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 07/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER- BROOKVIEW	7145 E 21ST ST INDIANAPOLIS, IN 46219

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F000000	This visit was for the Investigation of Complaint IN00152117. Complaint IN00152117 - Unsubstantiated due to lack of evidence. Unrelated deficiencies are cited. Survey dates: July 5, 7, and 8, 2014 Facility number: 000031 Provider number: 155076 AIM number: 100266150 Survey team: Chuck Stevenson, RN-TC Census bed type: SNF/NF: 111 Total: 111 Census payor type: Medicare: 5 Medicaid: 82 Other: 24 Total: 111 Sample: 4 This deficiency also reflects State findings cited in accordance with 410 IAC 16.2.3-1.	F000000		

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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	Quality review completed on July 10, 2014; by Kimberly Perigo, RN.			
F000224 SS=A	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure a resident (Resident #E) was protected from staff mistreatment when a staff member was observed slapping the resident on the forehead with her open palm for 1 of 4 residents reviewed for potential mistreatment. Findings include: The record of Resident #E was reviewed on 7/08/14 at 9:45 A.M. Diagnoses included, but were not limited to, Alzheimer's type dementia, undefined psychosis, depression, hypertension, and osteoporosis. A quarterly Minimum Data Set (M.D.S.)	F000224	**F224** It is the practice of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows**: Resident #E was provided with full skin assessment. No injury noted. Incident reported to ISDH. **How other residents having the potential to be affected by the same deficient practice identified and the corrective actions will be taken are as follows**:	07/14/2014

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	assessment dated 5/21/14, indicated Resident #E had unclear speech, was rarely or never understood, and rarely or never understood when spoken to. She was unable to complete a mental status interview and a staff interview of mental status indicated "Cognitive Skills for Daily Decision Making: Severely impaired." Resident #E required staff assistance for activities of daily living, ambulated with staff assistance, and was frequently incontinent of bowel and bladder. Health care plans for Resident #E included, but were not limited to, issues related to cognitive impairment and dementia, failure to understand staff and refusal of care, and difficulty making herself understood and understanding others. A facility "Incident Report Form" dated 7/07/14, and filed with the State Agency on that date indicated: "Incident Date: 7/02/14 Residents Involved: [Resident #E] Staff Involved: [C.N.A. #1] Brief description of incident: ACU [Alzheimer's Care Unit] Director		All residents who have had care provided for them by CNA #1 have the potential to be affected. CNA immediately suspended. CNA works only on the Alzheimer's Care Unit (ACU). All ACU residents given full skin assessments with no findings of injuries or concerns. ACU residents (who are interviewable) interviewed about care concerns with no findings of concern. Families of other ACU residents interviewed about care concerns with no findings. CNA #1 was terminated. **What measures will be put into place and the systemic changes will be made to ensure deficient practice does not recur are as follows:** Staff in-service on prevention and reporting of abuse and mistreatment completed. **How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:** The Director of Clinical Education and Director of Nursing Services will provide abuse and mistreatment in-services weekly x 4 weeks, every 2 weeks x 1 month. and monthly x 6 months. Findings will be presented to the monthly Quality Assurance/ Performance Improvement committee for further review and recommendations x 6 months. **By what date the systemic changes**	

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	received call on 7/7/14 at 2pm from resident [name of resident] daughter [name of daughter] stated she was visiting her mother on 7/2/14 and witnessed a CNA slap a resident on the forehead. ACU Director was able to determine that resident was [Resident #E] and CNA was [CNA #1]. Type of Injury/Injuries: No injury noted. Immediate action taken: CNA suspended immediately. MD, family notified. Full skin assessment performed on resident. ED [Executive Director] notified. Investigation initiated." A facility document received from the Executive Director on 7/08/14 at 9:30 A.M., and indicated to be a timeline of events related to the incident above indicated: "On 7-7-14 at 2pm ACU Director received call from family member...(she) stated that on 7-2-14 at around 7pm she was in visiting her mother...(she) stated that the adjoining bathroom door was cracked several inches and she went to close it. As she went to close it she looked in the room and saw a CNA [CNA #1] with a resident. At that moment (she) heard her [CNA #1] say, 'Stop acting like this,' and took her open		**will be completed is as follows:** 7/14/14 Requesting desk review paper compliance.	

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	hand and 'pop' it against the resident's [Resident #E] forehead..." The family member who reported the incident was interviewed by phone on 7/08/14 at 11:30 A.M. She indicated she had a clear view of the incident and was "sure" of what she saw, as represented in her report to the Director of the ACU. She indicated she heard no slap and saw no obvious signs of distress for Resident #E after the incident. She also indicated she saw no other behavior of concern from CNA #1. The Executive Director was interviewed on 7/08/14 at 8:45 A.M. He indicated the witness to the above incident had been consistent in reporting of the events. He indicated that when interviewed on 7/07/14, 5 days after the incident, CNA #1 was able to immediately recall and describe the incident, but denied slapping Resident #E. The Executive Director indicated that based on the facility's investigation to date that the incident likely happened as described by the witness, that CNA #1 would remain suspended and appropriate further disciplinary action would be pursued. The Director of the ACU was interviewed on 7/08/14 at 1:35 P.M. She indicated Resident #E had been assessed			

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	after the incident was reported with no signs of injury found and that Resident #E had exhibited no behavioral or mood changes or signs of distress. An undated facility policy titled "Employee Code of Conduct" received from the Executive director on 7/08/14 at 3:00 P.M. indicated: "Conduct with Patients: Our patients are the heart of our business. All patients must be treated with respect and dignity at all times...Treat patients professionally and with respect...Maintain a safe patient care environment at all times...Maintain at all times an atmosphere free from verbal, sexual, physical and mental abuse; corporal punishment; and involuntary seclusion." 3.1-28(a)			