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 03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-BRANDYWINE	745 N SWOPE ST GREENFIELD, IN 46140

(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
F000000	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey, completed on January 30, 2014. Survey Date: March 18, 2014. Facility Number: 000050 Provider Number: 155120 AIM Number: 100266170 Survey Team: Tom Stauss, RN - TC Courtney Mujic, RN Karina Gates, Generalist Census Bed Type: SNF/NF: 117 Total: 117 Census Payor Type: Medicare: 13 Medicaid: 90 Other: 14 Total: 117 This deficiency reflects State findings cited in accordance with 410 IAC 16.2. Quality review completed on March 21, 2014, by Janelyn Kulik, RN.	F000000	Please accept this Plan of Correction as proof that we have a system in place to prevent a reoccurance of the resident injury. Please grant a desk review to clear this citation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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F000323 SS=G	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 ensure a resident was safely assisted back to her room via wheelchair resulting in a large V-shaped, tendon exposed laceration to the right hand with an emergency room visit for multiple sutures. This affected 1 of 1 resident reviewed for accidents. (Resident #3) Findings include: The clinical record for Resident #3 was reviewed on 3/18/14 at 11:30 a.m. The diagnoses for Resident #3 included, but were not limited to, dementia. The 2/27/14 Quarterly MDS (Minimum Data Set) assessment indicated Resident #3 required extensive assistance of 1 person for locomotion on the unit. It indicated she had a BIMS (Brief Interview For Mental Status) score of 9. The BIMS scores range from 0 to 15 with 15 indicative of no cognitive impairment.	F000323	To accomplish corrective actions for resident affected by the practice, Resident # 3 received aggressive medical care immediately following the injury to her hand. She was transferred to the Emergency Department where they repaired the wound. She had appointments at the office of her physician on 03/07/2014, 03/14/2014,and 03/24/2014 for follow up. Her room entry was inspected to determine if there was a mechanical cause for the injury. There was sufficient clearance available to move through the doorway for entry and egress. To identify other residents having the potential to be affected by the practice, all rooms were inspected to ensure that there was sufficient clearance to enter and leave the room. There were no rooms with doorway space too narrow to move through safely. To ensure that the practice does not recur, all facility staff, contract beautician, therapists, and environmental staff at Brandywine were re-trained in the techniques for safely transporting a resident in a wheelchair through the doorways.	04/01/2014

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	The 3/6/14 Incident Report submitted to ISDH (Indiana State Department of Health) indicated, "Brief Description of Incident: Resident was assisted back to her room in her wheelchair by a CNA (Certified Nursing Assistant). When entering resident's room, resident dropped her hand down onto the side of the wheelchair and her hand caught between the wheel of the wheelchair and the foot board on her roommates bed. Type of Injury/Injuries: A large avulsed skin tear approximately 12 to 13 cm, to the back of the right hand with copious amounts of bleeding noted. Immediate Action Taken: Gauze and pressure applied, sent to (name of hospital) Emergency Department. Interview staff. Preventative measures taken: Pad foot board of roommate's bed, all rooms entry ways measured to ensure adequate space available to safely maneuver residents through. Therapy to screen for wheelchair positioning and transfers. In-service staff on ensuring resident placement of hands/arms are in lap or across chest while being assisted with propelling wheelchair." An observation of Resident #3 sitting in her wheelchair, eating lunch in the dining room was made on 3/18/14 at		This training, including a return demonstration, was conducted by the DNS, ADNS, and DCE starting March 18, 2014 and was completed on March 28, 2014. Additionally, this same formal training has been added to our New Employee Orientation. To monitor the changes in practice and ensure that the practice does not recur, the DNS or designee will audit 3 staff members transporting a resident in a wheelchair per week for 8 weeks. The DNS or designee will then audit 2 staff members transporting a resident in a wheelchair per week for 8 weeks. The DNS will then audit 1 staff member transporting a resident in a wheelchair per week for 8 weeks. The findings of the audit report will be shared at the next 6 monthly QAPI meetings to identify any trends and need to develop an action plan.	

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	12:42 p.m. with emphasis on the width of her wheelchair. Her right hand was wrapped and in a splint. Her right thumb was bruised and purplish brown. An observation of Resident #3's entry way to her room was made on 3/18/14 at 12:45 p.m. The door opened to the left approximately 8 inches from the wall. A night stand was located in front of the open door. Resident #3's roommate's footboard of her bed was on the right. Adequate space to maneuver was observed, given the observed width of Resident #3's wheelchair. A telephone interview was conducted with CNA #1 on 3/18/14 at 1:01 p.m. regarding the incident with Resident #3. She indicated, "She asked me to push her to her room, and I said yes. As I was pushing (name of Resident #3) into her room, the door was not open all the way. Before I pushed her, I asked her to put her hands on the armrest and I saw her do it, but when I was talking to another resident, she moved it." She indicated Resident #3's right hand was no longer on the armrest, but "down by the wheel." She stated, "Since the door wasn't all the way open, I tried to get the left footrest to			

