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	03/14/2017

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 IN00224271. Complaint IN00224271 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226, and F241. Survey dates: March 14, 2017 Facility number: 000088 Provider number: 155686 AIM number: 100289260 Census bed type: SNF/NF: 45 Total: 45 Census payor type: Medicare: 1 Medicaid: 36 Other: 8 Total: 45 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/15/17.	F 0000	This Plan of Correction is prepared and executed as a means to continually improve the 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 0225 SS=D Bldg. 00	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of			

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	actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview,	F 0225	. 1. Unable to correct the identified	04/13/2017

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	the facility failed to ensure allegations of abuse were reported, investigated, and reported timely to the Administrator and the Indiana State Department of Health (ISDH). The facility also failed to ensure residents' were protected in a timely manner from the alleged employee for 2 of 3 allegations of abuse reviewed. (Residents B and C) Findings include: 1. During an interview on 03/14/17 at 9:15 a.m., Resident B stated there had been a CNA who had been very "snippy and careless" with her, and would push the wheelchair hard. The CNA was reported and was no longer working in the facility. Resident B's record was reviewed on 03/14/17 at 10:53 a.m. The diagnoses included, but were not limited to heart failure and hypertension. The Annual Minimum Data Set assessment (MDS), dated 2/10/17, indicated the resident's cognition status was intact, had no behaviors, required extensive assistance of two for transfers, extensive assistance of one for locomotion, occasionally incontinent of bowel movement and frequently incontinent of urine.		issue related to regulation. 2. All alert and oriented residents were interviewed and no additional concerns were voiced. Staff were interviewed and no additional concerns were reported. All staff in service initiated for abuse reporting, investigation, reporting timely to the Administrator and State Board of Health, and protecting residents in a timely manner from any alleged employee for allegations of abuse. 3. Staff interviews will be completed by DNS or Designee: 4 staff members weekly for 4 weeks, then 3 staff members weekly for 4 weeks, then 2 staff member weekly per week for 4 weeks, then 1 staff member monthly for 3 months. Alert and oriented residents will be interviewed by SSD or Designee: 4 residents weekly for 4 weeks, then 3 residents weekly for 4 weeks, then 2 residents weekly for 4 weeks, then 1 resident monthly for 3 months. Family of non-interviewable residents will be interviewed by SSD or Designee: 4 family members weekly for 4 weeks, then 3 family members weekly for 4 weeks, then 2 family members weekly for 4 weeks, then 1 family member monthly for 3 months. (Attachments # 1, # 2, #3.)	

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	A Grievance Form, dated 3/3/17, signed by RN 1, read "It was reported to me that (CNA 2) was yelling at residents. It was reported that a resident was yelling at (CNA 2) and she slammed the door shut as she walked out of room and provided improper peri care. Reported to supervisor (Director of Nursing) 3/3/17. Reported to (Administrator) 3/3/17..." The ISDH Incident Report, was dated as 03/04/17. The date of occurrence was dated 03/03/17 at 6:50 p.m. The investigation dated 03/04/17 indicated the following employees were interviewed: CNA 2 - provided care to Resident B before dinner, when the resident was asked if she needed the bathroom, the resident stated yes she had needed to go for hours. CNA 4 assisted her with the resident and the resident was toileted and had a dry brief. Approximately 6:15 p.m. she informed the resident she had another resident using the sit the stand lift and Resident B was not happy she had to wait. When coming back with the sit to stand lift, CNA 3 and CNA 4 were going into the room to provide care. CNA 3 - After supper went to get the sit		4. Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified, then will review on PRN basis. 5. Completion date: 4-13-2017	

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	to stand lift, Resident B was sitting in the door way, CNA 2 came out of another room and said to the resident she told her she would have to wait in a loud and rude tone. CNA 2 then placed her hands on the residents wheelchair arm rests and pushed the chair abruptly backwards into her room and the resident said something but she could not hear her and CNA 2 told the resident she pushed her back so she could take care of her using a firm tone. CNA 3 informed CNA 2 they would take care of the resident when CNA 2 threw her hands up and said whatever and slammed the door as she exited. The resident then said she didn't understand why CNA 2 had not changed her brief when she toileted her earlier. The incident was reported to LPN 5 and LPN 6 and then when she saw RN 1 at approximately 6:45 p.m. and she informed her. CNA 4 - Before hall (food) cart was delivered the resident needed assistance to the bathroom. CNA 2 and CNA 4 assisted the resident to the bathroom, when finished toileting, the resident stated the brief was dirty and requested a different one. CNA 2 was pulling up the brief and told the resident she was fine. CNA 4 did not notice if the brief was dirty and as care continued CNA 2 kept telling the resident the brief was dry and			

