

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155120	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRANDYWINE	STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140
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F 0000 Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the Investigation of Complaint IN00197809 completed on May 25, 2016.</p> <p>This visit was done in conjunction with the PSR to the Investigation of Complaint IN00200645 completed on May 25, 2016.</p> <p>This visit was done in conjunction with the Investigation of Complaint IN00203241 and IN00203645.</p> <p>Complaint IN00197809-Corrected</p> <p>Survey dates: June 28, 29, and 30, 2016. July 1, 2016.</p> <p>Facility number: 000050 Provider number: 155120 AIM number: 100266170</p> <p>Census bed type: SNF/NF: 105 Total: 105</p> <p>Medicare: 2 Medicaid: 84 Other: 19</p>	F 0000		

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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F 0223 SS=D Bldg. 00	<p>Total: 105</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on July 06, 2016</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on observation, interview and record review, the facility failed to prevent rough treatment of a resident by a CNA during care for 1 of 4 residents reviewed for abuse (Resident #L).</p> <p>Finding include:</p>	F 0223	<p>A head to toe skin assessment was completed by a licensed nurse on Resident #L and no injuries were noted. Resident #L was monitored for any behavioral changes with none noted. CNA #1 was terminated. CNA#1 suspended immediately following</p>	07/27/2016

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	<p>Review of the reportable incident provided by the Administrator on 6/29/16 at 10:46 a.m., indicated on 6/22/16 at 11:54 a.m., it was reported to the Administrator by Speech Therapy (S.T.) #1 that CNA #1 was being rough with Resident #L while providing care. S.T. #1 indicated CNA #1 was "forcefully" taking Resident #L's head when attempting to reposition a pillow under his head. CNA #1 was immediately suspended pending an investigation.</p> <p>The "witness" statement, dated 6/22/16 at 4:48 p.m., indicated Speech Therapy intern #1 observed CNA #1 attempting to reposition Resident #L upright in his chair. Resident #L was leaning over his chair. Speech therapy intern #1 indicated she witness the cna push the right side of the resident's head "with too much force." Speech Therapy intern #1 indicated the resident continued to lean over his chair and CNA #1 continued to forcibly push his head into position four times.</p> <p>The "witness" statement, dated 6/22/16 at 6:38 p.m., indicated Dietary Aide #1 observed CNA #1 "forcibly slammed" Resident #L upwards. The Dietary Aide #1 indicated the force CNA #1 used on the resident was "shocking." Dietary Aide #1 indicated CNA #1 was using "too</p>		<p>allegation and terminated at completion of investigation All residents had the risk to potentially be affected by this deficient practice. CNA #1 was terminated. The facility will continue to train on resident abuse during new employee orientation, annually, and as needed. Facility continues to conduct staff interviews regarding signs of abuse and what to do when abuse is suspected. No other residents identified as being affected.</p> <p>All staff to be re-in-serviced on abuse guidelines including how to report. Also, initiated in-service on 6/30/2016 on employee burn-out and Golden Living Employee Assistant Program. Psychologist scheduled to meet with employees to discuss burn-out, stress management, and any other psychological assistance that the staff may need.</p> <p>ED/DNS/designee to continue to randomly ask staff what they would do if they saw a resident being abused. These audits to occur 3 times weekly x 30 days, 2 times weekly x 30 days, 1 time weekly x 30 days, then 1 time every other week x 30 days, then monthly times 60 days.</p> <p>ED/DNS/designee to randomly ask staff if they are feeling burnt-out or overwhelmed from work-related tasks and will address with employee as issues arise. These audits to occur 3</p>		

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	<p>much force."</p> <p>The "witness" statement, dated 6/22/16 at 7:45 p.m., indicated S.T. #1 observed CNA #1 taking Resident #L's head and "shoved" it multiple times trying to put a pillow under it. S.T. #1 observed "very rough treatment."</p> <p>The incident follow up, dated 6/27/16 (no time), indicated CNA #1 was terminated from the facility.</p> <p>Interview with S.T. #1 on 6/30/16 at 2:34 p.m., indicated on 6/22/16 she observed CNA #1 take both of her hands and grab Resident #L's head in attempt to reposition him in his chair. S.T. #1 indicated it was forceful and she immediately reported it to the Administrator.</p> <p>Interview with Speech Therapy intern #1 on 6/30/16 at 3:19 p.m., indicated on 6/22/16 she observed CNA #1 attempting to position Resident #L upright in his chair. Speech Therapy intern #1 indicated CNA #1 pushed his head 3-4 times in a forcible manner.</p> <p>Interview with Dietary Aide #1 on 6/29/16 at 4:25 p.m., indicated on 6/22/16, she witnessed CNA #1 shoving Resident #L with "way too much force"</p>		<p>times weekly x 30 days, 2 times weekly x 30 days, 1 time weekly x 30 days, then 1 time every other week x 30 days, then monthly times 60 days.</p> <p>Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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	<p>upright in his chair. Dietary Aide #1 indicated it was "shocking".</p> <p>During observation on 7/1/16 at 10:18 a.m., Resident #L was sitting in a broda chair leaning slightly to the right. The resident was making movements with his mouth as if he was chewing something with his eyes closed. The resident opened his eyes when spoken to, but did was not verbal or make eye contact.</p> <p>Review of the record of Resident #L on 7/1/16 at 10:25 a.m., indicated the resident's diagnoses included, but were not limited to, dementia, depression, Parkinson disease and essential tremors.</p> <p>The Quarterly Minimum Data Set assessment for Resident #L, dated 6/22/16, indicated the resident was severely impaired for decision making and his speech was rarely or never understood. The resident required extensive assistance of two people for transfers, dressing and hygiene. The resident was totally dependent of one person for eating and totally dependent of one person for toilet use.</p> <p>The abuse policy provided by the Administrator on 6/29/16 at 10:46 a.m., indicated it was the facilities policy to take appropriate steps to prevent the</p>			

