ENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155264	B. WING		08/10/2022
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	-
		E - GOLDEN RULE CARE CENTI		TRAIGHT LINE PIKE IOND, IN 47374	
DRICKT		E - GOLDEN ROLE CARE CENTI		UND, 11 47374	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
- 0000					
Bldg. 00					
Blug. 00	This visit was for t	he Investigation of Complaint	F 0000	Preparation, submission and	
	IN00387070.	ne investigation of complaint	F 0000	implementation of this Plan o	f
	1100507070.			Correction does not constitut	
	Complaint IN0038	7070 - Substantiated.		admission or agreement with	
	•	iencies related to the		facts and conclusions set for	
		d at F-557 & F-689.		the survey report. Our Plan o	
				Correction was prepared and	
	Survey dates: Aug	ust 9 & 10 2022		executed as a means to	
				continuously improve the qua	litv of
	Facility number: 0	00165		care and comply with all	5
	Provider number:			applicable federal and state	
	AIM number: 1002	288220		requirements.	
	Census Bed Type:			The facility respectfully reque	sts a
	SNF/NF: 87			desk review of our responses	
	Total: 87			this survey.	
	Census Payor Type	a.			
	Medicare: 6				
	Medicaid: 66				
	Other: 15				
	Total: 87				
		reflect State Findings cited in			
	accordance with 41	IU IAC 16.2-3.1.			
	Quality review cor	npleted on Aug 17, 2022			
- 0557	483.10(e)(2)				
SS=D		Right to have Prsnl Property			
Bldg. 00	§483.10(e) Resp	•			
g. 00		a right to be treated with			
	respect and digni	-			
		e right to retain and use			
	personal possess	sions, including furnishings,			
	and alotted	space permits, unless to do			

PRINTED:

09/08/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155264	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 08/10/2022	
	PROVIDER OR SUPPLIE	R E - GOLDEN RULE CARE CENT	ER	2330 S	ADDRESS, CITY, STATE, ZIP COD STRAIGHT LINE PIKE 10ND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
	so would infringe and safety of othe Based on interview failed to provide d verbalizing the ina was directed to tra assistance resulting reviewed for abuse Finding include: Review of the reco 11:10 a.m., indicat included, but were disease, osteoarthr obstructive pulmon heart disease, perind dementia with Lew post traumatic stre The Admission Mi Resident B, dated cognitively intact for resident is consister resident required e person to transfer, standing was not s with staff assistant The post fall evalut 6/28/22 at 4:20 a.m witnessed fall in th self on the floor. T falls prior to admis injury from the fall The progress note 4:35 a.m., indicate assisted by a CNA	upon the rights or health er residents. v and record review the facility ignity for a resident that was bility to assist with transferring, nsfer by staff with no additional g in a fall for 1 of 3 residents e (Resident B). ord of Resident B on 8/9/22 at ed the resident's diagnoses not limited to, Huntington's itis of the right knee, chronic nary disease, hypertensive obteral vascular disease, vy bodies, depressive disorder, ss disorder and repeated falls. inimum Data Set (MDS) for 6/27/22, the resident was for daily decision making, the ent and reasonable. The xtensive assistance of one balance moving from seated to teady and only able to stabilize exe. ation for Resident B, dated n., indicated the resident had a the bathroom. The resident sat he resident had a history of ssion at home. There was no	F 0.		F 577 (D) Respect, Dignity/Ri to have Personal Property What corrective actions will accomplished for those residents found to have been affected by the deficient practice? Resident B: no longer resides the facility CNA1: received 1:1 educated Resident Rights and Dignity to include but not limited to follow the residents plan of care, transfers and providing care a services as needed. How other residents having to potential to be affected by the same deficient practice will to identified and what corrective action will be taken Residents that require assista with transfer have the potential be affected by the same allege deficient practice. Initial audit: The facility comple an audit of all residents that, p MDS, require assistance with transfers to ensure their plan of care and Kardex reflect the leve assistance needed. What measures will be put in place and what systemic changes will be made to	be h at d on o wing ind the be re nce al to ed ber of vel of	09/02/202

