

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 07/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>This visit was for the Investigation of Complaint IN00111313 and Complaint IN00111617.</p> <p>Complaint IN00111313 -- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00111617 -- Substantiated. Federal/state deficiencies related to the allegations are cited at F282 and F323.</p> <p>Survey dates: July 9 and 10, 2012</p> <p>Facility number: 000077 Provider number: 155157 AIM number: 100266490</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF/NF: 87 Total: 87</p> <p>Census payor type: Medicare: 18 Medicaid: 62 Other: 7 Total: 87</p> <p>Sample: 4</p>	F0000	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements</u></p>	

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.

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 07/10/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND			STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 7/11/12 Cathy Emswiller RN</p>				

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 07/10/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND				STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0282 SS=G	<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 the physician's written orders were followed for 1 of 4 residents reviewed for accidents in a total sample of 4 as evidenced by not utilizing the resident's safety belt when up in the wheelchair, resulting in two falls from the wheelchair. The first fall resulted in no injury and the second fall resulted in him receiving a laceration to the forehead which required an evaluation in the local emergency room and subsequent stitches to close the laceration. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 7-9-12 at 11:32 a.m. His diagnoses included, but were not limited to profound mental retardation, and cerebral palsy with spastic diplegia (paralysis associated with cerebral palsy in which some degree of paralysis exists of like parts on either side of the body, usually affecting the legs and/or arms.) His most recent Minimum Data Set assessment, dated 6-20-12, indicated he has moderately impaired cognitive</p>	F0282	<p>F 282</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>R#B's care plan was reviewed and updated as indicated.</p> <p>R#B's CNA assignment sheet was reviewed and updated as indicated.</p> <p>On 7-11-12 all CNA's who care for R#B were in-serviced on ensuring residents belt in place when up in Wheel Chair.</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>Residents with an order for a Seat belt were reviewed and new interventions implemented if indicated.</p> <p>C.N.A. assignment sheets were reviewed and updated as needed to ensure residents with seat belts had</p>	07/18/2012			

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 07/10/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND			STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>abilities. It indicated he does not walk, but uses a wheelchair for mobility. It indicated he has impairment of his upper and lower extremities. A discharge summary, dated 3-14-12, from his previous home setting of a group home indicated he had declined in general over the previous several months. It indicated he has limited speech abilities, but has a limited vocabulary, and can use "yes" and "no" and gestures to get his wants and needs met.</p> <p>Review of the clinical record indicated he was physician ordered upon admission on 3-14-12 for the use of a seat belt while up in his wheelchair to help maintain a safe upright position. Additionally, on the same date, his written nursing plan of care indicated, "Lap belt while up in wheelchair to help prevent falls. Resident has poor sitting balance [related to] cerebral palsy."</p> <p>On 3-15-12 at 4:32 p.m., the nursing notes indicated the staff heard a cup of water fall in Resident #B's room. Upon investigation, the staff found the resident to be sliding out of his wheelchair. It indicated he landed on his knees and fell forward onto his right side. It indicated an assessment yielded no findings of injury. It did not indicate if the seat belt was in place as ordered. In interview with</p>		<p>intervention on sheet.</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>On 7-11-12 all CNA's who care for R#B were in-serviced on ensuring residents belt in place when up in wheel Chair.</p> <p>On 7-11-12 all nurses were in-serviced on daily prior to giving report to the CNA's they are to print off the CNA assignment sheets to verify the accuracy of the sheets prior to giving out during report.</p> <p>Licensed Nurses will verify by documenting on the treatment record sheet that the seat belt is in place after residents shower prior to transporting him back to his room.</p> <p>DNS/Designee will audit resident care plans for Seat belts , C.N.A. assignment sheets and Resident treatment record 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly.</p> <p>These corrective actions will be monitored and a quality assurance program</p>		

