

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 02/22/2016
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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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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00189522.</p> <p>Complaint IN00189522 -- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: February 18, 19 and 22, 2016</p> <p>Facility number: 000077 Provider number: 155157 AIM number: 100266490</p> <p>Census bed type: SNF/NF: 81 Total: 81</p> <p>Census payor type: Medicare: 14 Medicaid: 57 Other: 10 Total: 81</p> <p>Sample: 5</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<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>- <u>GoldenLiving of Richmond respectfully request a paper compliance.</u></p>	
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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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F 0225 SS=D Bldg. 00	<p>Quality review completed by 30576 on March 1, 2016.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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</p>			

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	<p>the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure staff immediately reported an allegation of sexual abuse to the Executive Director for 1 of 3 residents reviewed for sexual abuse in a sample of 5. (Resident #D)</p> <p>Findings include:</p> <p>In an interview with the Executive Director on 2-22-16 at 3:45 p.m., she indicated she learned of an allegation of abuse on 2-11-16 at 8:00 a.m. from the Speech Therapist who had been working with Resident #D at breakfast on that date. The resident had shared with the Speech Therapist that someone had attempted to rape her during the night.</p> <p>In interview with the Executive Director on 2-18-16 at 3:22 p.m., she indicated she had been informed of an allegation of abuse on 2-11-16 at approximately 8:00 a.m., although the allegation had taken place at approximately 1:00 a.m. on 2-11-16 when two staff members were attempting to assist Resident #D with cleaning her up after an incontinent episode of stool. She indicated the resident alleged the staff members were attempting to rape her. She indicated the</p>	F 0225	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>RN #1 and C.N.A. #2 both received counseling and reeducation on Preventing, investigating, and reporting alleged sexual assault and abuse violation.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken areas follows:</p> <p>Residents have been interviewed through guardian angel rounds for abuse violation, no indications have been noted.</p> <p>Staff were re-in-serviced on 3/4/16 (see attachment A) for Preventing, investigating and reporting alleged sexual assault and abuse violation.</p> <p>New staff will have education on Preventing, investigating, and reporting alleged sexual assault and abuse violation.</p>	03/23/2016

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	<p>staff members attributed her allegations to behavioral issues and not to an allegation of abuse. She indicated she addressed with both staff that even though they thought it was a behavior, it was expected for staff to recognize the resident was alleging abuse against both of them and it should have been handled like any other allegation of abuse. She indicated hospital records, from prior to admission to the facility, for Resident #D indicated she had made similar accusations toward staff with routine care in the recent past.</p> <p>In an interview with RN #1 on 2-18-16 at 7:18 p.m., she indicated she and CNA #2 were working with Resident #D on 2-11-16 around 1:00 a.m. She indicated CNA #2 "responded to her bell [for assistance]. Saw she was a mess with BM [bowel movement/stool] all the way up to mid back, all over the recliner, [the resident had] threw her brief that was clean with no BM, but laying by her, [with BM] all over her blanket. [Name of CNA #2] rang the call light to get me to help and I responded. When I got there, [we] attempted to walk with her to the bathroom. [We] explained what we were doing. She started screaming and calling us all kinds of names. Attempted to get her to let us wash her up, but she was hitting at us. I offered to let her do it</p>		<p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>ED and DNS or designee will monitor 24 hour reports, nurses notes, concern forms, guardian angel rounds and observations of staff and residents for any allegations of sexual assault and abuse violation. This monitoring will occur, 5 times per week for 4 weeks then 3 times per week for 4 weeks, then monthly thereafter. (See attachment B) Any concerns will be addressed as discovered.</p> <p>Any patterns or trends will be reported to monthly QA meeting for 6 months or until compliant, and appropriate plans will be written and implemented if indicated.</p>				

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	<p>her self, but she refused. Tried to speak softly to her, nothing seemed to help. She called us lesbians and told us we were trying to rape her because we were trying to remove her clothing. She wasn't yelling, but it was not a soft voice." She indicated she reported this at the beginning of the day shift to the nursing management. RN #1 indicated she was aware Resident #D had behaviors prior to admission here.</p> <p>In an interview with CNA #2 on 2-18-16 at 7:36 p.m., she indicated she had worked with Resident #D on 2-11-16. She indicated Resident #D had turned her call light on and she had answered it. "I stepped in her room and saw BM all over the recliner and brief thrown across the room. I stepped out to get [name of RN #1]. [Name of RN #1] very calmly started talking to her and explained we needed to get her cleaned up. BM was all the way up her back. She started yelling and not wanting to go get cleaned up. She wouldn't even sit down to start with on the toilet. [Name of RN #1] offered to let her clean herself up, but she wouldn't do that. We probably barely even got her half cleaned up. She started calling us f.....g lesbians and saying we were trying to rape her." CNA #2 continued, " We were told [by the facility's administration] that we both should have called the</p>			