	R MEDICARE & MEDIONT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPL	ETED
		155264	B. WING	<u></u>	08/10/2022	
JAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
BRICKY	ARD HEALTHCAR	E - GOLDEN RULE CARE CEN		STRAIGHT LINE PIKE 10ND, IN 47374		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
REFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	-	e CNA assisted the resident by		ensure that the deficient		
		der the resident's arm to help		practice does not recur		
		esident resident sat herself on		Education		
	the floor. Writer as	sked the resident if she fell and		Clinical staff were educate	d on	
	the resident stated	"no" that she had sat on the		Resident Rights and Dignit	y to	
		ight leg did not work properly.		include but not limited to for	ollowing	
		ated she was at the facility for		the residents plan of care,		
	nursing staff to tak	e 100% total care of her. The		transfers and providing car	e and	
	resident indicated	she would try to assist the		services as needed.		
	nurse and CNA to	a standing position off the				
	floor. The resident	then walked to the bed and		On-going monitoring		
	climbed into the be	ed with no issues observed. The		The DNS or designee will of		
	resident then stated	d she was going to talk to		5 transfers a week to ensu	re staff	
	someone about her	complaint of staff telling her		are providing dignity and		
	needed to help and	use her legs when standing.		assistance per the plan of		
	The nurse offered	the resident a grievance form		care/Kardex. These review	rs to be	
	and the resident de	clined. The resident did accept		conducted 5 times weekly	x 4	
	assistance from the	e nurse and CNA, but stated		weeks, then 3 times week	y x 4	
	she was still upset	and was going to speak with		weeks, then weekly x 4 mc	onths.	
	someone later toda	y about not receiving total				
		entioned the CNA was just		The ED or designee will		
	trying to make sur	e she understood that we are		interview/observe 10 reside	ents a	
		the resident could do as much		week to ensure staff are pr	oviding	
	for herself as possi	ble in a safe manner.		services and assistance wi	ith	
				dignity per the plan of		
	-	t for Resident B, dated 6/28/22		care/Kardex. These review	s to be	
	at 10:30 a.m., indi	cated the resident reported that		conducted 5 times weekly,	for a	
		peak to someone about		total of 10 residents, times	4	
	e e	. The resident states that while		weeks. Then 3 times week	ly, for a	
		et, CNA grabbed her by the		total of 6 residents, times 4	Ļ	
		ed her "forcibly" off the toilet,		weeks. Then weekly, for a	total of	
		ere was no counting no		2 residents, times 4 month	S.	
		grabbed the resident and				
	-	nt indicated if her body would		How the corrective action	will	
	not have turned sh	e would have hit her face on		be monitored to ensure the	ne	
	the wall. The resid	ent indicated the CNA stood		deficient practice will not		
	there telling her the	at she needed to do things for		recur, i.e., what quality		
	herself and that the	e was resident was fully able to		assurance program will b	e put	
	do more then what	she was doing. The resident		into place		
	indicated the falt f	he CNA did not want to care for				1

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 3 of 12

PRINTED: 09/08/2022 FORM APPROVED

Event ID: ZQ2411 Facility ID: 000165

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155264	(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 08/10/2022	
	PROVIDER OR SUPPLIE	R E - GOLDEN RULE CARE CEN	2330	t address, city, state, zip co STRAIGHT LINE PIKE MOND, IN 47374	OD	
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETIC DATE
	her and that the resident she required help. of deep purple disc located on the upp prior to the incident her body twisted a slid down the wall indicated the CNA falling and that the wrong. The resident give people the be the CNA to provid left to get assistant the floor. The skin assessme at 2:11 p.m., indic on the right inner a measured 4 centim During an intervie p.m., indicated she 6/28/22 when she indicated when she the toilet the resident force to assist her full force, the CNA arm like she alway the CNA to use he the resident she co 1 told the resident knees. The resident then sat on the floo like she could safe the resident was at admission she cou herself. CNA 1 inco belt with Resident	sident bothered the CNA when The resident stated that an area coloration with reddish edges er right deltoid was not present nt. The resident indicated once nd in a standing position she to the floor. The resident to the floor. The resident to the floor. The resident for c CNA did not do anything int told the CNA she tried to nefit of doubt, but did not want de care to her longer. The CNA ce due to the resident being on nt for Resident B, dated 6/28/22 ated the resident had bruising aspect of her deltoid that heters (cm) by 2.4 cm. w with CNA 1 on 8/9/22 at 5:57 e was caring for Resident B on fell getting off the toilet. CNA 1 e went to stand the resident off ent told the CNA to use her full up and the CNA did not use her A "just lifted her up under her as did" The resident indicated for r full force and the CNA told uld not use her full force. CNA to try and stand and to use her t stood up with the CNA and or. CNA 1 indicated she did feel ly care for Resident B and when the facility in 2021 on her first ld go to the bathroom by licated she did not use a gait B because she had asked other ld her that did not use a gait		Results of these audits brought to QAPI month months to identify trend make recommendation issues/trends are ident will continue audits bas QAPI recommendation noted, then will comple based on a prn basis.	ly x 6 ds and to s. If ified, then sed on . If none	