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F 0323 SS=D Bldg. 00	<p>occurrence of abuse. "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish."</p> <p>This deficiency was cited on 5/25/16. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-27(a)(1)</p> <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 observation, interview and record review, the facility failed to transfer a resident with the assistance of 2 staff and the use of a Marissa lift for 1 of 3 residents reviewed for accidents. (Resident #K)</p> <p>Findings include:</p> <p>Resident #K's record was reviewed on 6/30/16 at 2:59 p.m. Her diagnoses documented on her July 2016 physician's recapitulation orders included but were</p>	F 0323	<p>Resident #K continues to be appropriate for Marissa lift at this time. CNA #6 was immediately pulled off the floor and education provided regarding utilizing 2 staff members for Marissa lift transfers at all times.</p> <p>All residents identified who utilize a lift were reviewed to ensure appropriate lift was being used with appropriate number of staff for transfers. Care plans reviewed and updated as needed to reflect resident's current plan of care.</p>	07/27/2016

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	<p>not limited to, dementia without behavioral disturbance, hemiplegia and hemiparesis following a cerebrovascular accident (CVA) affecting her left non-dominant side, acute pain due to trauma, and disorders of her bone density and structure.</p> <p>Resident #K's significant change Minimum Data Set (MDS) assessment dated 6/8/16, indicated she was understood and had the ability to understand others. She was moderately impaired in her cognitive daily decision making skills. She required extensive assistance of 2 persons for bed mobility, transfer, and toileting. She had not walked and utilized a wheelchair for locomotion. She had 1 fall with an injury.</p> <p>A "Verification Of Investigation" provided by the Administrator on 6/30/16 at 3:18 p.m., indicated on 6/5/16 at 8:10 p.m., CNA #5 had transferred Resident #K to the bathroom with the use of a Mechanical Sara (Stand Up) lift. When CNA #5 transferred Resident #K back to her recliner Resident #K let go of the handles on the Sara lift and slid out of the sling to the floor. Resident #K complained of pain and was sent to a local emergency room. It was determined at the local</p>		<p>Nursing staff in-serviced on types of lifts and the number of staff needed for transfers for each lift. Name tags of residents were updated with a code that includes the type of lift and number of staff members needed for that resident. CNA assignment sheets were also updated with this information. All CNAs conducted a return demonstration for each lift utilized in the facility. DCE/Unit Manager/designee to watch CNAs complete transfer using lifts. These audits to occur 5 times weekly x 30 days, 3 times weekly x 30 days, 2 times weekly x 30 days, then weekly x 90 days. Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>				

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	<p>hospital she had a fractured pelvis. The Interdisciplinary Team review and recommendation indicated Resident #K would be transferred with a Marissa lift for all transfers.</p> <p>A plan of care for Resident #K initiated 10/9/13, indicated she was at risk for falls related to medications, a history of CVA with left sided hemiplegia, congestive heart failure, a history right hip surgery, and a right pelvic fracture on 6/5/16. An intervention initiated 6/6/16, indicated staff would utilize a Marissa lift for all of her transfers.</p> <p>A "Lift/Mobility Assessment" for Resident #K dated 6/9/16, indicated a Marissa lift with 2 staff assistance was required for transfer.</p> <p>On 6/30/16 at 9:55 a.m., Resident #K indicated she had fell and broken her pelvic bone. She indicated she remembered the fall. She indicated "yeah, I was going to the bathroom and an aide was with me and I fell out of the thing." She indicated she had been strapped in the lift and she had straps under her arms and around her waist. She indicated she had 1 staff assisting her when she had fell from the lift. When queried if staff currently used a different type of lift to transfer her than the type</p>			

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	<p>she had fell from, she stated "yes." She indicated she was supposed to be transferred with 2 staff but was transferred in the lift with 1 staff member.</p> <p>On 6/30/16 at 11:45 a.m., Resident #K was observed being transferred from her recliner to her bed with the assistance of CNA #6 and CNA #7 and the use of a Marissa lift. CNA #6 operated the Marissa lift and CNA #7 assisted by guiding Resident #K in the lift sling to her bed. CNA #6 indicated she had transferred Resident #K from her bed to her recliner that morning by herself and the use of the Marissa lift. She indicated the facility required 2 staff when transferring a resident with the Marissa lift but that was not always feasible. She indicated she had not requested help from another staff member that morning when she had transferred Resident #K by herself.</p> <p>This deficiency was cited on 5/25/16. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-45(a)(2)</p>			

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F 9999 Bldg. 00		F 9999	Was not re-sited during re-visit	07/27/2016	