of CNA." The document indicated a contributing factor could have been the need for 2 persons to assist with the transfer. It indicated the resident sustained no injuries. It indicated the date of occurrence as 3-16-14 at 4:50 p.m.</p> <p>On 3-27-14 at 11:20 a.m., the ED provided a copy of a document entitled, "Personnel Conference" for CNA #2, dated 3-19-14. This document indicated, "CNA Assignment Sheet specifically stated assist of 2 with gait belt to transfer [sic]...Always follow CNA sheet instructions on how to transfer residents." This document was signed by CNA #2 and RN #3.</p> <p>CNA #2 was unable to be reached by</p>			
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	<p>phone or in person for an interview.</p> <p>In an interview with PT #4 on 3-27-14 at 12:20 p.m., he indicated both Resident #F and Resident #G were being followed by physical therapy for services at the time of their assisted falls. He indicated that although the therapy notes for around the time of their assisted falls indicated each was making some progress, he would not generally recommend any changes to the plan of care for nursing staff until the resident's progress was more consistent. He indicated for both Resident #F and Resident #G, neither resident's progress at the time of their assisted fall, or currently, was consistent enough to suggest changing nursing's plan of care from a 2 person assistance with the gait belt for any transfers.</p> <p>In an interview with the ED on 3-27-14 at 12:20 p.m., he indicated the facility does not have a policy on "CNA Assignment Sheets." He indicated it is understood that one would follow the information on the sheet.</p> <p>This Federal tag relates to Complaint IN00143695.</p> <p>This deficiency was cited on February</p>				

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	6, 2014. the facility failed to implement a systemic plan of corrections to prevent recurrence. 3.1-35(g)(2)			
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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure staff members followed each resident's plan of care during transfers which resulted in 2 assisted falls with no injuries for 2 of 2 assisted falls reviewed in a sample of 3. (Resident #F and Resident #G)</p> <p>Findings include:</p> <p>1. Resident #G's clinical record was reviewed on 3-27-14 at 9:50 a.m. Her diagnoses included, but were not limited to, anemia, breast cancer with metastasis (spread) to the bone, chronic obstructive pulmonary disease (COPD), anxiety and depression.</p> <p>In review of Resident #G's most recent Minimum Data Set (MDS) Assessment, a significant change MDS, dated 2-12-14, indicated she had significant cognitive impairment, did not ambulate, required extensive assistance with bed mobility of 2 or more persons and required extensive</p>	F000323	<p>F323</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Both residents #F and #G care plans have been reviewed to ensure that the care plan and CNA assignment sheets match. All Nursing Staff are being educated on following residents plan of care during transfers.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>All Nursing Staff are being educated on following residents plan of care during transfers.</p>	04/18/2014			

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	<p>assistance with transfers of one person. Her most recent fall risk assessment, dated 2-13-14, indicated she was at high risk for falls.</p> <p>In review of Resident #G's plan of care, it indicated the resident was at risk for falls related to the "use of medication and incontinence and need for assist with transfers." The goal of no falls with injury through the next review period was indicated. Interventions listed to address the fall risk were indicated to include, "Gait belt with transfers assist of 2 staff." The plan of care indicated two separate entries for this concern of falls. Both entries indicated a date of initiation for this concern of fall risk to be 2-28-14. For the intervention listed, one entry indicated the initiation date of 10-10-13; the second entry indicated the initiation date of 3-19-14 with a revision date of 3-21-14.</p> <p>In review of the "CNA Assignment Sheet" for Resident #G, provided by the Executive Director (ED) on 3-27-14 at 11:20 a.m., it indicated she required 2 persons to assist her with transfers; it indicated with toileting she required 2 persons and a gait belt to assist her. In an interview with the ED on 3-27-14 at 11:20 a.m.,</p>		<p>New staff will have education All Nursing Staff are being educated on following residents plan of care during transfers.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>All Nursing Staff are being educated on following residents plan of care during transfers.</p> <p>New staff will have education All Nursing Staff are being educated on following residents plan of care during transfers</p> <p>DNS/Designee will observe 2 transfers daily 5 times a week for 4 weeks then 3 times a week for 4 week then weekly for 4 months, that require the use of a gate belt to ensure CNA's are following the plan of care.</p> <p>These corrective actions will be monitored and a quality assurance program</p>				

