STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155686	A. BUILDING 00 B. WING	08/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-KNOX	300 E CULVER RD KNOX, IN 46534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00236450. Complaint IN00236450 - Substantiated. Federal/State deficiencies related to the allegations are cited at F221 and F250. Survey date: August 1, 2017 Facility number: 000088 Provider number: 155686 AIM number: 100289260 Census Bed Type: SNF/NF: 47 Total: 47 Census Payor Type: Medicare: 5 Medicaid: 38 Other: 4 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/7/17.	F 0000	Preparation, submission and implementation of this plan of correction is prepared and executed as a means to continually improve 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

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F 0221 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on observation, record review, and interview, the facility failed to ensure residents were assessed for physical restraints to determine if needed to treat a medical symptom, to provide alternative interventions to prevent restraint usage,	F 0221	1.Both resident B&C restraints have been assessed and restraints have been discontinued. 2.There are currently no residents in the facility with a physical restraint. All staff	08/31/2017

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	and to use the least restrictive alternative, to apply the restraint as ordered by the Physician, and failed to have a Physician's order for a restraint, for 2 of 2 residents with restraints, in a total sample of 3. (Residents B and C) Findings include: 1. During an observation on 08/01/17 at 9:10 a.m., with RN 1 present, Resident B was sitting in a wheelchair with a clip seatbelt around the lower waist and socks on both hands, in the main lounge. RN 1 indicated at the time of the observation, the resident was unable to release the seatbelt and gloves were to be used not socks on the hands due to the resident chewing on her fingers causing sores. During an interview on 08/01/17 at 9:25 a.m., CNA 3 indicated the socks were taken off the resident's hands but was unable to find the gloves which were to be used. During an interview on 08/01/17 at 9:50 a.m., CNA 2 indicated she provided morning care and the resident had a pair of "Jersey" gloves, which were too big and the only pair available. The resident came to the facility with socks on the		educated on The Restraint Evaluation and Utilization Guide to ensure residents are assessed for physical restraints to determine if needed to treat a medical symptom, to provide alternative interventions to prevent restraint usage and to use the least restrictive alternative, to apply restraint as ordered by the Physician. 3.Currently there are no restraints in place to monitor. In the event a resident exhibits behaviors or symptoms of dementia (depending on diagnosis), causal factors will be reviewed by IDT using Root Cause Analysis. Interventions (least restrictive) will be put into place using resident's Life Story to be able to put meaningful life activities of interest into place. Interventions will be monitored for effectiveness and adjustments will be made as necessary. If restraints are considered for a resident after least restrictive interventions have been exhausted, OT screen/evaluate & treat for possible recommendations prior to restraint assessment, physician's order with medical reason for restraint, Informed Consent will be obtained from resident/POA/Guardian and Care Plan will be implemented. Follow-up evaluations for restraint reduction will be completed @ least quarterly and Significant Change of Condition. Social	

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	hands because of chewing on fingers and causing sores. The staff went back to using socks on the hands because the gloves were too big and socks were placed on the hands daily. During an observation on 08/01/17 at 11:15 a.m., Resident B was sitting outside the Dining Room. The socks were off the hands and the hands were not in the mouth, the seat belt remained clipped, and the resident was sitting straight in the wheelchair. During an observation on 08/01/17 at 11:30 a.m., Resident B was in the Dining Room, the clip seatbelt was unclipped, no socks were on the hands, and the hands were not in the resident's mouth. The record was reviewed on 08/01/17 at 9:50 a.m. Diagnoses included, but were not limited to, Down's syndrome. An Admission Minimum Data Set (MDS) assessment, dated 06/20/17, indicated short and long term memory impairments with severely impaired decision making skills, extensive assistance for transfers, locomotion, toileting, eating, and hygiene, unsteady with standing and surface to surface transfers, no range of motion impairments, history of falls with no falls		Services designee will, upon initiation of a restraint and at least quarterly and significant change of condition, will evaluate Psycho-Social Well-Being. Behavior/Symptom of Dementia (depending upon diagnosis) Care Plan indicating interventions that should be attempted with the resident, will be available for all staff. 4.In the event a physical restraint is implemented, tracking will be done through QAPI using Restraint Check List (attachment #1) every month until restraint is reduced and discontinued. Upon any noted concerns or trends that are identified, monitoring/audits will be completed based upon QAPI recommendations.	

