| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 09/27/2012 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOLDEN LIVING CENTER-VALPARAISO | 251 STURDY RD<br>VALPARAISO, IN 46383 |

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| F0000 | This visit was for the Investigation of Complaint IN00116734.<br><br>Complaint IN00116734-Substantiated. Federal/state deficiencies related to the allegations are cited at F166 and F312.<br><br>Survey dates:<br>September 26 & 27, 2012<br><br>Facility number: 000062<br>Provider number: 155137<br>AIM number: 100271400<br><br>Survey team:<br>Janet Adams, RN<br><br>Census bed type:<br>SNF/NF: 77<br>Total: 77<br><br>Census payor type:<br>Medicare: 17<br>Medicaid: 50<br>Other: 10<br>Total: 77<br><br>Sample: 13<br><br>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. | F0000 | Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of Correction is prepared and executed as a means to continuously 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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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| | Quality review completed 10/2/11<br>Cathy Emswiller RN | | | |

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| F0166 SS=E | 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES<br>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.<br>Based on record review and interview the facility failed to ensure grievance resolutions were completed and the residents or family members who voiced the grievance were notified of the resolution for 4 of 4 grievances related to food and resident care concerns for 3 residents in the sample of 13. (Residents #G, #N, & #P)<br><br>Findings include:<br><br>The facility complaint and grievances related to food concerns and concerns related to ADL (activities of daily living) were reviewed on 9/27/12 at 9:30 a.m.<br><br>A Grievance Form completed by and LPN #6 on 9/19/12 indicated Resident G's wife voiced a concern to staff related to the resident not eating meals. The Action Plan listed on the form indicated staff reviewed the resident's meal intakes and noted the wife had been asking other residents on the dementia unit about her husband's meal intakes. The plan also indicated staff were to set up a care plan conference with the wife. There was no | F0166 | *Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.* **F-166**<br>It is the practice of this facility to promptly resolve grievances the resident may have. Consistent with this practice, the following has been done: ***The corrective action taken for the residents found to have been affected by the deficient practice was:***<br>·The family of resident #G agreed to a meeting on 10/3 to further discuss and resolve the concerns voiced by the spouse. The meeting included Therapy, Nursing and the Director of ACU. Appropriate resolution and follow up was established.<br><br>·Resident #P has been discharged and no further follow up was possible. Note that Resident #P did not have voice any further related grievances during her stay. | 10/27/2012 |

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| | Associate assigned to investigate the grievance. The form did not indicate the resolution to the plan had been implemented. There was a section on the form indicating an Associate was to review the resolution and discuss it with the resident or family. The form was to be reviewed and signed by the Executive Director and the Social Service Director. Neither the Executive Director nor the Social Service Director had completed this.<br><br>A Grievance form completed by Resident #P was initiated on 8/26/12. The form indicated the resident's brother voiced a concern indicating the resident had said her food needed to be warmer. The Dietary Manager signed the form on 8/27/12 and indicated the resolution was to "make sure staff come and get it when paged, haven't heard any other complaints." There was a section on the form indicating an Associate was to review the resolution and discuss it with the resident or family. The form was to be reviewed and signed by the Executive Director and the Social Service Director. Neither the Executive Director nor the Social Service Director had completed this.<br><br>Two Grievance Forms were initiated for Resident #N. The first form was initiated | | ·Resident #N agreed to a meeting with the Dietary manager to discuss concerns. Likes and dislikes were discussed and documented to satisfactory resolution. The Dietary Manager will meet weekly with Resident #N to determine any further issues. Dietary staff were in-serviced on preparation processes for food. Resident #N has voiced no further related concerns.<br>***The corrective action taken for those residents having the potential to be affected by the same deficient practice is:***<br>·All grievances received in the last 30 days have been reviewed for appropriate resolution and follow-up. Any unresolved issues have had additional steps taken to ensure satisfaction and resolution to any voiced concerns.<br>***The measures put into place and a systemic change made to ensure the deficient practice does not recur is:***<br>·Facility staff has been in-serviced on the grievance procedure and follow up when a resident or family member has a concern. All staff was in-serviced on the location of the grievance forms. Grievances are discussed and reviewed in AM meeting to evaluate progress towards resolution.<br>***To ensure the deficient practice does not recur, the monitoring system established*** | |

