

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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F000000	<p>This visit was for the Investigation of Complaint IN00125106 and Complaint IN00125387.</p> <p>Complaint IN00125106 Unsubstantiated - due to lack of evidence.</p> <p>Complaint IN00125387 Substantiated - Federal/State deficiencies related to the allegations are cited at F226.</p> <p>Survey date: March 6 and 7, 2013</p> <p>Facility number: 000033 Provider number: 155375 AIM number: 100266280</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF/NF: 62 Total: 62</p> <p>Census payor type: Medicare: 5 Medicaid: 42 Other: 15 Total: 62</p> <p>Sample: 9</p>	F000000	Goldenliving Center - Petersburg request a paper compliance on this deficiency. The facility responded to allegation immediately upon notification of complaint and completed investigation and in-servicing before survey date. Facility will continue to inservice per F226 corrective actions.	

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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	<p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2 .</p> <p>Quality review completed on March 12, 2013, by Jodi Meyer, RN</p>				

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure staff immediately reported alleged verbal abuse to the Administrator, for 1 of 6 residents reviewed for abuse, in a sample of 9. Resident E</p> <p>Findings include:</p> <p>1. On 3/6/13 at 1:50 P.M., the Administrator provided a "Facility Incident Reporting Form," faxed to the Indiana State Department of Health on 2/25/13. The form included: "...Incident Date: 2/24/13, Incident Time: 02:00 am, Resident Name: [Resident E]...Staff Name [LPN # 1], [LPN # 2], Brief Description of Incident: Resident returning from Dining Room when [LPN # 1] stopped her and told her she needed to return to her unit. A verbal exchange ensued [sic] with a heated discussion in regards to resident returning to unit. Resident alledges [sic] LPN used cuss word at her...Immediate Action Taken: Executive Director notified, LPN</p>	F000226	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Staff in-service conducted on 2/25/13 on policy of immediate notification to Administration and facility Abuse Policy. An Immediate Notification Form was placed at each nurses station with Executive Director and Director of Nursing Services telephone numbers for immediate notification.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All residents have the potential to be affected by this deficient practice. Staff was in serviced on 2/25/13 on proper and immediate notification of any allegation of abuse.</p> <p>What measures will be put into</p>	03/08/2013	

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	<p>suspended pending outcome of investigation. Follow up: After complete investigation with staff and resident, the result of the investigation found that associate [LPN # 1] was inappropriate to argue with resident but did not call resident any names...[LPN # 2] will receive written warning for not reporting to Administration in a timely manner."</p> <p>On 3/6/13 at 2:40 P.M., during interview with LPN # 3, she indicated, "Approximately 1 week ago, a nurse reported to me that a staff member had yelled at a resident." LPN # 3 indicated LPN # 2 had been working night shift, and she was receiving change of shift report. LPN # 3 indicated LPN # 1 allegedly raised his voice to Resident E. LPN # 3 indicated she immediately informed the Social Services Director [SSD], who was in the facility, who then called the Administrator. LPN # 3 indicated she informed LPN # 2 that she should have notified Administration immediately of the incident.</p> <p>On 3/7/13 at 7:15 A.M., during interview with the SSD, she indicated she was the weekend manager on 2/24/13. The SSD indicated she entered the facility at approximately 6:45 A.M., and was informed by LPN # 3 that LPN # 2 told her Resident E was upset because LPN #</p>		<p>place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Quarterly in-services will be conducted to review facility Abuse Policy and proper notification to Administration. Interviews of staff will be conducted for each shift on a weekly basis times 4 weeks, then monthly times 4, then ongoing as needed.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Quarterly in-services will be conducted to review facility Abuse Policy and proper notification to Administration. Interviews of staff will be conducted for each shift on a weekly basis times 4 weeks, then monthly times 4, then ongoing as needed. This will be reviewed monthly during facility QA&A meeting for 3 months then quarterly times 3 months, then as needed.</p> <p>Date the systemic changes will be completed: 3/8/13</p>				

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	<p>1 yelled at her. The SSD indicated she immediately called the Administrator, and began her investigation. The SSD indicated the incident happened at approximately 2:00 A.M. The SSD indicated she immediately interviewed LPN # 2. LPN # 2 indicated to her that Resident E had gone to the dining room to get a soda, and upon returning, was told by LPN # 1 that she needed to stay on her unit. An argument between LPN # 1 and Resident E resulted in Resident E returning to her room. LPN # 2 informed the SSD that she stayed with the resident and talked with her, and LPN # 1 returned to his unit. The SSD indicated LPN # 1 "had already left" before she was able to interview him or send him home. The SSD indicated Resident E was alert and oriented, and no longer resided at the facility.</p> <p>Immediate reporting to the Administrator was not complete for 5 hours.</p> <p>The closed clinical record of Resident E was reviewed on 3/7/13 at 8:40 A.M.</p> <p>An admission Minimum Data Set [MDS] assessment, dated 2/18/13, indicated Resident E had no memory problems.</p> <p>Progress Notes included the following notations:</p>						

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	<p>2/24/13 at 11:56 A.M.: "Reported this am that resident had gotten upset during the night when resident went to dining area to get her a soda pop and had a disagreement with a staff member. Reported that there was yelling involved and curse words. Resident had went back to her room per reports and staff gave resident reassurance and resident reported to had been upset, crying on and off during the am [A.M.] hours post situation in dining area. Resident interviewed this am [A.M.] per this writer. Resident still appeared to be anxious [sic], upset over situation. And one episode [sic] of being tearful for short period. Resident stated that she had went to dining area to get her a soda and another staff member from another unit told her she could not leave her unit during the night and felt that he could have used a different approach with her...."</p> <p>2/25/13 at 9:24 A.M.: "Resident noted this am [A.M.] to be nervous/anxious and talking about the situation that happened early Sunday morning. Staff gives comfort, reassurance, redirected. Appeared to help resident feel better...."</p> <p>On 3/7/13 at 9:30 A.M., during interview with the Administrator, she indicated LPN # 2 "never heard [LPN # 1] cuss or</p>			

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	<p>yell." The Administrator indicated LPN # 2 did report the incident to the oncoming shift. The Administer indicated LPN # 2 got a written warning because it may have helped if she would have reported the situation earlier. The Administrator indicated LPN # 1 "went back to his unit" for the remainder of the night shift, and did not return to Resident E's unit, but was not sent home.</p> <p>2. On 3/7/13 at 11:50 A.M., the Administrator provided the current facility policy on "Reporting Alleged Violations," dated May 2001. The policy included: "...It is also the policy of this facility to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse...are reported immediately to the executive director of the facility...."</p> <p>This federal tag relates to Complaint IN00125387.</p> <p>3.1-28(a) 3.1-28(c)</p>				

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