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	<p>Executive Director and left the floor immediately.</p> <p>In review of the clinical record of Resident #D on 2-19-16 at 2:15 p.m., it indicated her diagnoses included, but were not limited to, unspecified psychoses, drug and alcohol addiction, diabetes, heart failure and viral hepatitis C. In review of records from a recent geriatric psychiatric stay, a notation, dated 10-3-15, denoted the resident became, "verbally aggressive with staff...exhibits rapid shifts of mood, at times becoming inappropriately flirtatious with male peers...suddenly yelled, 'FIRE!' She also accused staff of 'raping' her when trying to assist her with a shower." On 10-10-15, a notation indicated, "Today, earlier this morning, patient was fine. Voiced no complaints and then probably 15-20 minutes later, she was screaming, 'fire, rape,' just out of control for no reason. When asked why she is screaming, patient states, 'because no body is paying attention to her.' [sic]"</p> <p>In review of Resident #D's admission Minimum Data Set assessment, dated 2-13-16, it indicated she is cognitively intact with hearing and vision within normal limits and has the ability to understand and be understood. It indicated she is able to walk with</p>			

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	<p>supervision of two or more persons and requires extensive assistance of two or more persons with toileting needs, bathing and hygiene. Nursing notes reflected Resident #D was generally alert and oriented with periods of confusion.</p> <p>On 2-18-16 at 5:40 p.m., the Executive Director provided a copy of a policy entitled, "Preventing, Investigating and Reporting Alleged Sexual Assault and Abuse Violation." This policy was indicated to be the current policy utilized by the facility and had a creation date of 1-13-16. The policy indicated, "Policy Statement; It is the responsibility of all employees to immediately report any reasonable suspicion of a crime, alleged violation of abuse, neglect, injuries of unknown source and misappropriation of resident property...It is also the policy of this center to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property ('alleged violation") are reporting [sic] immediately to the Executive Director or Director of Nursing of the Living Center..."</p> <p>3.1-28(a) 3.1-28(c)</p>			

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F 0226 SS=D Bldg. 00	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 their policies and procedures regarding prompt reporting of allegations of abuse were implemented in regard to a delayed report of an allegation of abuse of one of three residents in a sample of five reviewed for sexual abuse by two staff members of the facility. (Resident #D)</p> <p>Findings include:</p> <p>In interview with the Executive Director on 2-18-16 at 3:22 p.m., she indicated she had been informed of an allegation of abuse on 2-11-16 at approximately 8:00 a.m. She indicated this allegation took place at approximately 1:00 a.m. on 2-11-16 when two staff members were attempting to assist Resident #D with cleaning her up after an incontinent episode of stool. She indicated the resident alleged the staff members were attempting to rape her. She indicated the staff members attributed her allegations to behavioral issues and not to an allegation of abuse. She indicated she</p>	F 0226	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>RN #1 and C.N.A. #1 received counseling and reeducation on Preventing, investigating and reporting alleged sexual assault and abuse violation.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken areas follows:</p> <p>Residents have been interviewed through guardian angel rounds for abuse violation, no indications have been noted.</p> <p>Staff were re in-serviced on 3/4/16 (See attachment A) For Preventing, investigating, and reporting alleged sexual assault and abuse violation.</p>	03/23/2016	

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	<p>learned of the allegation when she came in that morning. She indicated she addressed with both staff that even though they thought it was a behavior, it was expected for staff to recognize the resident was alleging abuse against both of them and it should have been handled like any other allegation of abuse. "They were both suspended, pending the outcome of the investigations. We were unable to substantiate any abuse. She indicated hospital records for Resident #D indicated she had made similar accusations toward staff with routine care during a hospitalization, prior to admission to the facility.</p> <p>In an interview with the Executive Director on 2-22-16 at 3:45 p.m., she clarified she learned of the allegation on 2-11-16 at 8:00 a.m. from the Speech Therapist who had been working with Resident #D at breakfast that morning. The resident had shared with the Speech Therapist that someone had attempted to rape her during the night.</p> <p>In an interview with RN #1 on 2-18-16 at 7:18 p.m., she indicated she and CNA #2 were working with Resident #D on 2-11-16 around 1:00 a.m. She indicated CNA #2 "responded to her bell [for assistance]. Saw she was a mess with BM [bowel movement/stool] all the way</p>		<p>New staff will have education on Preventing, investigating, and reporting alleged sexual assault and abuse violation.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>ED and DNS or designee will monitor 24 hour reports, nurses notes, concern forms, guardian angel rounds and observation of staff and residents for preventing, investigating and reporting alleged sexual assault and abuse violation. (See attachment B) This monitoring will occur, 5 times per week for 4 weeks, then 3 times per week for weeks thereafter. Any concerns will be addressed as discovered.</p> <p>Any patterns or trends will be reported to monthly QA meeting for 6 months or until compliant, and appropriate action plans will be written and implemented if indicated.</p>				