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| | on 8/25/12. This form indicated the resident voiced concerns that the ribs and potatoes served were hard. The Action Plan section indicated the Dietary department was listed as the "investigating department." The Action Plan also indicated the potatoes come in pre cooked and they will re-cook them as necessary and the ribs would be boiled and then cooked in the oven if the steamer was not working. The date of resolution on the form was 8/27/12. There was a section on the form indicating an Associate was to review the resolution and discuss it with the resident or family. The form was to be reviewed and signed by the Executive Director and the Social Service Director. Neither the Executive Director nor the Social Service Director had completed this.<br><br>The second Grievance Form was initiated on 9/8/12 for Resident #N. This form indicated the resident stated he had filed grievances with many staff members about food in the last week and no one had followed up with him. The Action Plan section on the form was completed by the Dietary Manager and indicated she speaks with the resident "at least once a week on the above issue." The Nature of the Resolution section on the form indicated the manager had spoken to the resident "last week and today... told I | | ***is:***<br>·A Quality Assurance tool has been established in accordance with the grievance process. Executive Director or designee will complete the indicator weekly for 12 weeks and then monthly for 3 months or until thirty days of compliance is met.<br>·Results of audits will be forwarded to the QA committee monthly x 3 months and then quarterly as an ongoing process for further evaluation or resolution.<br>·Any trends or patterns noted will have an action plan written and implemented.<br>The Director of Operations will oversee this process through a monthly review x 6 months or until compliance is achievedBy what date the systematic changes will be completed.<br>10/27/2012With respect to the above sited deficiency we would like to request a desk review. POC Date 9/27/2012 | |

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| | would check into the issue same have to deal w/ (with) pre-cooked item."<br>There was a section on the form indicating an Associate was to review the resolution and discuss it with the resident or family. The form was to be reviewed and signed by the Executive Director and the Social Service Director. Neither the Executive Director nor the Social Service Director had completed this.<br><br>The current facility "Grievance Guideline" policy was received from the acting Executive Director. The policy had a revised date of January 2011. The policy indicated ..."when resolving the situation, parties should be in agreement of the resolution or consider other avenues for resolution until satisfaction is achieved." The policy also indicated the Executive Director, Social Service Director, or Designee were to "notify the resident and/or individual completing the Grievance Form of the findings and the method of resolution."<br><br>When interviewed on 9/27/12 at 10:30 a.m., the acting Executive Director indicated the above Grievance Forms should have been followed up by an Executive Director.<br><br>This federal tag relates to Complaint IN00116734. | | | |

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| | 3.1-7(a)(2) | | | |

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| F0312 SS=B | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. | | | |
| | Based on observation, record review, and interview, the facility failed to ensure incontinence care was provided in a timely manner for 6 of 7 residents observed for incontinent care on the North Unit. (Residents #E, #F, #G, #H, #J, and #K)<br><br>Findings include: w<br>1. On 9/26/12 at 5:45 a.m., Resident #G was observed in bed. CNA #2 entered the resident's room and removed the resident's brief to check for incontinence. The brief was removed and was wet with urine. The CNA touched the resident's bed sheet and indicated the sheet was wet.<br><br>The record for Resident #G was reviewed on 9/26/12 at 9:25 a.m. The resident's diagnoses included, but were not limited to, senile dementia, Alzheimer's disease, and depressive disorder.<br><br>Review of the 6/27/12 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) indicated the resident's | F0312 | *Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.*<br>**F312** *It is the practice of this facility to ensure incontinence care is provided in a timely manner for all incontinent residents.* ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.***<br>·Residents # E, F, G, H, J, and K were provided with incontinent care at the point of discovery. Further the above residents were assessed to ensure there were no areas of skin concerns noted.<br>·The C.N.A who provided care for resident # E, F, G, H, J, and K received written disciplinary education on maintaining incontinent care in a timely manner for assigned residents according to their plan of care. | 10/27/2012 |

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| | cognitive patterns were severely impaired. The assessment also indicated the resident was frequently incontinent of urine and required extensive assistance of staff for toilet use, dressing, and transfers.<br><br>A care plan initiated on 7/10/12 indicated the resident had an alteration in elimination of bowel and bladder and briefs were used for incontinence protection<br><br>2. On 9/26/12 at 5:55 a.m., Resident #F was observed in bed. The resident's brief was removed by CNA #2 and the brief was wet with urine.<br><br>The record for Resident #F was reviewed on 9/26/12 at 9:55 a.m. The resident's diagnoses included, but were not limited, Alzheimer's disease, urinary incontinence, and chronic pain.<br><br>Review of the 7/17/12 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident was frequently incontinent of urine and required extensive assistance of staff for toilet use, personal hygiene, and dressing. The assessment also indicated the resident | | ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken***<br>·All resident's have the potential to be affected<br>· Education was held with Nursing staff to include making rounds, checking and changing and incontinent care per resident's plan of care. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.*** · Education was held with Nursing staff to include making rounds, checking and changing and incontinent care per resident's plan of care. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.*** · Observation audits of incontinent residents will be conducted on all shifts 5 x week for 4 weeks, then 3 x a week x 8 weeks, then weekly x 3 months until 30 days of compliance is met. · Results of audits will be presented to the QA committee each month. · Results of the audits will be reviewed by the QA committee monthly for 6 months or until substantial compliance is achieved. · Any trends or patterns noted will have action plans written and interventions | |