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	it was fine. After dinner, CNA 4 and CNA 3 told CNA 2 they would take care of the resident. The resident was upset and crying and stating she was sick and tired of girls that didn't care taking care of her. CNA 4 had not witnessed any of the alleged occurrences. CNA 4 stated a little after 6 (p.m.) is when they completed the resident's care and talked to the resident and she calmed down. Resident B - Went to the door hoping she could find someone to help her, CNA 2 came to the door and placed her hands on the wheelchair arms and pushed her back beside the bed as fast as she could. "I thought I was in a torture room". Asked for brief to be changed and the CNA said it was alright. RN 1 - Had not observed any of alleged events and was informed of the incident by CNA 3 after 6:30 p.m. CNA 3 had reported CNA 2 was done with her shift, so she had not ask her to leave the building. During an interview on 03/14/17 at 11:30 a.m., CNA 3 indicated she had informed LPN 5 and LPN 6 of the incident and then reported it to RN 1. CNA 2 was getting ready to leave and she did not think the Nurses had said anything to CNA 2. CNA 2 was still here for at			

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	about an hour after the occurrence happened. During an interview on 03/14/17 at 11:45 a.m., the Administrator stated she was not immediately notified of the incident and was not notified until 10:45 p.m. She indicated once she was informed, CNA 2 was suspended. She was unsure of the time the allegation was reported to the nurses working and how long CNA 2 remained in the building after the allegation. She stated the allegation came close to the end of CNA 2's shift. During an interview on 03/14/17 at 12:18 p.m., the Administrator indicated she was under the understanding she had 24 hours to report the incident to the ISDH. She indicated CNA 2 was still working with residents after the allegation. The time card for CNA 2 was reviewed and the CNA clocked out from the building on 03/03/17 at 7:26 p.m. During an interview on 03/14/17 at 12:30 p.m., RN 1 stated CNA 3 reported the incident to her after dinner around 6:30 or 7 p.m. and CNA 2 was getting ready to leave. She stated CNA 3 had informed her the other nurses on shift were notified and she was not sure what they did after it was reported. She indicated the shift got busy and she did not call the			

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	Administrator and Director of Nursing until after her shift when she returned home. During an interview on 03/14/17 at 2:04 p.m., LPN 6 stated she was not aware of the allegation and had left the facility before it was reported. She stated the allegation had not been reported to her. During an interview on 03/14/17 at 2:05 p.m., CNA 4 stated she assisted the resident along with CNA 2 to the bathroom, when the resident was finished, CNA 2 was pulling the resident's brief up and the resident had said the brief was wet and wanted it changed and CNA 2 was telling the resident the brief was fine. The brief was not changed though the resident had stated it was wet. After dinner CNA 3 was going into the resident's room and she followed her in. CNA 2 was in the room, the resident was upset and ready to cry and informed them she did not want CNA 2 in the room. CNA 3 and CNA 4 then provided the resident with care. The resident was upset and crying over the brief not being changed. CNA 4 did not witness the incident with pushing the wheelchair. 2. Resident C's record was reviewed on 03/14/17 at 1:44 p.m. Diagnoses			

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	included, but were not limited to, dementia and anxiety. The Quarterly MDS assessment, dated 03/02/17, indicated the resident had long and short term memory problems, no behaviors, required extensive assistance of two for transfers and extensive assistance of one for locomotion. Review of an investigation of an allegation of abuse for another resident, dated 03/04/17, indicated: Statement received from CNA 3 - CNA 2 was observed before dinner trying to propel Resident C in her wheelchair, the resident's feet were on the floor preventing the wheelchair from propelling forward. CNA 2 abruptly "flung" the wheelchair around and hit the resident's feet on a door jam, the resident cried out and CNA 2 continued to push the resident backward to the dining room and the Nurse was informed. Statement from RN 1 - Also reported by CNA 3, CNA 2 "whipped" (Resident C) wheelchair around fast and her feet hit door frame. The feet were checked with no red or bruised areas. The resident was transferred backwards in the wheelchair to the dining room.			

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	During an interview on 03/14/17 at 12:24 p.m., the Administrator stated she had not reported or investigated the report of the resident being abruptly "flung" around in the wheelchair, hitting her feet, and transferring the resident backward in the wheelchair. When she spoke with CNA 3 again, she had not felt it was abuse. During an interview on 03/14/17 at 1:25 p.m., the Administrator stated there was no intent of abuse and "did not interpret it as an allegation". She indicated CNA 3 had not reported the incident in a timely manner. This Federal Tag relates to complaint IN00224271. 3.1-28(c) 3.1-28(d) 3.1-28(e)			
F 0226 SS=D Bldg. 00	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and			