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	at facility and chair restraint used daily. The Care Area Assessment (CAA), dated 06/20/17, indicated the restraint was triggered due to a lap belt when in the wheelchair due to poor safety awareness and had a fall prior to admission. A Significant Change MDS assessment, dated 07/24/17, indicated short and long term memory impairments with severely impaired decision making skills, Extensive assistance for transfers, locomotion, toileting, eating, and hygiene, no falls, no limb restraints, and other restraint used in wheelchair daily. The CAA, dated 07/24/17, indicated the physical restraint was used due to poor safety awareness. A care plan, dated 06/19/17, indicated a skin alteration of bilateral hands due to biting on hands and fingers related to cognitive impairment. The interventions were, keep hands and fingers dry, report signs and symptoms of infection, treat per orders and notify Physician of lack of healing. A care plan, dated 06/29/17, indicated history of falls. The interventions included, low bed, gait belt for transfers, side rail for enabler, therapy referral.			

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	A care plan, dated 06/29/17, indicated risk for injury related to physical restraint/lap belt. The interventions included, call light in reach, complete appropriate restraint and/or side rail assessment, educate family/responsible party of risk, maintain toileting, re-assess for potential redirection, velcro lap belt in wheelchair. A Physician's Order, dated 06/29/17, indicated velcro lap belt while up in wheelchair due to poor safety awareness. There were no Physician Orders for the socks on the bilateral hands. Review of the Nurses' Notes, dated 06/13/17 at 6:34 p.m., 06/14/17 at 12:14 p.m. and 8:17 p.m., 06/16/17 at 12:24 a.m., 06/18/17 at 10:20 a.m., 06/22/17 at 1:31 a.m. , indicated socks were placed on bilateral hands to protect the hands. A Nurse's Note, dated 06/13/17 at 6:34 p.m., indicated the seatbelt was in place due to leaning forward and falling from chair. A Nurse's Note, dated 07/09/17 at 8:09 a.m., indicated leaning in wheelchair, was repositioned and would lean forward again.			

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The Restraint Record, dated 07/2017, indicated a velcro lap belt was being used while in the wheelchair.

An Occupational Discharge Summary, dated 06/23/17, indicated the leaning had improved with wheelchair positioning and was able to sit upright with fair posture during functional tasks, and if leaning occurs, lay down in bed due to decline in posture when tired.

There was no assessment and consent for the lap belt or the socks usage for the hands located in the record.

Interviews on 08/01/17 indicated:

10:10 a.m., the Interim Director of Nursing (DON) indicated there was no restraint record for the socks being worn on the hands.

10:15 a.m., RN 1 indicated the belt on the wheelchair was a clip belt and not a self release velcro belt.

11:15 a.m., COTA (Certified Occupational Therapy Assistant) 4 indicated there was no documentation in the Occupational Therapy (OT) Notes about the restraint. Lateral supports were attempted and was not effective for the

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	leaning and the plan was to lay the resident down when leaning because of her being tired. Nursing Department completes the restraint assessments, OT only treats with supports and positioning. 11:40 a.m., Interim DON indicated there were no assessments or consents for the socks on the hands or the seat belt usage. The resident was admitted with the seat belt on, and she was not sure why she had the seat belt. The resident had not tried to stand up unassisted and she "barely moves". She leans forward but the belt would not prevent falling leaning forward. There was no medical reason for the belt restraint and no order for the socks to be used on the hands. Gloves were used, but they were too big and she would take them off. 2. During an observation on 08/01/17 at 9:10 a.m., Resident C was sitting in a locked wheelchair, with a self-release plastic clip belt on at the hip area. During an observation and interview on 08/01/17 at 9:15 a.m., RN 1 indicated the resident could remove the belt at times. The resident was unable to open the clip with instructions and would pick at pants. RN 1 indicated the resident could propel her own wheelchair, then unlocked the wheels. The resident then			