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	<p>he indicated the CNA Assignment Sheets are updated daily and the previous ones are not kept on file. He indicated this was a current CNA Assignment Sheet for Resident #G.</p> <p>In review of a document entitled, "Verification of Investigation," dated 3-21-14, it indicated, "[Name of CNA #1] was attempting to transfer res [resident] from bed to wc [wheelchair] when res stopped helping with transfer and had to be lowered to floor by staff." It indicated she was needing to be toileted. The document indicated CNA#1 failed to use a gait belt. It indicated the resident sustained no injuries. It indicated the date of occurrence as 3-15-14 at 7:20 p.m.</p> <p>On 3-27-14 at 2:00 p.m., the ED provided a copy of a document entitled, "Personnel Conference" for CNA #1, dated 3-27-14 and signed by RN #3. This document indicated the CNA Assignment Sheet for Resident #G indicated she was to have 2 persons to assist her with transfers, as well as the use of a gait belt with transfers. It indicated CNA #1 failed to follow the plan of care via the CNA Assignment Sheet and utilized only 1 person to transfer and failed to use a gait belt with the</p>		<p>implemented to ensure the deficient practice will not recur per the following:</p> <p>The DNS/Designee will question C.N.A's regarding where do you obtain the information on how to transfer a patients 5 times a week for 4 weeks, then 3 times a week for 4 weeks then weekly for 4 months or ongoing if indicated.</p> <p>DNS/Designee will observe 2 transfers daily 5 times a week for 4 weeks then 3 times a week for 4 week then weekly for 4 months, that require the use of a gate belt to ensure CNA's are following the plan of care.</p> <p>Results of audits will be reviewed at the monthly QAA meetings for 6 months then audits will be conducted randomly then reviewed during monthly QAA. The Facility will evaluate the audits for trends or patterns and action plans will be implemented if indicated.</p>		

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	<p>transfer for Resident #G. This document indicated the conference was conducted by telephone with CNA #1.</p> <p>In an interview with the ED on 3-27-14 at 11:20 a.m., he indicated CNA #1 worked at the facility "on a casual [not routinely scheduled] basis." At this time, the ED provided a copy of CNA #1's time card summary which indicated she has worked for the facility a total of 15.47 hours for 2014, with 7.53 of those hours in the month of March, 2014. The time card summary indicated on 3-15-14, CNA #1 clocked in at 7:00 p.m. and clocked out at 9:32 p.m. It indicated she had not clocked in at the facility since that date. He indicated CNA #1 had not been counseled at this time regarding the assisted fall of Resident #G which occurred on 3-15-14.</p> <p>CNA #1 was unable to be reached by phone or in person for an interview.</p> <p>2. Resident #F's clinical record was reviewed on 3-27-14 at 9:25 a.m. His diagnoses included, but were not limited to, syncope (fainting) with collapse, transient ischemic attacks (TIA's), macular degeneration, glaucoma, diabetes and generalized</p>						

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374
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	<p>pain.</p> <p>In review of Resident #F's Admission Minimum Data Set (MDS) Assessment, dated 2-1-14, it indicated he had moderate cognitive impairment, did not ambulate and required extensive assistance with bed mobility and transfers of 2 or more persons. The most recent fall risk assessment, dated 1-25-14, indicated he was at high risk for falls.</p> <p>In review of Resident #F's plan of care, it indicated the resident was at risk for falls related to falls in the last 3 months. The goal for this concern was indicated as, "No fall related injuries." Interventions listed to address the fall risk were indicated to include, "Gait belt with transfers x2 staff [2 staff members]." The date for the plan of care indicated for this concern of fall risk to be 1-29-14. For the intervention listed, it indicated the date of initiation as 1-29-14 with a revision date of 1-30-14.</p> <p>In review of the "CNA Assignment Sheet" for Resident #F, provided by the Executive Director (ED) on 3-27-14 at 11:20 a.m., it indicated he required 2 persons and a gait belt to assist him with transfers. In an interview with the ED on 3-27-14 at</p>			
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	<p>11:20 a.m., he indicated the CNA Assignment Sheets are updated daily and the previous ones are not kept on file. He indicated this was a current CNA Assignment Sheet for Resident #F.</p> <p>In review of a document entitled, "Verification of Investigation," dated 3-21-14, it indicated, "Resident was being transferred to w/c [wheelchair] when he lost his balance regardless of CNA assist with gait belt. CNA was able to ease Resident to the floor, as he slid down at front of CNA." The document indicated a contributing factor could have been the need for 2 persons to assist with the transfer. It indicated the resident sustained no injuries. It indicated the date of occurrence as 3-16-14 at 4:50 p.m.</p> <p>On 3-27-14 at 11:20 a.m., the ED provided a copy of a document entitled, "Personnel Conference" for CNA #2, dated 3-19-14. This document indicated, "CNA Assignment Sheet specifically stated assist of 2 with gait belt to transfer [sic]...Always follow CNA sheet instructions on how to transfer residents." This document was signed by CNA #2 and RN #3.</p>			