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155264	ì í	JILDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/10/2022	
	PROVIDER OR SUPPLIE	BR E - GOLDEN RULE CARE CENT	TER	2330 S ⁻	ADDRESS, CITY, STATE, ZIP TRAIGHT LINE PIKE OND, IN 47374	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	member on 8/10/2 Resident B did no off the toilet and h also had a lot of re- reported to the fam 1 to assist her to th was at the facility resident she had h herself. The reside would tell my bod to the bathroom. T 4:30 a.m., CNA 1 take herself to the her she could not. bathroom, when th the toilet CNA 1 g pulled the resident resident falling to incontinent brief v the resident's botto felt like CNA did and the resident w incident. The fami Administrator the voicemail about th for the resident ag During an intervie Director on 8/10/2 Resident B had co felt like CNA 1, but v at the facility. The check on the resident	w with the Social Service 22 at 12:10 p.m., indicated encerns with CNA 1. Resident B as rude, disrespectful and rough red her off the toilet and she 2. Resident B was not happy vas happy with everything else e Social Service Director would ent often. The Social Service Resident B did not use the					

AND PLAN OF CORRECTION IDENTIF		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155264			(X3) DATE SURVEY COMPLETED 08/10/2022	
	PROVIDER OR SUPPLIE	R E - GOLDEN RULE CARE CENT	STREET 2330 S TER RICHM	DD		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN LL PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED T		RECTION IOULD BE PPROPRIATE	(X5) COMPLETIC DATE
	 12:38 p.m., indica help her go to the gait belt or the resist the resident's arm bathroom. When t restroom the reside get up, CNA 1 starneeded to do more told her she could indicated she start and the CNA jerket three. The resident face on the wall ar was going down to leaving a bruise on fell anyway. The r incontinence brief nightgown was ab indicated CNA 1 wto her. The resider upset her to this dare ported the incided Director. During an interviet 8/10/22 at 3:20 p.r concluded after im Resident B and CN was poor custome and there was no a CNA 1 with custo incident. The Adm resident said they 	w with Resident B on 8/10/22 at ted on 6/28/22, she had CNA 1 to pathroom. CNA 1 did not use a dent's walker. CNA 1 held onto when she walked with her to the ne resident was done using the ent asked CNA 1 to help her to ted "gripping" that the resident for herself and the resident not do it. The resident ed counting to three to get up d her up before she could get to indicated she almost hit her d CNA 1 grabbed her as she prevent her from falling her right arm, but the resident esident indicated her was around her knees and her ove her breast. The resident vas disrespectful to her and rude t indicated the incident still ty. Resident B indicated she nut to the Administrator, ag and the Social Service w with the Administrator on n., indicated the facility vestigating the incident with VA 1 on 6/28/22 that the incident eservice provided by CNA 1 buse. The facility provided mer service training after the inistrator reminded CNA 1 if a could not do something then o go get more assistance from per.				
	The resident rights	policy provided by the				

