

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELY AVE ELKHART, IN 46517
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F0000	<p>This visit was for the Investigation of Complaint IN00104860.</p> <p>Complaint IN00104860 - Substantiated. Federal/state deficiencies related to the allegation are cited at F323.</p> <p>Survey dates: March 9, 12, 13, 2012</p> <p>Facility Number: 000039 Provider number: 155685 AIM number: 100275130</p> <p>Survey team: Ann Armey, RN</p> <p>Census bed type: SNF/NF: 161 Total: 161</p> <p>Census payor type: Medicare: 21 Medicaid: 114 Other: 26 Total: 161</p> <p>Sample: 5</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 3/14/12 by Jennie Bartelt, RN.</p>	F0000		

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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F0323 SS=G	<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 provide supervision to prevent resident to resident altercations on the secured Alzheimer's unit, resulting in 1 resident sustaining a fracture (Resident #C) and 2 residents being sent to the hospital (Resident #E and #F). This deficiency affected 5 of 5 residents whose behaviors were reviewed and who were involved in 3 resident to resident altercations on the secure Alzheimer's Unit, in a sample of 5. (Resident #B, #C, #D, #E, #F)</p> <p>Findings include:</p> <p>1. On 3/9/12 at 10:00 a.m., during the orientation tour, the DON (Director of Nursing) indicated Resident #F hit Resident #E and was moved off the secure Alzheimer's unit. The DON indicated Resident #F was doing well on his new unit and had had no altercations since he moved. Resident #F was observed in his room and gave a pleasant greeting when his room was entered.</p>	F0323	<p>1. Resident B,C,D,E and F were not identified due to the nature of this survey. There were no adverse outcomes related to the alleged deficient practice Future attempts of resident to resident altercations will be investigated and appropriate interventions will be put into place as needed.</p> <p>2. Residents residing at the facility have the potential to be affected by the alleged deficient practice.</p> <ul style="list-style-type: none"> · Residents will be assessed by the Executive Director, Director of Nursing and/or designee prior to the time of admission to ensure residents at risk for wandering and behavioral risks are identified and have appropriate care plans and interventions in place. · An additional staff member has been put into place during the hours of 2:00 p.m. to 6:00 p.m. on the Alzheimer's Unit to provide additional supervision and observations. · Family style dining was put into place on 3/8/12. · The Alzheimer's Association will be providing additional training for direct care staff, with emphasis on prevention of behaviors and supervision on 3/29/12 and 4/5/12. · Screen Doors were applied to 2 resident doors on 3/14/12 to prevent wandering residents from entering. · Staff were in-serviced on 2/28/12 on Safety protocols including 	04/12/2012	

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	<p>The incident investigation, completed on 2/21/12, indicated on 2/18/12 at 2:40 p.m., staff on the Alzheimer unit heard yelling coming from the large dining room on the unit. The investigation indicated staff observed Resident #F standing over Resident #E swinging his fists, and Resident #E was on the floor with her hands on her head. Resident #E sustained a 5 cm bruise on her forehead and a 9 cm bruise on her right posterior head. Resident #F sustained a superficial abrasion to the left forehead and a 1 cm abrasion to the upper left forehead. The investigation further indicated Resident #F was transferred to a behavioral unit, and Resident #E was transferred to the hospital for evaluation of her head injuries.</p> <p>The clinical record of Resident #E was reviewed on 3/12/12 at 9:30 a.m. and indicated the resident was admitted to the facility on 12/4/07, with diagnoses which included, but were not limited to, dementia and cardiomyopathy.</p> <p>The MDS (Minimum Data Set) Assessment, dated 2/24/12, indicated Resident #E had severe cognitive impairment (scoring 3 of 15 on the Brief Interview of Mental Status) and required supervision for transfer and ambulation.</p>		<p>prevention of accidents. On 3/6/12 Staff were in-serviced on Family style dining process to assist in the minimization of behaviors when residents' are engaged in the process. On 3/12/12 Staff were in-serviced on Managing difficult behaviors and communication tips on communicating with residents with Alzheimer's or advanced Alzheimer's disease.</p> <p>3. Staff and the Department Managers will be re-educated by April 15, 2012 on supervision to prevent accidents protocol which will include the reportable guidelines regarding resident to resident altercations</p> <p>Nursing Managers will review new admissions, quarterly and annual clinical assessments for accuracy to ensure residents at risk for wandering and/or behaviors have appropriate care plans and interventions in place.</p> <p>4. Resident to Resident Altercations totals will complied monthly for 12 months. Patterns and trends will be reported to the QA& A Committee by the Director of Nursing and/or designee. Results of these trends and patterns will be reviewed by the QAA committee for 12 months and then the QAA team will determine the need for additional auditing until a threshold of 100% is achieved</p> <p>5. Date of Compliance 04/12/2012</p>				

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	<p>Nursing notes, dated 2/18/12 at 4:34 p.m., indicated staff heard yelling coming from the large dining room and found a resident standing over Resident #E swinging his fists. The note indicated Resident #E said, "He and I got into it and he hit me." The note indicated Resident #E complained of discomfort to her head and was transferred to the hospital at 3:40 p.m.</p> <p>The hospital CT (Computerized Tomography) Scans, dated 2/18/12, indicated the resident had a scalp hematoma but no acute intracranial abnormality, acute intra-abdominal abnormalities and no acute fractures.</p> <p>Nursing notes, dated 2/18/12 at 9:30 p.m., indicated Resident #E returned from the hospital at 9:15 p.m. with no new orders.</p> <p>On 3/12/12 at 10:00 a.m., Resident #E was observed up walking on the Alzheimer's secure unit. The resident was carrying a Bible and wearing a straw hat. She expressed no concerns.</p> <p>On 3/13/12 at 12:30 p.m., the Alzheimer Unit Manager was interviewed. She indicated, on 2/18/12, at the time of the altercation between Resident #E and #F, she was at the nurses station with another staff person, two nurses were in the</p>			

