

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155264	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/27/2012
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-GOLDEN RULE	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 STRAIGHT LINE PIKE RICHMOND, IN 47374
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F0000	<p>This visit was for the Investigation of Complaint IN00116429.</p> <p>Complaint IN00116429 -- Substantiated. Deficiencies related to the allegations are cited at F223, F225 and F226.</p> <p>Survey dates: September 26 and 27, 2012</p> <p>Facility number: 000165 Provider number: 155264 AIM number: 100288220</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF/NF: 135 Total: 135</p> <p>Census payor type: Medicare: 18 Medicaid: 96 Other: 21 Total: 135</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October 3,</p>	F0000	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.	

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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	2012 by Bev Faulkner, RN			

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F0223 SS=D	<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. Based on interview and record review, the facility failed to ensure a resident was not subjected to verbal abuse by a staff member for 1 of 3 residents reviewed for abuse in a sample of 3. (Resident #C and CNA #1)</p> <p>Findings include:</p> <p>The clinical record of Resident #C was reviewed on 9-27-12 at 9:35 a.m. It indicated his diagnoses included, but were not limited to dementia with behaviors, paranoia, anxiety and depression. It indicated on 9-6-12, he had been re-admitted to the facility's advanced Alzheimer's unit after an extended stay at an area geriatric psychiatry facility related to self-harming behaviors.</p> <p>The Director of Nursing (DON) provided a copy of a verbal abuse investigation on 9-27-12 at 8:45 a.m., conducted by the facility earlier in the month. This investigation indicated Resident #C had</p>	F0223	<p>POC 97 Sept 2012 F223 SS=D</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice as follows:</p> <p>Resident # C was discharged from facility on 9/27/12.</p> <p>CNA#1 employment was terminated.</p> <p>Mandatory all staff in-service was held on 9/21/12, topic abuse, reporting abuse and timely notification of allegations of abuse. All staff signed acknowledgement of this training. Staff will be in-serviced every 6 months on requirements of timely notification and abuse.</p> <p>Other residents having the potential to be affected by the</p>	10/02/2012	

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	<p>been verbally abused by CNA #1 on 9-8-12 at approximately 6:00 a.m. It indicated CNA #2 "heard [name of CNA #1] scold [name of Resident #C], who resides on the advanced Alzheimer's unit...'Go to the kitchen and sit your a--down, I don't have time to follow your a-- all day.' [Name of CNA #1] stated she came into work in a bad mood with a lot of family issues going on." This document indicated the facility concluded CNA #1 did verbally abuse Resident #C. An "Employee Memorandum," dated 9-12-12, indicated CNA #1 was suspended on 9-10-12, pending an investigation for gross misconduct and was terminated upon the completion of the investigation on 9-12-12. In additional documentation associated with this document, it indicated CNA #1 was interviewed by the Assistant Director of Nursing and the Unit Manager of the advanced Alzheimer's unit on 9-10-12. It indicated CNA #1 did not deny the verbal abuse, but did indicate she may have used the term "butt" instead of "a--." It indicated she said, "I may have said it, just write me up...Oh, well." It indicated she demonstrated "...no remorse at all."</p> <p>In interview with CNA #2 on 9-27-12 at 1:51 p.m., she indicated she was concluding her nightshift on the advanced Alzheimer's unit on the morning of 9-8-12</p>		<p>alleged deficient practice will be identified and the corrective actions taken are as follows:</p> <p>CNA # 1's employment was terminated.</p> <p>Weekend RN Supervisor will check on compliance during weekend rounds.</p> <p>Mandatory all staff in-service was held on 9/21/12, topic abuse, reporting abuse and timely notification of allegations of abuse. All staff signed acknowledgement of this training. Staff will be in-serviced every 6 months on requirements of timely notification and abuse.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the corrective actions accomplished to prevent the alleged deficient practice from recurring:</p> <p>Deficient practice with be monitored monthly through QA&amp;A process.</p> <p>Appropriate employee discipline will be followed for failure to follow facility policy.</p>				

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	<p>at approximately 6:00 a.m. She indicated she had worked with Resident #C, who was being monitored on a one on one basis during the night as he had been up and awake most of the night. She indicated the resident was in his room, "messaging with things in his closet." She indicated the day shift CNA came to relieve her. She indicated CNA #1 was standing in the hallway at the resident's doorway when she heard her speak to the resident in a "kind of hateful [tone] for him to get his a-- down to the kitchen, that she didn't have time to follow his a-- around all day." She indicated she was uncertain of what to do, but did report the incident to LPN #1 immediately.</p> <p>The Administrator provided a copy of a facility policy entitled, "Protection from Abuse," on 9-26-12 at 11:50 a.m. This policy was identified as the current policy in use. This policy indicated, "All residents in the facility will be free from verbal, sexual, physical, or mental abuse, neglect, corporal punishment, and involuntary seclusion."</p> <p>This Federal tag relates to Complaint IN00116429.</p> <p>3.1-27(b)</p>		Weekend RN Supervisor will check on compliance during weekend rounds. Unit Supervisors will monitor compliance during weekdays.		