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155264	(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 08/10/2022	
	ROVIDER OR SUPPLIE	R E - GOLDEN RULE CARE CENT	2330	I ADDRESS, CITY, STATE, ZIP COD STRAIGHT LINE PIKE MOND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION 3/10/22 at 3:00 p.m., indicated	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
⁻ 0689 SS=D Bldg. 00	the resident had the dignity and respect This Federal tag ref 3.1-3(t) 483.25(d)(1)(2) Free of Accident Hazards/Supervis §483.25(d) Accid The facility must §483.25(d)(1) The remains as free of possible; and §483.25(d)(2)Ead adequate supervise failed to safely trans walker, assist of two plan of care with a further falls after the residents reviewed Finding include: Review of the recons 11:10 a.m., indicatt included, but were disease, osteoarther obstructive pulmon heart disease, pering dementia with Lew	e right to be treated with t. lates to Complaint IN00387070. sion/Devices ents. ensure that - e resident environment of accident hazards as is ch resident receives ision and assistance devices	F 0689	F 689 (D) Free of Accidents Hazards/Supervision/Devices What corrective actions will I accomplished for those residents found to have beer affected by the deficient practice? Resident B: no longer resides the facility CNA1: received 1:1 educated Resident Rights and Dignity to include but not limited to follow the residents plan of care, transfers and providing care a services as needed. How other residents having f	at on ving nd	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155264	(X2) MULTIPLE C A. BUILDING B. WING	<u>00</u>	x3) date survey completed 08/10/2022
	PROVIDER OR SUPPLIE	R E - GOLDEN RULE CARE CENTI	2330 \$	ADDRESS, CITY, STATE, ZIP COD STRAIGHT LINE PIKE MOND, IN 47374	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIO
TAG	falling.	R LSC IDENTIFYING INFORMATION	TAG	identified and what corrective	
	8			action will be taken	
	The fall care plan f	For Resident B, dated 6/21/22,			
	-	ent was at risk for falls related		Residents that require assistant	ce
	to the resident had	fell in the last 30 days, history		with transfer have the potential	
		onment, epilepsy, pain,		be affected by the same alleged	
		ded assist with transfers and		deficient practice.	
		ventions included, but were not			
	limited to, gait belt	with transfers. There were no		Initial audit: The facility complet	ed
	interventions imple	emented after the resident fell		an audit of all residents that, pe	
	on 6/28/22.			MDS, require assistance with	
				transfers to ensure their plan of	
	The plan of care fo	r Resident B, dated 6/21/22,		care and Kardex reflect the leve	el of
	indicated the reside	ent had physical functioning		assistance needed.	
	deficit. The interve	entions included, but were not			
	limited to, toileting	g assistance of two people and		What measures will be put into	o
	transfer assistance	of two people.		place and what systemic	
				changes will be made to	
		nimum Data Set (MDS) for		ensure that the deficient	
		5/27/22, the resident was		practice does not recur	
		or daily decision making, the		Education	
		nt and reasonable. The		Clinical staff were educated on	
	-	xtensive assistance of one		Resident Rights and Dignity to	
		s, balance moving from seated		include but not limited to followi	ng
		t steady and only able to		the residents plan of care,	
		assistance. The resident		transfers and providing care and	d
	•	assistance of one person to		services as needed.	
		om. The resident required			
		e of one person for toileting.		On-going monitoring	
		ed a walker and wheelchair for		The DNS or designee will obser	
		lent had a history of falls prior		10 staff assisted transfers a we	
		facility. The resident had a fall ure within the last six months		to include all shifts to ensure sta	
	prior to admission.			are providing dignity and assistance per the plan of	
	prior to admission.			care/Kardex. These reviews to	he
	The nost fall evaluation	ation for Resident B, dated		conducted 5 times weekly, for a	
	-	n., indicated the resident had a		total of 10 residents, times 4	
		e bathroom. The resident sat		weeks. Then 3 times weekly, fo	ra
		he resident had a history of		total of 6 residents, times 4	14
		sion at home. There was no		weeks. Then weekly, for a total	of
	fails prior to admis	sion at nome. There was no		weeks. Then weekly, for a total	

Event ID: ZQ2411 Facility ID: 000165

If continuation sheet Page 8 of 12

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155264	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/10/2022
	PROVIDER OR SUPPLIE	R E - GOLDEN RULE CARE CENT	2330 S	ADDRESS, CITY, STATE, ZIP COD TRAIGHT LINE PIKE IOND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C injury from the fall The progress note 4:35 a.m., indicate assisted by a CNA resident told the C the resident up. Th placing her arm un her stand and the r the floor. Writer at the resident stated floor and that her r The resident indic nursing staff to tak resident indicated	for Resident B, dated 6/28/22 at d the resident was being in the restroom and the NA that she would have to help the CNA assisted the resident by oder the resident's arm to help resident resident sat herself on sked the resident if she fell and "no" that she had sat on the right leg did not work properly. ated she was at the facility for the 100% total care of her. The she would try to assist the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 2 residents, times 4 months. How the corrective action wi be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be p into place Results of these audits will be brought to QAPI monthly x 6 months to identify trends and t make recommendations. If issues/trends are identified, th will continue audits based on	DATE II ut to en
	floor. The resident climbed into the b resident then state someone about he needed to help and The nurse offered and the resident de assistance from the she was still upset someone later toda care. The nurse me trying to make sure here to make sure	a standing position off the then walked to the bed and ed with no issues observed. The d she was going to talk to r complaint of staff telling her l use her legs when standing. the resident a grievance form eclined. The resident did accept e nurse and CNA, but stated and was going to speak with ay about not receiving total entioned the CNA was just e she understood that we are the resident could do as much ible in a safe manner.		QAPI recommendation. If nor noted, then will complete audi based on a prn basis.	
	at 10:30 a.m., indi she would like to s concerning a CNA getting off the toil right arm and pull resident stated, "th warning" she just	t for Resident B, dated 6/28/22 cated the resident reported that speak to someone about The resident states that while et, CNA grabbed her by the ed her "forcibly" off the toilet, here was no counting no grabbed the resident and nt indicated if her body would			

