

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/01/2013
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN 46219
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F000000	<p>This visit was for the Investigation of Complaint IN00138927.</p> <p>Complaint IN00138927 - Substantiated. Federal/State deficiencies related to the allegations are cited at F221.</p> <p>Survey dates: October 30, 31, November 1, 2013</p> <p>Facility number 000031 Provider number 155076 AIM number 100266150</p> <p>Survey team: Chuck Stevenson RN</p> <p>Census bed type: SNF/NF: 112 Total: 112</p> <p>Census payor type: Medicare: 5 Medicaid: 89 Other: 18 Total: 112</p> <p>Sample: 5</p> <p>This deficiency reflects 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 11/06/13 by Suzanne Williams, RN			

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F000221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on record review and interview, the facility failed to ensure a resident (Resident B) remained free from the use of physical restraints without documented medical necessity for 1 resident of 3 reviewed for the use of physical restraints in a sample of 5.</p> <p>Findings include:</p> <p>The record of Resident B was reviewed on 10/30/13 at 1:00 p.m.</p> <p>Diagnoses included, but were not limited to, Alzheimer's Disease, diabetes mellitus, convulsions, chronic obstructive pulmonary disease, and dementia with behavioral disturbance.</p> <p>A significant change Minimum Data Set assessment dated 8/28/13 indicated Resident B was cognitively impaired, required staff assistance for all activities of daily living, and was incontinent of bowel and bladder.</p>	F000221	F221 RIGHT TO BE FREE FROM PHYSICAL RESTRAINTSSS=D What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:The resident was immediately released from restraint when observed, and a head-to-toe assessment revealed no apparent injuries. The employee (CNA) was immediately suspended pending completion of the investigation per facility policy. Resident's family and physician notified. Executive Director and Director of Nursing Services notified. Indianapolis Metropolitan Police Department notified and a report made of the alleged deficient practice. ISDH notified. Employee's employment terminated subsequent to completion of investigation. Indiana Nurse Aide Registry notified of the employee's deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:All other residents in facility were immediately observed to ensure their safety - no other	11/18/2013	

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	<p>A report prepared and signed by the Director of Nursing Services dated 10/31/2013 indicated in its entirety:</p> <p>"On 10-26-2013 at approx. (approximately) 8:00 pm (R.N. #2) called this writer to inform her that she found (Resident B) in her w/c (wheel chair) in her room tied with a sheet around her waist and anchored to the bed frame behind her. She states that she immediately released the resident upon finding her and took her with her to inform the weekend nurse supervisor and then called writer. She states the resident did not have any injuries noted and did not have any response about the event other than asking the nurse to 'please cut this off me.' She was unsure who did this to the resident. Writer instructed (R.N. #2) to obtain the CNA's on the unit and call writer back immediately.</p> <p>At approximately 8:08 pm writer received call (sic) from (R.N. #2) and the 2 CNA's that were working on (Resident B's) unit, writer discussed with them the findings and asked who did it, (C.N.A. #1) spoke up and said 'I did it', talked privately with (C.N.A. #1) at that time and asked her why, she stated because 'she kept getting up from her chair', explained to (C.N.A.</p>		<p>residents affected by the deficient practice. Residents on same unit as affected resident were interviewed relative to deficient practice, with no concerns expressed. Staff interviewed relative to deficient practice, with no concerns expressed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Staff in-services were immediately started on 10.26.13 on the facility's policy on Abuse and Neglect Prevention, Protection, Identification, Reporting, and Investigation, as well as the Elder Justice Act, and continued until all staff were in-serviced. Confirmed staff compliance with annual dementia training. How will the corrective actions be monitored to ensure the deficient practice will not recur: Residents are instructed to report incidents of abuse or inappropriate interactions at the monthly resident council meetings. Residents throughout the facility will be interviewed regarding feeling free to report incidents of abuse or inappropriate interactions monthly x 3, and quarterly thereafter. An audit of staff knowledge of the Abuse and Neglect policy as well as the Elder Justice Act will be conducted monthly x 3, and quarterly thereafter. Results of the audits will be brought to QAPI monthly for review and trending. What date systemic</p>				

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	<p>#1) that what she had done was inappropriate and that she would have to be immediately suspended, she indicated she understood. Writer then spoke with (R.N. #2) to ensure her understanding of the process and to ensure that (C.N.A. #1) clocked out immediately to leave the building."</p> <p>A facility Incident Report Follow Up prepared by the Executive Director dated 10/31/13 indicated:</p> <p>"Incident Date: 10/26/2013</p> <p>Incident Time: 8:00 pm</p> <p>Resident name: (Resident B)</p> <p>Staff Involved: (C.N.A. #1)</p> <p>Brief description of incident: (Resident B) observed to be sitting in wheelchair in resident's room with a bed sheet around her waist that was anchored behind the wheelchair to the bed frame...Charge nurse immediately released resident from bed sheet...Charge nurse determined that (C.N.A. #1) was responsible for the event. CNA immediately suspended... after admitting to tying the bed sheet around the resident's waist...CNA disciplined for resident abuse and involuntary confinement, and</p>		changes will be completed:November 18, 2013				

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	<p>subsequently her employment was terminated. CNA Registry notified of incident..."</p> <p>Resident B's record contained no assessment, order for, or care plan for the use of a restraint.</p> <p>C.N.A. #1 was interviewed on 10/31/13 at 1:30 p.m. She indicated she did use a bed sheet to restrain Resident B as described in the above documents, and that she recognized this was an inappropriate use of a restraint.</p> <p>The Executive Director and Director of Nursing Services were interviewed on 11/01/13 at 11:30 a.m. Both indicated that Resident B had not been assessed for, had a physician's order for, or care plan for a restraint, and that CNA #1's use of a bed sheet to tie Resident B to her bed while in her wheel chair amounted to an inappropriate use of a restraint, which was in violation of regulation and facility policy.</p> <p>A facility policy titled Restraint Evaluation and Utilization dated 2013 indicated:</p> <p>"Purpose: If a restraint is utilized to treat a resident's medical symptoms,</p>				

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	<p>to prevent injury and promote the highest practicable level of independence. Careful evaluation will precede this decision...</p> <p>The process for restraint evaluation and utilization include the following:</p> <p>1. The Interdisciplinary Team will discuss the predisposing factors that resulted in the conclusion that restraint evaluation may be needed...Restraint utilization should be considered only if and when other alternatives practices (sic) have been attempted and proved ineffective... The center will obtain a physician's order for the least restrictive device...A plan of care is developed..."</p> <p>This federal tag relates to Complaint IN00138927.</p> <p>3.1-3(w) 3.1-26(a) 3.1-26(b) 3.1-26(c)</p>				