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	<p>CNA #2 was unable to be reached by phone or in person for an interview.</p> <p>In an interview with PT #4 on 3-27-14 at 12:20 p.m., he indicated both Resident #F and Resident #G were being followed by physical therapy for services at the time of their assisted falls. He indicated that although the therapy notes for around the time of their assisted falls indicated each was making some progress, he would not generally recommend any changes to the plan of care for nursing staff until the resident's progress was more consistent. He indicated for both Resident #F and Resident #G, neither resident's progress at the time of their assisted fall, or currently, was consistent enough to suggest changing nursing's plan of care from a 2 person assistance with the gait belt for any transfers.</p> <p>In an interview with the ED on 3-27-14 at 12:20 p.m., he indicated the facility does not have a policy on "CNA Assignment Sheets." He indicated it is understood that one would follow the information on the sheet.</p> <p>On 3-27-14 at 2:00 p.m., the ED provided a copy of a policy entitled, "Gait Belts." This policy indicated,</p>				

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	<p>"Gait belts provide increased security for the resident and staff, and prevent injury during movement of a resident. A designated staff member uses a gait or ambulation belt during ambulation or movement of a resident who needs security and assistance. A gait belt is not used unless the resident has been evaluated, and it has been approved for use by licensed nurse..."</p> <p>This Federal tag relates to the Post Survey Revisit for Complaint IN00143695.</p> <p>This deficiency was cited on February 6, 2014. the facility failed to implement a systemic plan of corrections to prevent recurrence.</p> <p>3.1-45(a)</p>			
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F000498 SS=D	<p>483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>Based on interview and record review, the facility failed to ensure staff members followed each resident's plan of care during transfers which resulted in 2 assisted falls with no injuries for 2 of 2 assisted falls reviewed in a sample of 3. (Resident #F and Resident #G)</p> <p>Findings include:</p> <p>1. Resident #G's clinical record was reviewed on 3-27-14 at 9:50 a.m. Her diagnoses included, but were not limited to, anemia, breast cancer with metastasis (spread) to the bone, chronic obstructive pulmonary disease (COPD), anxiety and depression.</p> <p>In review of Resident #G's most recent Minimum Data Set (MDS) Assessment, a significant change MDS, dated 2-12-14, it indicated she had significant cognitive impairment, did not ambulate, required extensive assistance with bed mobility of 2 or</p>	F000498	<p>F498</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Both residents #F and #G care plans have been reviewed to ensure that the care plan and CNA assignment sheets match. All Nursing Staff are being educated on following residents plan of care during transfers.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>All Nursing Staff are being educated on following residents plan of care</p>	04/18/2014			