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 07/10/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND			STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>LPN #1 on 7-9-12 at 4:35 p.m., she indicated she was unsure if the seat belt was in place before he fell. Review of the facility's investigation of this fall indicated nursing staff were educated after the fall on the routine use of the seat belt and foot pedals for the wheelchair.</p> <p>On 6-25-12 at 9:30 p.m., nursing notes indicated Resident #B was being pushed down the hall in his wheelchair by an CNA when he fell out of the wheelchair and received a laceration to his forehead, measuring 4 centimeters (cm) by 0.2 cm. It indicated the assessment indicated his neurological evaluation was within normal limits and first aide was administered to him. The physician was contacted and he ordered the resident to be sent to a local emergency room for evaluation and treatment. The facility's investigation into the fall indicated the resident's safety belt was not in place at the time of the fall and the resident did return from the emergency room with stitches to the laceration on his forehead.</p> <p>In interview with CNA #2 on 7-9-12 at 4:35 p.m., she indicated she had not placed the safety belt on Resident #B on 6-25-12 after his shower. She indicated CNA #3 and CNA #4 assisted her with transferring the resident from the shower chair into his wheelchair prior to being</p>		<p>implemented to ensure the deficient practice will not recur per the following:</p> <p>DNS/Designee will audit resident care plans for Seat belts , C.N.A. assignment sheets and Resident Treatment sheets 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly.</p> <p>Results of audits will be reviewed at the monthly QAA meetings for 3 months or until compliant. The Facility will evaluate the audits for trends or patterns and action plans will be implemented if indicated.</p>		

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 07/10/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND			STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>pushed down the hall toward his room. She indicated she had worked with Resident #B once or twice before. CNA #2 indicated she has been a CNA for almost 3 years and has worked at this same facility during this almost 3 years.</p> <p>In interview with CNA #3 on 7-10-12 at 1:54 p.m., she indicated on the evening of 6-25-12, CNA #2 was the aide caring for Resident #B. She indicated she and CNA #4 assisted CNA #2 in transferring Resident #B from his wheelchair to the shower chair prior to his shower and then after he received his shower and care from CNA #2, they assisted CNA #2 to get him back into his wheelchair. She indicated after assisting with the transfer, she went to get a drink [from the water fountain] and was in the process of returning to care for her assigned residents when she heard CNA #2 yell for help. She indicated immediately prior to the call for help, she heard a "thud." She indicated at that time, she yelled for assistance from the nurse. She indicated she had provided care previously for Resident #B and was aware he required the use of the safety belt. She indicated she assumed that CNA #2 would place the safety belt on the resident once he was transferred into his wheelchair.</p> <p>In interview with CNA #4 on 7-10-12 at</p>				

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 07/10/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND			STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	2:04 p.m., she indicated on the evening of 6-25-12, CNA #2 was the aide caring for Resident #B. She indicated she and CNA #3 assisted CNA #2 in transferring Resident #B from his wheelchair to the shower chair prior to his shower and then after he received his shower and care from CNA #2, they assisted CNA #2 to get him back into his wheelchair. She indicated CNA #2 then asked if she could assist her in getting the resident transferred from his wheelchair to his bed. She indicated she agreed to do this, but momentarily stepped out of the shower room to gather dirty linens. She indicated she assumed CNA #2 had placed the seat belt and did not think to check to see that the seat belt was in place. She indicated when she returned to the shower room, she began pushing the wheelchair. She indicated she was talking to CNA #2 while pushing the wheelchair when she heard CNA #2 say, "Oh," as she saw the resident begin to fall forward out of the wheelchair. She indicated she tried to catch him, but could not do so. She indicated Resident #B immediately began to bleed from his forehead. She indicated she yelled for the nurse and first aide was administered to the resident. She indicated when she had provided care to Resident #B previously, "the aide assignment sheet said he was a fall risk and has the seat belt listed under alarms.				