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the</p>	F0225				10/02/2012	

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	<p>facility failed to ensure a licensed nursing staff member immediately reported to the Administrator or designee an allegation of verbal abuse for 1 of 3 residents reviewed for abuse in a sample of 3. (Resident #C and LPN #1)</p> <p>Findings include:</p> <p>The clinical record of Resident #C was reviewed on 9-27-12 at 9:35 a.m. It indicated his diagnoses included, but were not limited to dementia with behaviors, paranoia, anxiety and depression. It indicated on 9-6-12, he had been re-admitted to the facility's advanced Alzheimer's unit after an extended stay at an area geriatric psychiatry facility related to self-harming behaviors. Additional documentation indicated he was returned to the area geriatric psychiatric facility on 9-8-12 at 4:20 p.m. for self-harming behaviors.</p> <p>The Director of Nursing (DON) provided a copy of a verbal abuse investigation on 9-27-12 at 8:45 a.m., conducted by the facility earlier in the month. This investigation indicated Resident #C had been verbally abused by CNA #1 on 9-8-12 at approximately 6:00 a.m. It indicated CNA #2 "heard [name of CNA #1] scold [name of Resident #C], who resides on the advanced Alzheimer's</p>		<p>F 225 SS=D</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice as as follows:</p> <p>CNA #1's employment was terminated.</p> <p>Resident # C was discharged from facility on 9/27/12. Mandatory all staff in-service was held on 9/21/12, topic abuse, reporting abuse and timely notification of allegations of abuse. All staff signed acknowledgement of this training. Staff will be in-serviced every 6 months on requirements of timely notification and abuse.</p> <p>Other residents having the potential to be affected by the alleged deficient practice will be identified and the corrective actions taken are as follows:</p> <p>CNA # 1's employment was terminated.</p> <p>Mandatory all staff in-service was held on 9/21/12, topic abuse, reporting abuse and timely notification of allegations of abuse. All staff signed acknowledgement</p>				

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	<p>unit...'Go to the kitchen and sit your a-down, I don't have time to follow your a- all day.' [Name of CNA #1] stated she came into work in a bad mood with a lot of family issues going on." This document indicated the facility concluded CNA #1 did verbally abuse Resident #C. An "Employee Memorandum," dated 9-12-12, indicated CNA #1 was suspended on 9-10-12, pending an investigation for gross misconduct and was terminated upon the completion of the investigation on 9-12-12. In additional documentation associated with this document, it indicated CNA #1 was interviewed by the Assistant Director of Nursing and the Unit Manager of the advanced Alzheimer's unit on 9-10-12. It indicated CNA #1 did not deny the verbal abuse, but did indicate she may have used the term "butt" instead of "a--." It indicated she said, "I may have said it, just write me up...Oh, well." It indicated she demonstrated "...no remorse at all."</p> <p>In interview with CNA #2 on 9-27-12 at 1:51 p.m., she indicated she was concluding her nightshift on the advanced Alzheimer's unit on the morning of 9-8-12 at approximately 6:00 a.m. She indicated she had worked with Resident #C, who was being monitored on a one on one basis during the night as he had been up and awake most of the night. She</p>		<p>of this training. Staff will be in-serviced every 6 months on requirements of timely notification and abuse.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the corrective actions accomplished to prevent the alleged deficient practice from recurring:</p> <p>Appropriate employee discipline will be followed for failure to follow facility policy.</p> <p>Deficient practice with be monitored monthly through QA&amp;A process.</p> <p>Weekend RN Supervisor will check on compliance during weekend rounds. Unit Supervisors will monitor compliance on weekdays.</p>				

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	<p>indicated the resident was in his room, "messing with things in his closet." She indicated the day shift CNA came to relieve her. She indicated CNA #1 was standing in the hallway at the resident's doorway when she heard her speak to the resident in a "kind of hateful [tone] for him to get his a-- down to the kitchen, that she didn't have time to follow his a-- around all day." She indicated she was uncertain of what to do, but did report the incident to LPN #1 immediately.</p> <p>In interview with the Director of the Alzheimer's Care Unit (DACU) on 9-27-12 at 10:10 a.m., she indicated the event of the verbal abuse with Resident #C occurred on the morning of 9-8-12, but was not reported to her, as the director of the unit, until the morning of 9-10-12. She indicated 9-8-12 was on a Saturday and she was not working until Monday, 9-10-12. She indicated the verbal abuse was reported by CNA #2 to LPN #1 on the morning that it occurred. She indicated LPN #1 informed CNA #2 that the event needed to be reported to the DACU. She indicated CNA #2 did leave her a written note, which she found on Monday morning when she arrived to work. She indicated at that time, when she was made aware of the verbal abuse allegation, CNA #1 was immediately suspended and the investigation was</p>			