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	<p>more persons and required extensive assistance with transfers of one person. Her most recent fall risk assessment, dated 2-13-14, indicated she was at high risk for falls.</p> <p>In review of Resident #G's plan of care, it indicated the resident was at risk for falls related to the "use of medication and incontinence and need for assist with transfers." The goal of no falls with injury through the next review period was indicated. Interventions listed to address the fall risk were indicated to include, "Gait belt with transfers assist of 2 staff." The plan of care indicated two separate entries for this concern of falls. Both entries indicated a date of initiation for this concern of fall risk to be 2-28-14. For the intervention listed, one entry indicated the initiation date of 10-10-13; the second entry indicated the initiation date of 3-19-14 with a revision date of 3-21-14.</p> <p>In review of the "CNA Assignment Sheet" for Resident #G, provided by the Executive Director (ED) on 3-27-14 at 11:20 a.m., it indicated she required 2 persons to assist her with transfers; it indicated with toileting she required 2 persons and a gait belt to assist her. In an interview</p>		<p>during transfers and our gate belt policy.</p> <p>DNS/Designee will observe 2 transfers daily 5 times a week for 4 weeks then 3 times a week for 4 week then weekly for 4 months, that require the use of a gate belt to ensure CNA's are following the plan of care.</p> <p>New staff will have education All Nursing Staff are being educated on following residents plan of care during transfers and our gate belt policy.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>All Nursing Staff are being educated on following residents plan of care during transfers.</p> <p>DNS/Designee will observe 2 transfers daily 5 times a week for 4 weeks then 3 times a week for 4 week then weekly for 4 months, that require the use of a</p>				

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	<p>with the ED on 3-27-14 at 11:20 a.m., he indicated the CNA Assignment Sheets are updated daily and the previous ones are not kept on file. He indicated this was a current CNA Assignment Sheet for Resident #G.</p> <p>In review of a document entitled, "Verification of Investigation," dated 3-21-14, it indicated, "[Name of CNA #1] was attempting to transfer res [resident] from bed to wc [wheelchair] when res stopped helping with transfer and had to be lowered to floor by staff." It indicated she was needing to be toileted. The document indicated CNA#1 failed to use a gait belt. It indicated the resident sustained no injuries. It indicated the date of occurrence as 3-15-14 at 7:20 p.m.</p> <p>On 3-27-14 at 2:00 p.m., the ED provided a copy of a document entitled, "Personnel Conference" for CNA #1, dated 3-27-14 and signed by RN #3. This document indicated the CNA Assignment Sheet for Resident #G indicated she was to have 2 persons to assist her with transfers, as well as the use of a gait belt with transfers. It indicated CNA #1 failed to follow the plan of care via the CNA Assignment Sheet and utilized only 1 person to transfer and</p>		<p>gate belt to ensure CNA's are following the plan of care.</p> <p>New staff will have education All Nursing Staff are being educated on following residents plan of care during transfers</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>The DNS/Designee will question C.N.A's regarding where do you obtain the information on how to transfer a patients 5 times a week for 4 weeks, then 3 times a week for 4 weeks then weekly for 4 months or ongoing if indicated.</p> <p>Results of audits will be reviewed at the monthly QAA meetings for 6 months then audits will be conducted randomly then reviewed during monthly QAA. The Facility will evaluate the audits for trends or patterns and action plans will be</p>		

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	<p>failed to use a gait belt with the transfer for Resident #G. This document indicated the conference was conducted by telephone with CNA #1.</p> <p>In an interview with the ED on 3-27-14 at 11:20 a.m., he indicated CNA #1 worked at the facility "on a casual [not routinely scheduled] basis." At this time, the ED provided a copy of CNA #1's time card summary which indicated she has worked for the facility a total of 15.47 hours for 2014, with 7.53 of those hours in the month of March, 2014. The time card summary indicated on 3-15-14, CNA #1 clocked in at 7:00 p.m. and clocked out at 9:32 p.m. It indicated she had not clocked in at the facility since that date. He indicated CNA #1 had not been counseled at this time regarding the assisted fall of Resident #G which occurred on 3-15-14.</p> <p>CNA #1 was unable to be reached by phone or in person for an interview.</p> <p>2. Resident #F's clinical record was reviewed on 3-27-14 at 9:25 a.m. His diagnoses included, but were not limited to, syncope (fainting) with collapse, transient ischemic attacks (TIA's), macular degeneration,</p>		implemented if indicated.				