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	push the door open, so I had to turn the wheelchair to the right a little, and that's when her hand got caught between the wheel of her wheelchair and the bed." Regarding the use of Resident #3's left foot rest in an attempt to push the door open rather than open the door herself, she indicated it was because she was distracted by the other resident. Regarding the physical location of the door while pushing Resident #3 into her room, she stated, "The door was not close to the wall. I could have opened the door all the way, so there would have been enough room to push her through, but I was distracted by the other resident that I was talking to. Normally, that's what I would have done. There's always been room to get her through." Regarding whether the furniture had been rearranged since the incident, and whether she'd been in-serviced, she stated, "They put the padding on the bed, but didn't rearrange the furniture...The DON (Director of Nursing) talked to me afterwards, and she said I would need a drug screen, and I took that 2 Thursdays ago. I haven't had the in-service yet. She said the in-service would be with everyone and an individual one for me. I haven't had either. She didn't write anything down or make me sign			

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	anything." Regarding whether she would have done anything differently regarding the incident with Resident #3, she stated, "Differently, I would have paid more attention by looking at (name of Resident #3) while pushing her. I was looking back at (name of resident by which CNA #1 alleges to have been distracted) while pushing her in, and would have pushed the door open with my hand." An interview was conducted with the DON on 3/18/14 at 1:30 p.m. regarding the incident and whether CNA #1 had been in-serviced. She stated, "After I investigated, we found 10 inches of clearance on both sides of the wheelchair. We haven't in-serviced all CNA's, but will this coming Thursday. I in-serviced (name of CNA #1) by telling her over the phone to ensure proper hand placement while pushing a resident." She indicated she documented verification of the in-service in the investigation. An observation of Resident #3's entryway into her room was made with the DON on 3/18/14 at 1:35 p.m. The DON indicated adequate space was observed to safely maneuver Resident #3 into her room in her wheelchair. The DON placed the			

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	door 1/3 to 1/2 way shut. She indicated that was where CNA #1 indicated to her the door was positioned when the incident occurred. Regarding whether she thought Resident #3 would have been able to safely enter if the door had been opened more, the DON nodded her head. The 3/5/14 Verification Of Investigation was provided by the DON on 3/18/14 at 2:00 p.m. It indicated, "Provide a detailed description of event/allegation: (name of Resident #3) was being wheeled into her room, in wc (wheelchair), after supper by staff. Hand caught between wheel of w/c (symbol for "and") end of bed, causing large s/t (skin tear) to back of rt (right) hand...Resident Interview Summary: 'I, I, I, hurt it,' making sounds after that could not be understood...Causal/Contributing factors and observations: Poor safety awareness, grabs at wheels on wheelchair while being assisted with mobility in wheelchair. Thin fragile skin...Specify recommendations/interventions taken to prevent reoccurrence: Resident reminded to keep hands and arms in lap while being assisted with mobility in wheelchair, especially when			

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	entering or exiting narrow spaces...Witness Name: (name of CNA #1) Date: 3/5/14 Time: 07:15 Interview Summary: (Name of Resident #3) was by the Fireside Dining Room and asked me to push her back to her room after supper. I told (name of Resident #3) to let go of the wheel and to put her hand up on the arm of the wheelchair. Another resident asked me to help her to her room and I told her I would be right there. I started to push (name of Resident #3) into her room and the door was partially shut. I angled the wheelchair slightly so that I could open the door farther. (Name of Resident #3) said 'ouch, ouch'. I looked down as I asked her what was the matter and she said 'my hand.' (Name of Resident #3's) hand was between the foot of roommates bed and the wheel of the wheelchair. I saw her hand was bleeding and had a bad cut on it. I called for the nurse to come in right away and then started to wipe the blood from the bottom of her hand with a wipe, and then nurse came in. (Name of CNA #1) was reminded that when transporting a resident in the wheelchair to always ensure proper placement of hands away from wheels and into lap area for safety. Name of interviewer: (Name of DON)			

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	Date: 3/6/14 Time: 15:50." The Causal/Contributing Factors section did not indicate the door being partially shut as a factor, nor did the Interview Summary indicate CNA #1 was spoken to regarding ensuring a resident's door was open to ensure adequate space to maneuver. The 3/5/14 Emergency Department Note indicated, "Patient has a large V-shaped laceration with the apex of the skin flap denuded and very thin. The patient's extensor tendons are exposed, there are no obvious discontinuities. Patient's laceration is approximately 12-13 cm in length. Discussion of ED (emergency department) Course: I discussed the case with (Name of doctor), the hand surgeon at (name of hospital). He recommended approximating the wound is (sic) loosely as possible, placing a splint, and having the patient follow up in clinic for reevaluation. See the procedure note for wound closure, the wound was closed with as little tension as possible, however this was a difficult task given a portion of the wound it was missing, her thin skin, and the large size of the skin flap. Procedures Performed: 1. hand laceration repair --- 2% lidocaine used to anesthetize the area.			

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	Following this the wound was cleaned with saline. Multiple horizontal mattress sutures were placed with 3-0 nylon to get the large wound to come together. I had to remove the apex of the flap as it was nonviable and very thin. Following the mattress sutures, several interrupted simple 3-0 nylon sutures were placed to approximate the wound better. Unfortunately, I was unable to close the apex of the wound. I was able to approximate the rest of the wound, but this was under some pressure. He had to take fairly large bites for the mattress sutures. Following closure, a dressing was placed and a splint was placed to minimize movement of that hand...Additional Instructions: Keep the splint and dressing clean, dry, and in place until evaluated by hand surgery. Return for worsening symptoms, weakness, color changes of the fingers, or any other concerns. Follow up with hand surgery in 2-3 days, call to make an appointment." This deficiency was cited on January 30, 2014. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-45(a)(2)			

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