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	<p>begun, including the notification of the Administrator and the DON.</p> <p>In review of the nursing work schedule for the advanced Alzheimer's unit, for September 8, 9 and 10, 2012, it indicated CNA #1 worked 6:00 a.m. to 2:00 p.m. on September 8 and 9; on September 10, it indicated she worked from 6:00 a.m. until she was escorted from the facility that morning.</p> <p>Review of LPN #1's employee personnel file indicated she was counseled on 9-10-12 and received a one day suspension for failure to follow the facility's abuse policy.</p> <p>The DON provided a fax confirmation form which indicated the initial report of the verbal abuse allegation was sent to the State agency, the Indiana State Department of Health (ISDH) on 9-10-12 at 5:28 p.m. This was more than 48 hours after the occurrence of the verbal abuse allegation, but less than 12 hours after the administrative team had been notified of the abuse allegation.</p> <p>The Administrator provided a copy of a facility policy entitled, "Protection from Abuse," on 9-26-12 at 11:50 a.m. This policy was identified as the current policy in use. This policy indicated, "All</p>				

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	<p>residents in the facility will be free from verbal, sexual, physical, or mental abuse, neglect, corporal punishment, and involuntary seclusion...All allegations of abuse will be reported immediately to the administrator or his/her designated representative." An accompanying document, entitled, "Reporting Alleged Violations," indicated, "Such violations are also reported to a state agencies in accordance with existing state law. If the suspected perpetrator is an associate,,,the ED places the associate on immediate investigatory suspension while completing the investigation." This document continued, "If the circumstances require it, the DNS or his/her designee removes a resident suspected of being the subject of an alleged violation to an environment where the resident safety can be protected...Any associate who suspects an alleged violation immediately notifies the ED or designee. The ED notifies the appropriate state agency in accordance with state law..."</p> <p>This Federal tag relates to Complaint IN00116429.</p> <p>3.1-28(a) 3.1-28(c)</p>						

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure a licensed staff nurse followed the facility policy regarding the reporting of an allegation of abuse to administration immediately and failed to protect other residents by not suspending the employee at the time of the allegation was reported to the licensed nurse for 1 of 3 residents reviewed for abuse in a sample of 3. (Resident #C, CNA #1 and LPN #1)</p> <p>Findings include:</p> <p>The clinical record of Resident #C was reviewed on 9-27-12 at 9:35 a.m. It indicated his diagnoses included, but were not limited to dementia with behaviors, paranoia, anxiety and depression. It indicated on 9-6-12, he had been re-admitted to the facility's advanced Alzheimer's unit after an extended stay at an area geriatric psychiatry facility related to self-harming behaviors. Additional documentation indicated he was returned to the area geriatric psychiatric facility on 9-8-12 at 4:20 p.m. for self-harming</p>	F0226	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice as follows: CNA #1's employment was terminated. Resident #C was discharged from facility on 9/27/12. Mandatory all staff in-services was held on 9/21/12, topic abuse, reporting abuse, and timely notification of allegations of abuse. All staff signed acknowledgement of this training. Staff will be inserviced every 6 months on requirements of timely notification and abuse. Other residents having the potential to be affected by the alleged deficient practice will be indentified and the corrective actions taken are as follows: CNA#1's employment was terminated. Mandatory all staff in-service was held on 9/21/12, topic abuse, reporting abuse, and timely notification of allegations of abuse. All staff signed acknowledgement of this training. Staff will be in-serviced every 6 monthson requirements of timely</p>	10/02/2012	

