

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/21/2013
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
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F000000	<p>This visit was for the Investigation of Complaint IN00134141.</p> <p>Complaint IN00134141 - Substantiated, Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: August 20 and 21, 2013</p> <p>Facility number: 000411 Provider number: 155384 AIM number: 100275100</p> <p>Survey team: Anne Marie Crays RN TC Anna Villain (August 20, 2013)</p> <p>Census bed type: SNF/NF: 77 Total: 77</p> <p>Census payor type: Medicare: 9 Medicaid: 54 Other: 14 Total: 77</p>	F000000	Please accept this as our credible plan of correction for the survey event IN00134141. Preparation and submssion of this plan of correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this plan of correction solely as a requirement under State and Federal Law that mandates a submission of a plan of correction as a condition to participate in Title 18 and Title 19 Programs. The facility is respectfully requesting a paper compliance related to this survey.	

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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	<p>Sample: 6</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 22, 2013, by Jodi Meyer, RN</p>			

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F000323 SS=D	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure either a mechanical lift, gait belt, or 2 person assist was used in transferring a dependent resident, resulting in an unsafe transfer and 2 large skin tears, for 1 of 3 residents reviewed with skin tears and bruising, in a sample of 6. Resident A</p> <p>Findings include:</p> <p>1. On 8/20/13 at 10:30 A.M., during interview with LPN # 1, she indicated Resident A was being treated for skin tears on her arms.</p> <p>On 8/20/13 at 10:40 A.M., Resident A was observed sitting in her wheelchair in her room. Both arms were wrapped with a Kerlix guaze wrap. LPN # 1 indicated at that time that the resident's skin tears were treated with bacitracin ointment and a telfa dressing. LPN # 1 unwrapped the kerlix, and a long, open, scratch-like area was observed on the resident's</p>	F000323	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident A was reassessed for transfer assistance. Resident A's care plan, lift assessment, orders and CNA assignment sheets were revised to reflect changes related to her transfer needs. Her transfers will be audited/monitored daily x 2 months, then 3 x a week for 2 months, 2 times a week for one month and 1x a week for one month. 2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by the alleged deficient practice. All new admissions and current residents at the facility will be assessed/reassessed for transfer assistance needs. Their care plans, lift assessments, orders, and CNA assignment sheets will be revised to reflect changes. Random audits will be performed on resident transfers daily x 2 months, 3 x a week x 2 months, 2x a week for one month</p>	09/20/2013			

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	<p>left arm, with 3 steri strips intact. The lower right arm also had an open scratch-like area, with 4 steri strips intact. Resident A indicated at that time that she "didn't know what happened."</p> <p>On 8/20/13 at 11:25 A.M., the Administrator provided an "Unusual Occurrence Report," undated, regarding Resident A. The report included: "...Incident Date: August 6, 2013 @ 1:30 p.m. Resident Involved [Resident A]...Staff Involved, [CNA # 1]...Description of Incident, As CNA was transferring resident from wheelchair to bedside commode, resident started to fall. CNA was trying to keep resident from falling by holding her up and transferring her to bed. Resident received two skin tears, the skin tear on the right arm measured 5.4 cm x 3.2 centimeters and the skin tear on the left arm measured 10.1 by 2.1 centimeters...Resident was assessed for two person assist and non skid socks while out of bed. Care plan will be updated...Resident was a one person assist and has been assessed for two person assist. Resident was admitted to the facility...and had many bruises on her arms and legs. The skin tears followed the bruising on her arms."</p>		<p>and one time a week for a month. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Inservicing for nursing staff on safe patient transfers will be completed with demonstration and emphasis on gait belt use when performing manual transfers. All CNAs will be given a new gait belt and random audits will be performed on resident transfers daily x 2 months, 3 x a week x 2 months, 2x a week for one month and one time a week for a month. 4. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Audit sheets, changes and revisions made to resident transfer needs will be reviewed/discussed in the monthly Quality Assurance Process Improvement meetings monthly times six months or until no further interventions are needed thereafter. 5. By what date will the systemic changes be completed? Systemic changes will be completed by September 20, 2013.</p>		

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	<p>The clinical record of Resident A was reviewed on 8/20/13 at 11:30 A.M.</p> <p>A "Lift Mobility Status Form," dated 7/29/13, included: "To be completed on residents requiring more than limited assist with transfers...Lift required, Sara 3000...May transfer [with] 1 or 2 assist or use Sara lift."</p> <p>A Physical Therapy Plan of Care, dated 8/1/13, included: "...Reason for Referral: (Functional Decline)...presents with a decline doing functional transfers, and functional mobility such as bed mobility and getting up from bed due to B LE [bilateral lower extremity] weakness, deficits in activity tolerance, and decreased ability to follow instructions due to confusion...Therapy necessary for increase [sic] muscle strength of both LE, improve patient's ability to perform bed mobility and getting up from bed and eventually able to perform transfers and ambulation with decrease level of assistance and difficulty. Without therapy patient at risk for further decline, bedsores and respiratory compromise when confined in bed...Current level of function, The patient is able to transfer sit&lt;-&gt;stand requiring MAX</p>			

