

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 01/31/2012
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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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F0000	<p>This visit was for the Investigation of Complaint IN00102834.</p> <p>Complaint IN00102834 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: January 30 and 31, 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: 0 SNF/NF: 95 Total: 95</p> <p>Census payor type: Medicare: 16 Medicaid: 71 Other: 8 Total: 95</p> <p>Sample: 4</p> <p>Golden Living Center - Richmond was found to be in substantial compliance</p>	F0000		
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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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	<p>with 42 CFR Part 483, Subpart B in regard to the Investigation of Complaint IN00102834. This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 2/6/12 by Jennie Bartelt, RN.</p>				

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F0223 SS=A	<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 interview and record review, the facility failed to ensure a staff member did not verbally abuse a resident during the provision of incontinence care. This deficient practice affected 1 of 3 residents reviewed for abuse in a sample of 4. (Resident #D)</p> <p>Findings include:</p> <p>During an interview with the Executive Director (ED) on 1-31-12 at 8:35 a.m., he indicated he had forwarded a written initial report of verbal abuse to the Indiana State Department of Health on 1-27-12 as a result of an allegation of abuse he had received on that date at approximately 3:00 p.m. He indicated the staff involved were immediately removed from the nursing unit and interviewed with the alleged abuser (CNA #3) immediately suspended, pending investigation. He indicated the resident was assessed for injury and family and physician were notified immediately. He indicated the resident did not seem to recall the incident shortly afterwards. He</p>	F0223	<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> <p>Tag F223 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: C.N.A. #2 received counseling and reeducation on immediately reporting alleged violations involving Mistreatment, Abuse, Injuries of unknown source, and misappropriation of resident property or Neglect. C.N.A. #3 This employee's employment with the facility has been terminated. 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>	02/13/2012	

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	<p>indicated this resident has end-stage Alzheimer's disease. He indicated staff inservicing on abuse began on Friday evening and should be nearly complete by the end of the day.</p> <p>In interview with CNA #1 on 1-31-12 at 1:44 p.m., she indicated she had entered Resident #D's room on 1-27-12 at approximately 2:45 p.m. in order to seek staff assistance with another resident. She indicated CNA #2 and CNA #3 were in the process of providing incontinence care for Resident #D. She indicated she requested their assistance when they were finished with their current task. She indicated, "I decided to stay to see if they needed anything." She indicated the resident was observed to "grab at her peri area," and she observed CNA #3 remove the resident's hand from the area. She indicated " [Name of CNA #2] said, 'Wait till she gets further along in her pregnancy; she'll have more of an attitude.' Then she added, 'Just kidding.'" She indicated the resident "Had a look of confusion on her face." She indicated, "[Name of CNA #3] then said to the resident, 'You need to get that nasty look off your face and lose your attitude.'" CNA #1 indicated CNA #3's voice was louder than normal and the tone "was mean, kinda [sic] harsh." She indicated upon exiting the room, she immediately</p>		<p>Staff were inserviced on 1-27-12 regarding immediately reporting alleged violations involving Mistreatment, Abuse, Injuries of unknown source, and misappropriation of resident property or Neglect. Also the staff were inserviced on Protecting Resident suspected of being subject of an alleged violation. New staff will have education on immediately reporting alleged violations involving Mistreatment, Abuse, Injuries of unknown source, and misappropriation of resident property or Neglect and protecting the Resident suspected of being subject of an alleged violation prior to working with residents. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Nursing Staff were inserviced on 1-27-12 regarding immediately reporting alleged violations involving Mistreatment, Abuse, Injuries of unknown source, and misappropriation of resident property or Neglect. Also the staff were inserviced on Protecting Resident suspected of being subject of an alleged violation. New staff will have education on immediately reporting alleged</p>		

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	<p>went to the restroom and then immediately to the Director of Nursing to inform her of what had occurred.</p> <p>In interview with CNA #2 on 1-31-12 at 2:15 p.m., she indicated she and CNA #3 were providing care to Resident #D on the afternoon of 1-27-12; time not specified. She indicated the resident's family member had requested the staff put the resident back to bed. She indicated after assisting the resident into bed, that she and CNA #3 were in the process of providing incontinence care. She indicated Resident #D "was grabbing onto the siderails. [Name of CNA #3] was explaining what we were doing and saying, 'Just let go.' Her voice was in a more stern manner than usual." She indicated she then told CNA #3, "If you are only 12 weeks pregnant, you're not going to be able to handle it." She indicated another person, identified as CNA #1, was also present. She indicated CNA #1 had come into the room to request assistance with another resident.</p> <p>In interview with a family member on 1-31-12 at 12:40 p.m., he indicated he had been informed by the ED on 1-27-12 regarding the verbal abuse allegation. He indicated he did not think the resident recalled the events of 1-27-12, nor did he indicate that he thought she had suffered</p>		<p>violations involving Mistreatment, Abuse, Injuries of unknown source, and misappropriation of resident property or Neglect and protecting the Resident suspected of being subject of an alleged violation prior to working with residents. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: ED and DNS or designee will monitor daily 24 hour reports, nurses notes, concern forms, and observations of staff and residents for any allegations of Mistreatment, Abuse, Injuries of unknown source, misappropriation of resident property or Neglect New staff will have education on immediately reporting alleged violations involving Mistreatment, Abuse, Injuries of unknown source, and misappropriation of resident property or Neglect and protecting the Resident suspected of being subject of an alleged violation prior to working with residents. Any patterns or trends will be reported to monthly QA meeting and appropriate action plans will be written and implemented.</p>				

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	<p>any adverse effects from the events of 1-27-12.</p> <p>The Executive Director provided a copy of a follow-up report on 1-31-12 at 4:10 p.m. which he submitted to the Indiana State Department of Health on the same date. Review of this document indicated, "The Facility did substantiate that incident did occur thru [sic] investigation. [Name of CNA #3]'s employment is being terminated."</p> <p>A policy entitled, "Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Property," with a revision date of 7-1-08, was provided by the Executive Director on 1-30-12 at 10:30 a.m. Review of this policy indicated, "It is the policy of the Company to take appropriate steps to prevent the occurrence of abuse, neglect...The Executive Director or his or her designee will direct a thorough investigation of each such alleged violation...is responsible to report the results of all investigations to the state agencies as required by state and federal law...Any employee who suspects an alleged violation shall immediately notify the ED or her designee. The ED shall also notify the appropriate state agency in</p>			
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	<p>accordance with state law...All investigations shall be conducted by the ED or DNS [Director of Nursing Services]." This document, under the heading of "Protection," indicated, "If the suspected perpetrator is an employee, the ED shall place the employee on immediate investigatory suspension while completing the investigation."</p> <p>3.1-27(b)</p>				