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	<p>behaviors.</p> <p>The Director of Nursing (DON) provided a copy of a verbal abuse investigation on 9-27-12 at 8:45 a.m., conducted by the facility earlier in the month. This investigation indicated Resident #C had been verbally abused by CNA #1 on 9-8-12 at approximately 6:00 a.m. It indicated CNA #2 "heard [name of CNA #1] scold [name of Resident #C], who resides on the advanced Alzheimer's unit...'Go to the kitchen and sit your a--down, I don't have time to follow your a-- all day.' [Name of CNA #1] stated she came into work in a bad mood with a lot of family issues going on." This document indicated the facility concluded CNA #1 did verbally abuse Resident #C. An "Employee Memorandum," dated 9-12-12, indicated CNA #1 was suspended on 9-10-12, pending an investigation for gross misconduct and was terminated upon the completion of the investigation on 9-12-12. In additional documentation associated with this document, it indicated CNA #1 was interviewed by the Assistant Director of Nursing and the Unit Manager of the advanced Alzheimer's unit on 9-10-12. It indicated CNA #1 did not deny the verbal abuse, but did indicate she may have used the term "butt" instead of "a--." It indicated she said, "I may have said it,</p>		<p>notification and abuse. These corrective actions will be monitored and a quality assurance program implemented to ensure the corrective actions accomplished to prevent the alleged deficient practice from recurring: Appropriate employee discipline will be followed for failure to follow facility policy. Deficient practice will be monitored monthly through QA&amp;A process. Weekend RN Supervisor will check on compliance during weekend rounds. Units Supervisors will monitor compliance during the weekdays.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155264		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2012	
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	<p>just write me up...Oh, well." It indicated she demonstrated "...no remorse at all."</p> <p>In interview with CNA #2 on 9-27-12 at 1:51 p.m., she indicated she was concluding her nightshift on the advanced Alzheimer's unit on the morning of 9-8-12 at approximately 6:00 a.m. She indicated she had worked with Resident #C, who was being monitored on a one on one basis during the night as he had been up and awake most of the night. She indicated the resident was in his room, "messaging with things in his closet." She indicated the day shift CNA came to relieve her. She indicated CNA #1 was standing in the hallway at the resident's doorway when she heard her speak to the resident in a "kind of hateful [tone] for him to get his a-- down to the kitchen, that she didn't have time to follow his a-- around all day." She indicated she was uncertain of what to do, but did report the incident to LPN #1 immediately.</p> <p>In interview with the Director of the Alzheimer's Care Unit (DACU) on 9-27-12 at 10:10 a.m., she indicated the event of the verbal abuse with Resident #C occurred on the morning of 9-8-12, but was not reported to her, as the director of the unit, until the morning of 9-10-12. She indicated 9-8-12 was on a Saturday and she was not working until Monday,</p>						

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	<p>9-10-12. She indicated the verbal abuse was reported by CNA #2 to LPN #1 on the morning that it occurred. She indicated LPN #1 informed CNA #2 that the event needed to be reported to the DACU. She indicated, "It was ridiculously misfortunate." She indicated nothing was done until she arrived for work on Monday morning. She indicated CNA #2 did leave her a written note, which she found on Monday morning when she arrived to work. She indicated at that time, when she was made aware of the verbal abuse allegation, CNA #1 was immediately suspended and the investigation was begun, including the notification of the Administrator and the DON.</p> <p>In review of the nursing work schedule for the advanced Alzheimer's unit, for September 8, 9 and 10, 2012, it indicated CNA #1 worked 6:00 a.m. to 2:00 p.m. on September 8 and 9; on September 10, it indicated she worked from 6:00 a.m. until she was escorted from the facility that morning.</p> <p>Review of LPN #1's employee personnel file indicated she was counseled on 9-10-12 and received a one day suspension for failure to follow the facility's abuse policy.</p>			

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	<p>The DON provided a fax confirmation form which indicated the initial report of the verbal abuse allegation was sent to the State agency, the Indiana State Department of Health (ISDH) on 9-10-12 at 5:28 p.m. This was more than 48 hours after the occurrence of the verbal abuse allegation, but less than 12 hours after the administrative team had been notified of the abuse allegation.</p> <p>In interview with the Administrator on 9-27-12 at 3:40 p.m., he indicated, "I just don't understand. We inservice and inservice on abuse. I just hate that this happened. Our residents deserved to be treated with only the utmost respect. We conduct mandatory inservices on abuse every six months and additional ones throughout the year if the need arises."</p> <p>The Administrator provided a copy of a facility policy entitled, "Protection from Abuse," on 9-26-12 at 11:50 a.m. This policy was identified as the current policy in use. This policy indicated, "All residents in the facility will be free from verbal, sexual, physical, or mental abuse, neglect, corporal punishment, and involuntary seclusion...All allegations of abuse will be reported immediately to the administrator or his/her designated representative." An accompanying document, entitled, "Reporting Alleged</p>				

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	<p>Violations," indicated, "Such violations are also reported to a state agencies in accordance with existing state law. If the suspected perpetrator is an associate,,the ED places the associate on immediate investigatory suspension while completing the investigation." This document continued, "If the circumstances require it, the DNS or his/her designee removes a resident suspected of being the subject of an alleged violation to an environment where the resident safety can be protected...Any associate who suspects an alleged violation immediately notifies the ED or designee. The ED notifies the appropriate state agency in accordance with state law..."</p> <p>This Federal tag relates to Complaint IN00116429.</p> <p>3.1-28(a)</p>			