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	exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. Based on record review and interview, the facility failed to follow the facility's policy for reporting an allegation of abuse to the Indiana State Department of Health (ISDH) and Administrator timely, ensuring protection of residents from the alleged employee, and investigating an allegation of abuse for 2 of 3 abuse allegations reviewed. (Residents B and C) Findings include:	F 0226	226 1. Unable to correct the identified issue related to regulation. 2. All alert and oriented residents were interviewed and no additional concerns were voiced. Staff were interviewed and no additional concerns were reported. All staff in service initiated for abuse reporting, investigation, reporting timely to the Administrator and State Board of Health, and protecting residents in a timely manner from any alleged employee for allegations of abuse.	04/13/2017

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	1. During an interview on 03/14/17 at 9:15 a.m., Resident B stated there had been a CNA who had been very "snippy and careless" with her, and would push the wheelchair hard. The CNA was reported and was no longer working in the facility. Resident B's record was reviewed on 03/14/17 at 10:53 a.m. The diagnoses included, but were not limited to heart failure and hypertension. A Grievance Form, dated 3/3/17, signed by RN 1, read "It was reported to me that (CNA 2) was yelling at residents. It was reported that a resident was yelling at (CNA 2) and she slammed the door shut as she walked out of room and provided improper peri care. Reported to supervisor (Director of Nursing) 3/3/17. Reported to (Administrator) 3/3/17..." The ISDH Incident Report, was dated as 03/04/17. The date of occurrence was dated 03/03/17 at 6:50 p.m. The investigation dated 03/04/17, indicated RN 1 had not observed any of alleged events and was informed of the incident by CNA 3 after 6:30 p.m. CNA 3 had reported CNA 2 was done with her shift, so she had not ask her to leave the		3. Staff interviews will be completed by DNS or Designee: 4 staff members weekly for 4 weeks, then 3 staff members weekly for 4 weeks, then 2 staff members weekly for 4 weeks, then 1 staff member monthly for 3 months. Alert and oriented residents will be interviewed by SSD or Designee: 4 residents weekly for 4 weeks, then 3 residents weekly for 4 weeks, then 2 residents weekly for 4 weeks, then 1 resident monthly for 3 months. Family of non-interviewable residents will be interviewed by SSD or Designee: 4 family members weekly for 4 weeks, then 3 family members weekly for 4 weeks, then 2 family members weekly for 4 weeks, then 1 family member monthly for 3 months. (Attachments # 1, #2, #3.) 4. Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified, then will review on PRN basis. 5. Completion date: 4-13-2017	

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	building. During an interview on 03/14/17 at 11:30 a.m., CNA 3 indicated she had informed LPN 5 and LPN 6 of the incident and then reported it to RN 1. CNA 2 was getting ready to leave and she did not think the Nurses had said anything to CNA 2. CNA 2 was still in the building for at about an hour after the occurrence happened. During an interview on 03/14/17 at 11:45 a.m., the Administrator stated she was not immediately notified of the incident and was not notified until 10:45 p.m. She indicated once she was informed, CNA 2 was suspended. She was unsure of the time the allegation was reported to the nurses working and how long CNA 2 remained in the building after the allegation. She stated the allegation came close to the end of CNA 2's shift. During an interview on 03/14/17 at 12:18 p.m., the Administrator indicated she was under the understanding she had 24 hours to report the incident to the ISDH. She indicated CNA 2 was still working with residents after the allegation. The time card for CNA 2 was reviewed and the CNA clocked out from the building on 03/03/17 at 7:26 p.m.			

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	During an interview on 03/14/17 at 12:30 p.m., RN 1 stated CNA 3 reported the incident to her after dinner around 6:30 or 7 p.m. and CNA 2 was getting ready to leave. She stated CNA 3 had informed her the other nurses on shift were notified and she was not sure what they did after it was reported. She indicated the shift got busy and she did not call the Administrator and Director of Nursing until after her shift when she returned home. During an interview on 03/14/17 at 2:04 p.m., LPN 6 stated she was not aware of the allegation and had left the facility before it was reported. She stated the allegation had not been reported to her. 2. Resident C's record was reviewed on 03/14/17 at 1:44 p.m. Diagnoses included, but were not limited to, dementia and anxiety. Review of an investigation of an allegation of abuse for another resident, dated 03/04/17, indicated: Statement received from CNA 3 - CNA 2 was observed before dinner trying to propel Resident C in her wheelchair, the resident's feet were on the floor preventing the wheelchair from propelling forward. CNA 2 abruptly			

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	155686	A. BUILDING 00 B. WING	03/14/2017