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	<p>up to mid back, all over the recliner, [the resident had] threw her brief that was clean with no BM, but laying by her, [with BM] all over her blanket. [Name of CNA #2] rang the call light to get me to help and I responded. When I got there, [we] attempted to walk with her to the bathroom. [We] explained what we were doing. She started screaming and calling us all kinds of names. Attempted to get her to let us wash her up, but she was hitting at us. I offered to let her do it her self, but she refused. Tried to speak softly to her, nothing seemed to help. She called us lesbians and told us we were trying to rape her because we were trying to remove her clothing. She wasn't yelling, but it was not a soft voice." She indicated she reported this at the beginning of the day shift to the nursing management. RN #1 indicated she was aware Resident #D had behaviors prior to admission here. She indicated after she had reported the event to the nursing management team, an investigation was initiated and she was suspended, pending the results of the investigation.</p> <p>In an interview with CNA #2 on 2-18-16 at 7:36 p.m., she indicated she had worked with Resident #D on 2-11-16. She indicated Resident #D had turned her call light on and she had answered it. "I stepped in her room and saw BM all over</p>			

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	<p>the recliner and brief thrown across the room. I stepped out to get [name of RN #1]. [Name of RN #1] very calmly started talking to her and explained we needed to get her cleaned up. BM was all the way up her back. She started yelling and not wanting to go get cleaned up. She wouldn't even sit down to start with on the toilet. [Name of RN #1] offered to let her clean herself up, but she wouldn't do that. We probably barely even got her half cleaned up. She started calling us f.....g lesbians and saying we were trying to rape her. " CNA #2 continued, " We were told [by the facility's administration] that we both should have called the Executive Director and left the floor immediately. I thought the nurses took care of all that, but we were told that both of us are responsible to make sure the Executive Director knows about any problems ASAP. "</p> <p>In review of the clinical record of Resident #D on 2-19-16 at 2:15 p.m., it indicated her diagnoses included, but were not limited to, unspecified psychoses, drug and alcohol addiction, diabetes, heart failure and viral hepatitis C. In review of records from a recent geriatric psychiatric stay, a notation, dated 10-3-15, denoted the resident became, "verbally aggressive with staff...exhibits rapid shifts of mood, at</p>						

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	<p>times becoming inappropriately flirtatious with male peers...suddenly yelled, 'FIRE!' She also accused staff of 'raping' her when trying to assist her with a shower." On 10-10-15, another notation indicated, "Today, earlier this morning, patient was fine. Voiced no complaints and then probably 15-20 minutes later, she was screaming, 'fire, rape,' just out of control for no reason. When asked why she is screaming, patient states, 'because no body is paying attention to her.' [sic]"</p> <p>In review of Resident #D's admission Minimum Data Set assessment, dated 2-13-16, it indicated she is cognitively intact with hearing and vision within normal limits and has the ability to understand and be understood. It indicated she is able to walk with supervision of two or more persons and requires extensive assistance of two or more persons with toileting needs, bathing and hygiene. Nursing notes reflected Resident #D was generally alert and oriented with periods of confusion.</p> <p>On 2-18-16 at 5:40 p.m., the Executive Director provided a copy of a policy entitled, "Preventing, Investigating and Reporting Alleged Sexual Assault and Abuse Violation." This policy was indicated to be the current policy utilized</p>			

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	<p>by the facility and had a creation date of 1-13-16. The policy indicated, "Policy Statement; It is the responsibility of all employees to immediately report any reasonable suspicion of a crime, alleged violation of abuse, neglect, injuries of unknown source and misappropriation of resident property...It is also the policy of this center to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property ('alleged violation") are reporting [sic] immediately to the Executive Director or Director of Nursing of the Living Center..."</p> <p>3.1-28(a) 3.1-28(c)</p>			