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 07/10/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND				STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>To me, this means he needs it on at all times when he's up [in his wheelchair.]"</p> <p>A copy of the current CNA assignment sheet for Resident #B was provided by the Director of Nursing on 7-10-12 at 9:58 a.m. Under the "Comments" section, it indicated, "[Safety] Belt on while up in chair."</p> <p>In interview with the Administrator on 7-10-12 at 3:30 p.m., he indicated the facility does not have a written policy on following physician orders. He indicated, "It's just the standard of practice that we follow the doctor's orders."</p> <p>This federal tag relates to complaint number IN00111617</p> <p>3.1-35(g)(2)</p>						

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 07/10/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND			STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0323 SS=G	<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.</p> <p>Based on interview and record review, the facility failed to ensure the physician's written orders were followed for 1 of 4 residents reviewed for accidents in a total sample of 4 as evidenced by not utilizing the resident's safety belt when up in the wheelchair, resulting in two falls from the wheelchair. The first fall resulted in no injury and the second fall resulted in him receiving a laceration to the forehead which required an evaluation in the local emergency room and subsequent stitches to close the laceration. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 7-9-12 at 11:32 a.m. His diagnoses included, but were not limited to profound mental retardation, and cerebral palsy with spastic diplegia (paralysis associated with cerebral palsy in which some degree of paralysis exists of like parts on either side of the body, usually affecting the legs and/or arms.) His most recent Minimum Data Set assessment, dated 6-20-12, indicated he</p>	F0323	<p>F323 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>R#B's care plan was reviewed and updated as indicated.</p> <p>R#B's CNA assignment sheet was reviewed and updated as indicated.</p> <p>On 7-11-12 all CNA's who care for R#B were in-serviced on ensuring residents belt in place when up in Wheel Chair.</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>Residents with an order for a Seat belt were reviewed and new interventions implemented if indicated.</p> <p>C.N.A. assignment sheets were reviewed and updated as needed to ensure residents</p>	07/18/2012	

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 07/10/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND				STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>has moderately impaired cognitive abilities. It indicated he does not walk, but uses a wheelchair for mobility. It indicated he has impairment of his upper and lower extremities. A discharge summary, dated 3-14-12, from his previous home setting of a group home indicated he had declined in general over the previous several months. It indicated he has limited speech abilities, but has a limited vocabulary, and can use "yes" and "no" and gestures to get his wants and needs met.</p> <p>Review of the clinical record indicated he was physician ordered upon admission on 3-14-12 for the use of a seat belt while up in his wheelchair to help maintain a safe upright position. Additionally, on the same date, his written nursing plan of care indicated, "Lap belt while up in wheelchair to help prevent falls. Resident has poor sitting balance [related to] cerebral palsy."</p> <p>On 3-15-12 at 4:32 p.m., the nursing notes indicated the staff heard a cup of water fall in Resident #B's room. Upon investigation, the staff found the resident to be sliding out of his wheelchair. It indicated he landed on his knees and fell forward onto his right side. It indicated an assessment yielded no findings of injury. It did not indicate if the seat belt</p>		<p>with seat belts had intervention on sheet.</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>On 7-11-12 all CNA's who care for R#B were in-serviced on ensuring residents belt in place when up in Wheel Chair.</p> <p>On 7-11-12 all nurses were in-serviced on daily prior to giving report to the CNA's they are to print off the CNA assignment sheets to verify the accuracy of the sheets prior to giving out.</p> <p>DNS/Designee will audit resident care plans for Seat belts , C.N.A. assignment sheets and resident treatment sheets 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly.</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>DNS/Designee will audit resident care plans for Seat belts , C.N.A. assignment sheets Resident Treatment</p>				