TERS FO	R MEDICARE & MEDIC	AID SERVICES		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 08/10/2022	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155264	A. I					
	PROVIDER OR SUPPLIER	GOLDEN RULE CARE CEN	TER	2330 S	ADDRESS, CITY, STATE, ZIP TRAIGHT LINE PIKE OND, IN 47374	COD		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAY PREFIX (EACH CORRECTIVE A (EACH CORRECTIVE A		SHOULD BE	(X5) COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE	
		would have hit her face on						
		nt indicated the CNA stood						
		t she needed to do things for						
	-	was resident was fully able to						
		she was doing. The resident						
		e CNA did not want to care for						
		dent bothered the CNA when						
		The resident stated that an area						
		oloration with reddish edges						
		-						
		r right deltoid was not present						
	-	d in a standing position she						
		to the floor. The resident						
		then blamed the resident for						
		CNA did not do anything						
		t told the CNA she tried to						
		efit of doubt, but did not want						
	_	care to her longer. The CNA						
		e due to the resident being on						
	the floor.							
	The skin assessmen	t for Resident B, dated 6/28/22						
		ted the resident had bruising						
		spect of her deltoid that						
		eters (cm) by 2.4 cm.						
	During an interview	with CNA 1 on 8/9/22 at 5:57						
		was caring for Resident B on						
	6/28/22 when she fe	ell getting off the toilet. CNA 1						
		went to stand the resident off						
	the toilet the resider	nt told the CNA to use her full						
	force to assist her u	p and the CNA did not use her						
		"just lifted her up under her						
	arm like she always	did" The resident indicated for						
		full force and the CNA told						
		ld not use her full force. CNA						
		o try and stand and to use her						
		stood up with the CNA and						
		r. CNA 1 indicated she did not						
		Resident B because she had						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155264	(X2) MULTIPLI A. BUILDINC B. WING	e construction G <u>00</u>	COMPLETE 08/10/202	
	PROVIDER OR SUPPLIE	E - GOLDEN RULE CARE CEN	2330	et address, city, stat 0 STRAIGHT LINE P HMOND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLA	AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	Z (EACH CORRECTIVE		COMPLETIC
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFIC	(ENCY)	DATE
	use a gait belt with	s and they told her that did not n Resident B. The CNA went to assist her in getting Resident				
	During an intervie	w with Resident B's family				
	-	2 at 10:05 a.m., indicated				
		t have enough strength to get				
		ad a lot of falls. The resident				
		spiratory issues. The resident				
		nily member on 6/28/22 around				
	-	told the resident she could take				
		room and the resident told her				
		A 1 then assisted her to the				
		ne resident was ready to get off				
		rabbed her under the arm and				
	-	off the toilet resulting in the				
	resident falling to					
	During an intervie	w with Resident B on 8/10/22 at				
	12:38 p.m., indica	ted on 6/28/22, she had CNA 1 to				
	help her go to the	bathroom. CNA 1 did not use a				
	gait belt or the res	ident's walker. CNA 1 held onto				
	the resident's arm	when she walked with her to the				
	bathroom. When t	he resident was done using the				
	restroom the resid	ent asked CNA 1 to help her to				
	get up. The resider	nt indicated she started				
	counting to three t	o get up and the CNA jerked				
	her up before she	could get to three. The resident				
		ost hit her face on the wall and				
		er as she was going down to				
	-	alling leaving a bruise on her				
	right arm, but the	resident fell anyway.				
		nandling/transfers policy				
		dministrator on 8/10/22 at 2:30				
		vas the policy of the facility to				
		nts are handled and transferred				
		r minimize risks for injury and				
	provide and promo	ote a safe, secure and				1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155264 B. WING 08/10/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2330 STRAIGHT LINE PIKE BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE comfortable experience for the resident resident. Compliance guidelines included, but were not limited to, handling aids may include gait belts and resident transferring would be performed according to the resident's individual plan of care. This Federal tag relates to Complaint IN00387070. 3.1-45(a)

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