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	was able to self propel without purpose. RN 1 indicated the belt was due to falls and if the resident stood, the belt would release and an alarm would activate. During an observation on 08/01/17 at 9:30 a.m., CNA 5 and CNA 6 were assisting the resident to the bathroom. They assisted the resident to a near standing position with the belt clasped, the belt clip did not release with standing. The CNAs sat the resident back into the wheelchair and released the belt clip and ambulated the resident to the bathroom. An interview at the time of the observation, CNA 5 and CNA 6 indicated they had not observed her trying to stand on her own after the seat belt had been applied, and before the seat belt usage, she was always trying to stand by herself. During an observation on 08/01/17 at 11:30 a.m., Resident C was sitting in the wheelchair in the Dining Room, a visitor was present, and the clip belt had been released. There were no attempts to stand. The record was reviewed on 08/01/17 at 12:10 p.m. The diagnoses included, Alzheimer's disease. A Significant Change MDS assessment, dated 06/16/17, indicated short and long			

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	term memory problems, decision making skills severely impaired, extensive assistance with activities of daily living, no range of motion impairments, two or more falls, and trunk restraint used daily. The CAA, dated 06/16/17, indicated there were multiple falls with poor safety awareness. The care plan indicated: 11/28/16 - Risk for falls. The interventions included, alarm to wheelchair and bed, check urine, 15 minute checks, fall mat at bedside when in bed, Medications per orders, provide assistance with transfers, anti-tippers on wheelchair, 06/13/17 - lap belt while in wheelchair, and 06/14/17 - velcro lap belt while up in wheelchair. 06/13/17 - Anxiety, fidgety, restless. The interventions included, medication as ordered, observe for signs and symptoms of anxiety, offer toilet, beverage, snack, take for a walk, keep near staff to prevent falls. 06/13/17 - Velcro seat belt in wheelchair due to poor safety awareness. The interventions included, enable the use of feet to self propel, offer fluids, release lap belt for meals, and toilet every two hours.			

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	A Pre-restraint Evaluation, dated 06/09/17, indicated a short attention span, falls back when walking, slides down in chair, unsteady at time on feet, poor balance with walking, history of falls, appears to be effected by noise. Interventions implemented were, activity program, body pillows or positioning devises, bed or chair alarms, low bed with mats, visual or verbal reminders, ambulation/activities. The interventions attempted without effectiveness were, bed and chair alarms due to making the resident irritable when sounding and unable to follow directions, poor safety awareness. Medical symptoms/diagnosis were anxiety, Alzheimer's disease, and dementia with behaviors. The recommendation by the Interdisciplinary Team was to implement a velcro lap belt when up in the wheelchair for poor safety awareness, unable to follow direction, agitation, hard to communicate needs, and unaware of limitations. A Physician's Order, dated 06/13/17, indicated velcro lap belt while up in wheelchair due to poor safety awareness. The Nurses' Progress Notes indicated: 06/03/17 at 9 a.m. - continuously tries to stand up, gets agitated with noise and multiple people talking.			

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	06/04/17 at 9:17 p.m. - several attempts to stand and bend forward. Needs constant supervision. 06/05/17 at 3:52 a.m. - over five attempts to get out of wheelchair at Nurses' Station. Assisted to bed and is sleeping. 06/06/17 at 7:54 p.m. - multiple attempts to stand. 06/10/17 at 12:47 a.m. - continues to attempt to ambulate without assistance. 06/11/17 at 1:46 a.m. - continues to attempt to ambulate without assistance. 06/16/17 at 6:56 p.m. - fall, resident stood and ambulated in room. Lap belt was off. Reminded visitor to reapply belt after visit. There were no further notes to indicate the resident had attempted to stand without assistance from 06/16/17 to 08/01/17. There was no documentation to indicate what interventions were used and effectiveness with the attempts to stand on own prior to application of the seat belt. Interviews on 08/01/17:			