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 07/10/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND				STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>was in place as ordered. In interview with LPN #1 on 7-9-12 at 4:35 p.m., she indicated she was unsure if the seat belt was in place before he fell. Review of the facility's investigation of this fall indicated nursing staff were educated after the fall on the routine use of the seat belt and foot pedals for the wheelchair.</p> <p>On 6-25-12 at 9:30 p.m., nursing notes indicated Resident #B was being pushed down the hall in his wheelchair by an CNA when he fell out of the wheelchair and received a laceration to his forehead, measuring 4 centimeters (cm) by 0.2 cm. It indicated the assessment indicated his neurological evaluation was within normal limits and first aide was administered to him. The physician was contacted and he ordered the resident to be sent to a local emergency room for evaluation and treatment. The facility's investigation into the fall indicated the resident's safety belt was not in place at the time of the fall and the resident did return from the emergency room with stitches to the laceration on his forehead.</p> <p>In interview with CNA #2 on 7-9-12 at 4:35 p.m., she indicated she had not placed the safety belt on Resident #B on 6-25-12 after his shower. She indicated CNA #3 and CNA #4 assisted her with transferring the resident from the shower</p>		<p>sheets 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly.</p> <p>Results of audits will be reviewed at the monthly QAA meetings for 3 months or until compliant. The Facility will evaluate the audits for trends or patterns and action plans will be implemented if indicated.</p>				

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 07/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>chair into his wheelchair prior to being pushed down the hall toward his room. She indicated she had worked with Resident #B once or twice before. CNA #2 indicated she has been a CNA for almost 3 years and has worked at this same facility during this almost 3 years.</p> <p>In interview with CNA #3 on 7-10-12 at 1:54 p.m., she indicated on the evening of 6-25-12, CNA #2 was the aide caring for Resident #B. She indicated she and CNA #4 assisted CNA #2 in transferring Resident #B from his wheelchair to the shower chair prior to his shower and then after he received his shower and care from CNA #2, they assisted CNA #2 to get him back into his wheelchair. She indicated after assisting with the transfer, she went to get a drink [from the water fountain] and was in the process of returning to care for her assigned residents when she heard CNA #2 yell for help. She indicated immediately prior to the call for help, she heard a "thud." She indicated at that time, she yelled for assistance from the nurse. She indicated she had provided care previously for Resident #B and was aware he required the use of the safety belt. She indicated she assumed that CNA #2 would place the safety belt on the resident once he was transferred into his wheelchair.</p>			

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 07/10/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND				STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	In interview with CNA #4 on 7-10-12 at 2:04 p.m., she indicated on the evening of 6-25-12, CNA #2 was the aide caring for Resident #B. She indicated she and CNA #3 assisted CNA #2 in transferring Resident #B from his wheelchair to the shower chair prior to his shower and then after he received his shower and care from CNA #2, they assisted CNA #2 to get him back into his wheelchair. She indicated CNA #2 then asked if she could assist her in getting the resident transferred from his wheelchair to his bed. She indicated she agreed to do this, but momentarily stepped out of the shower room to gather dirty linens. She indicated she assumed CNA #2 had placed the seat belt and did not think to check to see that the seat belt was in place. She indicated when she returned to the shower room, she began pushing the wheelchair. She indicated she was talking to CNA #2 while pushing the wheelchair when she heard CNA #2 say, "Oh," as she saw the resident begin to fall forward out of the wheelchair. She indicated she tried to catch him, but could not do so. She indicated Resident #B immediately began to bleed from his forehead. She indicated she yelled for the nurse and first aide was administered to the resident. She indicated when she had provided care to Resident #B previously, "the aide assignment sheet said he was a fall risk						

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 07/10/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND			STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>and has the seat belt listed under alarms. To me, this means he needs it on at all times when he's up [in his wheelchair.]"</p> <p>A copy of the current CNA assignment sheet for Resident #B was provided by the Director of Nursing on 7-10-12 at 9:58 a.m. Under the "Comments" section, it indicated, "[Safety] Belt on while up in chair."</p> <p>In interview with the Administrator on 7-10-12 at 3:30 p.m., he indicated the facility does not have a written policy on following physician orders. He indicated, "It's just the standard of practice that we follow the doctor's orders."</p> <p>This federal tag relates to complaint number IN00111617.</p> <p>3.1-45(a)(2)</p>				