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	<p>assist..."</p> <p>A Minimum Data Set (MDS) assessment, dated 8/2/13, indicated Resident A scored 8 out of 15 for cognition, with 15 indicating no memory impairment. The MDS assessment indicated the resident required extensive assistance of two staff for bed mobility and transfer ("how resident moves between surfaces including to or from: bed, chair, wheelchair....), and did not ambulate.</p> <p>Progress Notes included the following notations:</p> <p>8/2/13 at 2:18 P.M.: "...Transfers with two assist or use of sara lift [mechanical lift]...OT and PT work with her due to weakness of extremities, needs ext. [extensive] assist with transfers...."</p> <p>8/4/13 at 3:08 P.M.: "...Two assist with transfer, is able to bear weight to both extremities needs cueing...."</p> <p>8/4/13 at 11:13 P.M.: "...Transferred with 2 assist to toilet and recliner. Noted to be very weak and leaning forward...."</p> <p>8/5/13 at 9:51 A.M.: "...Appears to be</p>			

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	<p>very weak and leaning forward...Therapy provided for lower extremity weakness. Extensive assist with transfers...."</p> <p>8/6/13 at 1:57 P.M.: "Resident received skin tears to right and left forearms. May we have an order for Steri-strips, nonadhesive gauze, bacitracin, and kerlex [sic] applied to bilat. tears. Background: Significant bruising on forearms present prior to skin tears. Assessment: Left forearm tear measures 10.1 cm x 2.1 cm x 0 cm. Right forearm tear measures 5.4 cm x 3.2 cm x 0 cm...."</p> <p>8/6/13 at 6:22 P.M.: "The aide was laying down the resident after lunch. I went to see if she needed help...the resident was flat on her back crossways in the bed...When I went to sit her up, I noticed blood, then noticed that where the resident had already had bruising on her forearms, the skin had been torn and was bleeding...."</p> <p>A care plan, dated 7/29/13 and revised 8/6/13, indicated, "Focus, Risk for fall-related injury r/t [related to] new environment, confusion, and weakness." The Interventions included: "Transfer with 2 assist or use Sara lift." The word "May" was</p>			

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	<p>handwritten in front of "Transfer," and "1 or" was written in front of "2 assist," and was undated. A notation indicated, "D/C [discontinue] 8/6/13" was written by this intervention, and a new intervention indicated: "8/6/13 Transfer [with] Sara lift et [and] 2 assist."</p> <p>An additional care plan, dated 8/5/13, indicated, "Focus, ADL [activities of daily living] deficit r/t weakness." The Interventions included: "Requires extensive assist with bed mobility, transfers, locomotion...is non-ambulatory at this time."</p> <p>On 8/21/13 at 8:50 A.M., during interview with RN # 1, she indicated she was the nurse working when Resident A acquired the skin tears. She indicated she was not in the room, and so did not know what happened. She indicated the resident was in the dining room, and needed to go to the bathroom, and so CNA # 1 took her out of the dining room. She indicated she heard an alarm, and when she entered the resident's room, CNA # 1 informed her that she was transferring Resident A from the wheelchair to the bed, Resident A got weak, so she sat her back in the chair. RN # 1 indicated when she saw Resident A, the resident was already</p>			

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	<p>in the bed, and she "saw the blood on her arms and panicked," and could not remember if the CNA told her how the resident obtained the skin tears. RN # 1 indicated she supposed CNA # 1 thought she could transfer the resident herself. RN # 1 indicated CNA # 1 was no longer employed at the facility.</p> <p>On 8/21/13 at 10:30 A.M., during interview with the Director of Nursing (DON), she indicated Resident A's skin tears may have been caused by CNA # 1's fingernails. She indicated she did not know if the CNA was wearing jewelry. The DON indicated CNA # 1 was no longer employed at the facility.</p> <p>On 8/21/13 at 11:00 A.M., during interview with the DON, she indicated she did not think Resident A was assessed for the use of a gait belt at that time, and that the facility does not routinely use gait belts on all of the residents. She indicated that a "Lift Mobility Status Form" was filled out by the admitting nurse, and was revised on 8/6/13.</p> <p>2. On 8/21/13 at 11:00 A.M., the DON provided the current facility policy on "Safe Patient Handling," revised 2013. The policy provided was a</p>			

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	<p>worksheet, which included: "Admit&gt;Completes Clinical Health Status&gt;If requires more than limited assist with transfers and mobility complete...&gt;'Lift Mobility Status Form'&gt;Complete CNA Assignment sheet...&gt;Nurse periodically checks for accuracy to assure assignment sheet matches what is observed...."</p> <p>This Federal tag relates to Complaint IN00134141.</p> <p>3.1-45(a)(2)</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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