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	1 p.m. - RN 1 indicated the resident had a plastic clip belt on and not a velcro belt, which would be the less restrictive 1:20 p.m. - Interim DON indicated the resident could propel herself up and down the hallway and when "antsy" the staff were to toilet her and she would calm down. Staff had a doll and coloring book activities for her at the Nurse's Station. Acknowledged there were no interventions completed with the resident attempting to stand, due to no documentation. 2 p.m. - The Activity Director indicated during activities, the resident did not attempt to stand on her own. A facility policy, titled, "Physical Restraints Review Procedures", dated 01/21/6, and received from the Administrator as current, indicated, "...Review Medical Record for documentation evidencing the alternatives were attempted prior to physical restraint use...Ensure that the Restraint Assessment was completed and that documentation shows that the least restrictive restraint device was chosen. Review Physician's Orders for Restraint...Type of Restraint...Ensure that informed Consent from has been			

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	completed and signed and dated..." This Federal Tag relates to Complaints IN00236450. 3.1-3(w) 3.1-26(o)			
F 0250 SS=D Bldg. 00	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to provide medically-related Social Services, related to no Social Service involvement with a resident with continued behaviors/mood of anxiety leading to attempts to stand on her own and being a risk for falls with an order for a belt restraint obtained due to the behaviors/mood, for 1 of 2 residents reviewed for Social Service, in a total sample of 3. (Resident C) Finding includes:	F 0250	1.Both resident B&C restraints have been assessed and restraints discontinued. 2.There are currently no residents in the facility with a physical restraint. Behavior Monthly Flow Sheets, Antecedent Behavior Monitoring Forms and moods/behaviors documented in Care Tracker for prior 3 months to date, will be reviewed by Social Service Designee for all residents, to identify any residents that may be effected by the alleged deficient practice of lack of provision for medically related Social Services.	08/31/2017

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	During an observation on 08/01/17 at 9:10 a.m., Resident C was sitting in a locked wheelchair, with a self-release plastic clip belt on at the hip area. During an interview on 08/01/17 at 9:30 a.m., CNA 5 and CNA 6 indicated they had not observed her trying to stand on her own after the seat belt had been applied, and before the seat belt usage, she was always trying to stand by herself. The record was reviewed on 08/01/17 at 12:10 p.m. The diagnoses included, Alzheimer's disease. A Significant Change MDS assessment, dated 06/16/17, indicated short and long term memory problems, decision making skills severely impaired, no mood or behavior problems, extensive assistance with activities of daily living, two or more falls, and trunk restraint used daily. The care plan indicated: 06/13/17 - Anxiety, fidgety, restless. The interventions included, medication as ordered, observe for signs and symptoms of anxiety, offer toilet, beverage, snack, take for a walk, keep near staff to prevent falls. 06/13/17 - Velcro seat belt in wheelchair due to poor safety awareness. The		Care Plans and interventions will be reviewed and/or implemented as indicated after review by Social Service Designee/Designee. Any identified residents will continue to be monitored by Social Service Designee via the Monthly Behavior Meeting, Behavior Monthly Flow Sheets, Antecedent Behavior Monitoring Forms and moods/behaviors documented in Care Tracker review. Social Service Designee will be in-serviced by the Executive Director regarding follow-up and monitoring of the Behavior Monthly Flow Sheet that monitors current mood or behavior concerns (attachment #2) and Antecedent Behavior Monitoring Form (attachment # 3) that identifies new mood or behavior concerns, and moods/behaviors documented in Care Tracker. The Social Service Designee and staff will be educated by Executive Director regarding the Mood and Behavior Management policy. Staff education regarding Resident –Centered Behavior Plans and Interventions has been initiated by Director of Nursing Services and Social Service Designee. 3.Currently there are no restraints in place to monitor. In the event a resident exhibits behaviors or symptoms of dementia (depending on diagnosis), causal factors will be	

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	155686	A. BUILDING 00 B. WING	08/01/2017