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	<p>glaucoma, diabetes and generalized pain.</p> <p>In review of Resident #F's Admission Minimum Data Set (MDS) Assessment, dated 2-1-14, it indicated he had moderate cognitive impairment, did not ambulate and required extensive assistance with bed mobility and transfers of 2 or more persons. The most recent fall risk assessment, dated 1-25-14, indicated he was at high risk for falls.</p> <p>In review of Resident #F's plan of care, it indicated the resident was at risk for falls related to falls in the last 3 months. The goal for this concern was indicated as, "No fall related injuries." Interventions listed to address the fall risk were indicated to include, "Gait belt with transfers x2 staff [2 staff members]." The date for the plan of care indicated for this concern of fall risk to be 1-29-14. For the intervention listed, it indicated the date of initiation as 1-29-14 with a revision date of 1-30-14.</p> <p>In review of the "CNA Assignment Sheet" for Resident #F, provided by the Executive Director (ED) on 3-27-14 at 11:20 a.m., it indicated he required 2 persons and a gait belt to assist him with transfers. In an</p>			

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	<p>interview with the ED on 3-27-14 at 11:20 a.m., he indicated the CNA Assignment Sheets are updated daily and the previous ones are not kept on file. He indicated this was a current CNA Assignment Sheet for Resident #F.</p> <p>In review of a document entitled, "Verification of Investigation," dated 3-21-14, it indicated, "Resident was being transferred to w/c [wheelchair] when he lost his balance regardless of CNA assist with gait belt. CNA was able to ease Resident to the floor, as he slid down at front of CNA." The document indicated a contributing factor could have been the need for 2 persons to assist with the transfer. It indicated the resident sustained no injuries. It indicated the date of occurrence as 3-16-14 at 4:50 p.m.</p> <p>On 3-27-14 at 11:20 a.m., the ED provided a copy of a document entitled, "Personnel Conference" for CNA #2, dated 3-19-14. This document indicated, "CNA Assignment Sheet specifically stated assist of 2 with gait belt to transfer [sic]...Always follow CNA sheet instructions on how to transfer residents." This document was signed by CNA #2 and RN #3.</p>			

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	<p>CNA #2 was unable to be reached by phone or in person for an interview.</p> <p>In an interview with PT #4 on 3-27-14 at 12:20 p.m., he indicated both Resident #F and Resident #G were being followed by physical therapy for services at the time of their assisted falls. He indicated that although the therapy notes for around the time of their assisted falls indicated each was making some progress, he would not generally recommend any changes to the plan of care for nursing staff until the resident's progress was more consistent. He indicated for both Resident #F and Resident #G, neither resident's progress at the time of their assisted fall, or currently, was consistent enough to suggest changing nursing's plan of care from a 2 person assistance with the gait belt for any transfers.</p> <p>In an interview with the ED on 3-27-14 at 12:20 p.m., he indicated the facility does not have a policy on "CNA Assignment Sheets." He indicated it is understood that one would follow the information on the sheet.</p> <p>On 3-27-14 at 2:00 p.m., the ED provided a copy of a policy entitled,</p>				

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	<p>"Gait Belts." This policy indicated, "Gait belts provide increased security for the resident and staff, and prevent injury during movement of a resident. A designated staff member uses a gait or ambulation belt during ambulation or movement of a resident who needs security and assistance. A gait belt is not used unless the resident has been evaluated, and it has been approved for use by licensed nurse..."</p> <p>The Indiana State Department of Health, Division of Long Term Care, "Nurse Aide Training Program" Manual (July, 1998) indicated, "Topic 1: Health Care Delivery...The Comprehensive Care Plan (care plan) is a written plan of action developed by the Health Care Team to meet each resident's highest functional, medical, nursing, mental and psychosocial needs. The plan includes the identification of the cause and nature of a resident's needs, the short term and long term goals for the resident, the individualized approaches to reach those goals, and the disciplines responsible for meeting those goals. The comprehensive care plan fosters Continuity of Care [sic]. CNA's role:</p> <p>a. Provide care according to the resident's comprehensive care</p>						

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	<p>plan..."</p> <p>This Federal tag relates to the Post Survey Revisit for Complaint IN00143695.</p> <p>This deficiency was cited on February 6, 2014. the facility failed to implement a systemic plan of corrections to prevent recurrence.</p> <p>3.1-14(i)</p>				