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	"flung" the wheelchair around and hit the resident's feet on a door jam, the resident cried out and CNA 2 continued to push the resident backward to the dining room and the Nurse was informed. Statement from RN 1 - Also reported by CNA 3, CNA 2 "whipped" (Resident C) wheelchair around fast and her feet hit door frame. The feet were checked with no red or bruised areas. The resident was transferred backwards in the wheelchair to the dining room. During an interview on 03/14/17 at 12:24 p.m., the Administrator stated she had not reported or investigated the report of the resident being abruptly "flung" around in the wheelchair, hitting her feet, and transferring the resident backward in the wheelchair. When she spoke with CNA 3 again, she had not felt it was abuse. During an interview on 03/14/17 at 1:25 p.m., the Administrator stated there was no intent of abuse and "did not interpret it as an allegation". She indicated CNA 3 had not reported the incident in a timely manner. A facility abuse policy, dated 09/27/16, titled "Investigation and Reporting of all Alleged Violations..." received from the Administrator as current, indicated, "...If			

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	the suspected perpetrator is an employee...the ED (Executive Director) (Administrator)...shall place the employee on immediate investigatory suspension while completing the investigation...It is the responsibility of each individual employee to immediately report any...allegations of mistreatment, neglect, abuse...to the designated supervisor in charge at the time...It is the responsibility of the designated supervisor to immediately communicate any report of an alleged violation to the ED...The ED...shall also notify the appropriate state agency, in accordance with state law...All investigations shall be conducted by the ED or designee..." This Federal Tag relates to complaint IN00224271. 3.1-28(a)			
F 0241 SS=D Bldg. 00	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must			

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	protect and promote the rights of the resident. Based on interview, and record review, the facility failed to ensure a resident was treated with dignity, related to a not changing a resident's brief as requested by the resident, for 1 of 3 residents reviewed for dignity in a total sample of 3. (Resident B) Finding includes: During an interview on 03/14/17 at 9:15 a.m., Resident B stated there had been a CNA who had been very "snippy and careless" with her. The CNA was reported and was no longer working in the facility. Resident B's record was reviewed on 03/14/17 at 10:53 a.m. The diagnoses included, but were not limited to heart failure and hypertension. The Annual Minimum Data Set assessment (MDS), dated 2/10/17, indicated the resident's cognition status was intact, had no behaviors, required extensive assistance of two for transfers, extensive assistance of one for locomotion, occasionally incontinent of bowel movement and frequently incontinent of urine.	F 0241	1. Resident did assist resident with peri-care at time of alleged occurrence. 2. All alert and oriented residents were interviewed and no additional concerns were identified. All staff in service initiated regarding regulation that the facility must treat and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality, and protect and promote the rights and dignity of the resident. 3. . Staff interviews will be completed by DNS or Designee: 4 staff members weekly for 4 weeks, then 3 staff members weekly for 4 weeks, then 2 staff members weekly for 4 weeks, then 1 staff member monthly for 3 months. Resident interviews will be completed by SSD or Designee: 4 residents weekly for 4 weeks, then 3 residents weekly for 4 weeks, then 2 residents weekly for weeks, then 1 resident monthly for 3 months. Family of non-interviewable residents will be interviewed by SSD or Designee: 4 family members weekly for 4 weeks, then 3 family members weekly for 4 weeks, then 2 family members weekly for 4 weeks, then 1 family	04/13/2017

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	A Grievance Form, dated 3/3/17 and signed by RN 1, read "It was reported to me that (CNA 2)... provided improper peri care. Reported to supervisor (Director of Nursing) 3/3/17. Reported to (Administrator) 3/3/17..." The investigation, dated 03/04/17, indicated the following employees were interviewed: CNA 2 - provided care to Resident B before dinner, when the resident was asked if she needed the bathroom, the resident stated yes she had needed to go for hours. CNA 4 assisted her with the resident and the resident was toileted and had a dry brief. A new brief was not put on. CNA 3 - The resident said she didn't understand why CNA 2 had not changed her brief when she toileted her earlier. CNA 4 - Before hall (food) cart was delivered, the resident needed assistance to the bathroom. CNA 2 and CNA 4 assisted the resident to the bathroom. When finished toileting, the resident stated the brief was dirty and requested a different one. CNA 2 was pulling up the brief and told the resident she was fine. CNA 4 did not notice if the brief was dirty and as care continued, CNA 2 kept		member monthly for 3 months. (Attachments #1,#2,#3.) 4. Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified, then will review on PRN basis. 5. Completion date: 4-13-2017	

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	telling the resident the brief was dry and it was fine. After dinner, CNA 4 and CNA 3 told CNA 2 they would take care of the resident. The resident was upset and crying and stating she was sick and tired of girls that didn't care taking care of her. Resident B - Asked for brief to be changed and the CNA said it was alright. During an interview on 03/14/17 at 2:05 p.m., CNA 4 stated she assisted the resident along with CNA 2 to the bathroom. When the resident was finished, CNA 2 was pulling the resident's brief up and the resident had said the brief was wet and wanted it changed and CNA 2 was telling the resident the brief was fine. The brief was not changed even though the resident had stated it was wet. The resident was upset and crying over the brief not being changed. This Federal Tag relates to complaint IN00224271. 3.1-3(t)			

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