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	interventions included, enable the use of feet to self propel, offer fluids, release lap belt for meals, and toilet every two hours. The Nurses' Progress Notes indicated: 06/03/17 at 9 a.m. - continuously tries to stand up, gets agitated with noise and multiple people talking. 06/04/17 at 9:17 p.m. - several attempts to stand and bend forward. Needs constant supervision. 06/05/17 at 3:52 a.m. - over five attempts to get out of wheelchair at Nurses' Station. Assisted to bed and is sleeping. 06/06/17 at 7:54 p.m. - multiple attempts to stand. 06/10/17 at 12:47 a.m. - continues to attempt to ambulate without assistance. 06/11/17 at 1:46 a.m. - continues to attempt to ambulate without assistance. A Physician's Order, dated 06/13/17, indicated velcro lap belt while up in wheelchair due to poor safety awareness. A Psychosocial Note, dated 06/09/17, indicated the resident was "fidgety", restless, and uncooperative with care. Received medications for depression and		reviewed by IDT using Root Cause Analysis. Interventions (least restrictive) will be put into place using resident's Life Story to be able to put meaningful life activities of interest into place. Interventions will be monitored for effectiveness and adjustments will be made as necessary. If restraints are considered after least restrictive interventions have been exhausted, OT screen/evaluate & treat for possible recommendations prior to restraint assessment, physician's order with medical reason for restraint, Informed Consent will be obtained from resident/POA/Guardian and Care Plan will be implemented. Follow-up evaluations for restraint reduction will be completed @ least quarterly and Significant Change of Condition. Social Services designee will, upon initiation of a restraint and at least quarterly and significant change of condition, will evaluate Psycho-Social Well-Being. Behavior/Symptom of Dementia (depending upon diagnosis) Care Plan indicating interventions that should be attempted with the resident, will be available for all staff. Social Service Designee will review Behavior Monthly Flow Sheets and Antecedent Behavior Monitoring Forms, and moods/behaviors documented in Care Tracker, Monday through Friday, or as needed and this will be on-going with no end date.	

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	anxiety and staff ambulated with the resident. There was no documentation to indicate what interventions were used and effectiveness with the attempts to stand on own prior to application of the seat belt. There was no documentation to indicate Social Service was notified of the behaviors/moods until 06/09/17, and no Social Service assistance was implemented until 06/13/17 when the restraint was ordered by the Physician. During an interview on 08/01/17 at 1:10 p.m., the Social Service Director (SSD) indicated there had not been a behavior and considered the attempts to stand unassisted a mood concern due to the anxiety. During an interview on 08/01/17 at 2:40 p.m., the SSD indicated she was aware of the behavior/anxiety and helped with observing the resident. She indicated there was no documentation on a Behavioral Log to indicate the resident was having behaviors, so there was nothing she could do. At 2:50 p.m. the SSD indicated the resident was not discussed in the Behavioral Management Meeting because there were no Behavioral Logs filled out.		Social Service Designee will report to Interdisciplinary Team outcome of form reviews to include care plan and interventions that are either implemented or revised , Monday through Friday during morning Stand Up meetings for 2 months, then 2 times weekly for 2 months, then 1 time weekly for 2 months. Care Plans implemented that indicate interventions that should be attempted, will be available to all staff. 4.In the event a physical restraint is implemented, tracking will be done through QAPI using Restraint Check List (attachment #1) every month until restraint is reduced and discontinued. Results of Social Service involvement with Mood and Behavior monitoring and follow up as reported in daily Stand Up meetings, will be reviewed in QAPI for 6 months to provide change or redirection when necessary and dictate continuation or completion of the monitoring process based on compliance. Upon any noted concerns or trends that are identified, monitoring/audits will be completed based upon QAPI recommendations.	

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	An undated facility policy, titled, "Mood/Behavioral Management", received as current from the Administrator on 08/01/17 at 2:45 p.m., indicated, "...Behavioral management includes assessing behavior patterns that interfere with the resident's functional capacity...social services staff will assess resident's behavior(s) that are potentially harmful to self or others through observation, interview, and record review...Consider possible casual factors...formulate a specific, individualized behavior management plan to reduce or eliminate the causes of behavior(s)..." This Federal Tag relates to Complaints IN00236450. 3.1-34(a)			