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	<p>medication room and an aide was on the floor providing care. The Unit Manager indicated she heard yelling and was the third person to arrive in the dining room. She indicated no one actually saw who started the altercation.</p> <p>2. On 3/9/12 at 10:30 a.m., during the orientation tour, accompanied by the DON (Director of Nursing) Resident #C was observed sitting on the secured Alzheimer Unit porch area with a red cast on her right arm.</p> <p>On 3/9/12 at 10:30 a.m., the DON was interviewed and indicated there was an altercation between Resident #B and Resident #C, which resulted in Resident #C falling and fracturing her wrist. At this time, a stop sign was observed across the entry to Resident #C's room.</p> <p>The incident investigation, completed on 2/28/12, indicated on 2/27/12 at 7:30 p.m., Resident #C was in her room on the Alzheimer Unit and Resident #B entered the room. Resident #C did not want the resident in her room, and she began to push Resident #B. Resident #B pushed back and Resident #C fell on the floor. The investigation indicated an x-ray was obtained which showed Resident #C had a fracture of the right distal radius, and she was sent to the hospital for treatment.</p>						

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	<p>The clinical record of Resident #C was reviewed on 3/9/12 at 2:30 p.m. and indicated the resident was admitted to the facility on 8/23/10 with diagnoses which included, but were not limited to, Alzheimer's disease.</p> <p>The MDS (Minimum Data Set) Assessment, dated 1/27/12, indicated Resident #C had severe cognitive impairment (scoring 7 of 15 on the Brief Interview of Mental Status) and required supervision for transfer and ambulation.</p> <p>Nursing Notes indicated the following: On 2/27/12 at 9:58 p.m., "Pt (Patient) was in her room and another pt (patient) was in her room and trying to get him out and he pushed her to get her out of the way and she lost her balance and fell to the floor." On 2/28/12 at 12:06 a.m., an order was received to send the resident to the emergency room for treatment. On 2/28/12 at 6:34 a.m., indicated the resident returned to the facility at 4:00 a.m.</p> <p>On 3/9/12 at 12:30 p.m., Resident #C was asked about the cast and indicated she was "battling" the resident across the hall and slipped. She indicated she lost patience with him, because he came in her</p>			

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	<p>room every day.</p> <p>On 3/9/12 at 2:45 p.m., LPN #10, who was working on the day Resident #C fell, was interviewed. She indicated she was just coming back from lunch on 2/27/12 and she heard Resident #C yell, so she immediately went to the room and saw Resident #C falling into the hall by her doorway. She indicated she called for assistance. LPN #10 indicated no one actually saw the altercation.</p> <p>3. On 3/9/10 at 10:30 a.m., during the orientation tour on the Alzheimer's secured unit, the DON (Director of Nursing) indicated, in addition to the altercation with Resident #C, Resident #B was involved in a second altercation with Resident #D. The DON indicated Resident #B wandered into Resident #D's room, and Resident #D hit Resident #B in the face with a shoe. The DON indicated a stop sign was placed across Resident #D's door.</p> <p>The investigation, completed on 3/4/12, indicated on 3/4/12 at 3:30 p.m., Resident # D was in his room when Resident #B wandered into his room. Resident #D became upset and was able to hit Resident #2 in the left cheek twice, with his shoe, before staff could intervene. The investigation indicated there was a quarter</p>						

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	<p>sized abrasion on Resident # B's left cheek.</p> <p>The investigation indicated Resident #B was unable to follow orders or to move out of dangerous situations and "needs constant supervision."</p> <p>The clinical record of Resident #B was reviewed on 3/9/12 at 11:00 a.m. and indicated the resident was admitted to the facility on 12/19/12 with diagnoses which included, but were not limited to, advanced dementia.</p> <p>The MDS (Minimum Data Set) Assessment indicated the resident had severe cognitive impairment (scoring 0 out of 15 on the Brief Interview of Mental Status) and required supervision for ambulation.</p> <p>Nursing Notes indicated the resident wandered frequently on the Alzheimer Unit, as follows: On 2/19/12 at 1:21 p.m., "...Conts (continues) to wander in and out of other pts' (patients') rooms, and will climb in any empty bed. Very difficult to redirect...." On 2/22/12 at 8:27 a.m., "...was noted to wander into other resident's room on 2/21/12..." On 2/27/12 at 10:00 p.m., "PT (Patient) wondering (Sic) into other pt's rooms on</p>			

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	<p>this shift...."</p> <p>3/6/12 at 8:03 a.m., "noted to be wandering into other's rooms...."</p> <p>During interview on 3/9/12 at 2:50 p.m., CNA #11, who was working at the time of the altercation between Resident #B and #D, indicated she heard a noise and went to check. She indicated Resident #D's door was blocked, so she went through an adjoining bathroom to gain access to Resident #D's room. CNA #11 indicated when she entered the room, Resident #D was hitting Resident #B in the face with his shoe. She indicated she was able to separate the residents.</p> <p>On 3/9/12 at 4:00 p.m., Resident #B was observed entering another resident's room and lying in the bed. No other resident was in the room. Staff were providing activities and care at the time the resident entered the room and did not redirect the resident.</p> <p>This federal tag relates to Complaint IN00104860.</p> <p>3.1-45(a)(2)</p>				