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| | required limited assistance of staff for bed mobility and transfers.<br><br>A care plan initiated on 5/21/10 and last reviewed on 8/15/12 indicated the resident was at risk for an alteration in bowel and bladder stress incontinence due to a diagnosis of dementia.<br><br>3. On 9/26/12 at 6:10 a.m., Resident #E was observed in bed. The resident's brief was removed by CNA#2. The brief was wet with urine. The bath blanket on the bed and bottom sheet of the bed were wet with urine and an urine odor was noted.<br><br>The record for Resident #E was reviewed on 9/26/12 at 9:50 a.m. The resident's diagnoses included, but were not limited to, senile dementia and a history of urinary tract infections.<br><br>Review of the 6/19/12 Minimum Data Set (MDS) quarterly assessment indicated the resident's cognitive skills for decision making were moderately impaired. The assessment also indicated the resident was frequently incontinent of urine. The assessment also indicated the resident required extensive assistance of staff for toilet use, dressing, and personal hygiene.<br><br>A care plan initiated on 3/31/11 and last revised with a goal date of 9/27/12 | | implemented. · The Executive Director and the Director of Nursing will oversee this process. With respect to the above sited deficiency we would like to request a desk review. What date the systemic changes will be completed 10/27/2012 POC date 09/27/12 | |

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| | indicated the resident had a physical functional deficit related to self care impairment due to a diagnosis of dementia. The care plan also indicated the resident required assistance with most activities of daily living skills including extensive assistance with toileting.<br><br>4. On 9/26/12 at 6:20 a.m., Resident #H was observed in bed. The resident's brief was removed by CNA #2. The brief was wet with urine. The back section of the resident's night gown was wet. The bottom sheet on the bed was wet also. The CNA transferred the resident from the bed to the wheel chair and took the resident into the bathroom to toilet and cleanse her. When the removed the wheel chair the resident had been sitting in the cushion on the seat was wet where the resident had sat on it.<br><br>The record for Resident #H was reviewed on 9/27/12 at 8:30 a.m. The resident's diagnoses included, but were not limited to, urinary incontinence, dementia, and depressive disorder.<br><br>Review of the 7/31/12 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) indicated the resident's cognitive patterns were severely impaired. The assessment indicated the resident was | | | |

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| | frequently incontinent of urine and required assistance of staff for bed mobility, transfers, toilet use, and personal hygiene.<br><br>5. On 9/26/12 at 6:32 a.m., Resident #K was observed in bed. The resident's brief was removed by CNA #2. The brief was wet with urine.<br><br>The record for Resident #K was reviewed on 9/27/12 at 8:20 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and depressive disorder.<br><br>Review of the 9/13/12 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) indicated the resident's cognitive patterns were moderately impaired. The assessment also indicated the resident was frequently incontinent of urine and required assist of staff for toilet use, personal hygiene, dressing, bed mobility, and transfers.<br><br>A care plan initiated on 4/22/10 and last revised on 7/10/12 indicated the resident had an alteration in elimination of bowel and bladder and required a toileting plan related to incontinence. Interventions included for the resident to wear briefs or pads. Another care plan initiated on | | | |

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| | 4/22/10 and last revised on 7/10/12 indicated the resident had a physical functional deficit related to self care impairment. Interventions included for staff to provide limited assistance with personal hygiene and extensive assistance with toileting and bed mobility.<br><br>6. On 9/26/12 at 5:25 a.m., Resident #J was observed in bed. The resident's brief was removed by CNA #2. The brief was wet with urine. The bed sheet was wet with urine also.<br><br>The record for Resident #J was reviewed on 9/26/12 at 10:50 a.m. The resident's diagnoses included, but were not limited to, urinary incontinence, diabetes mellitus, and depressive disorder.<br><br>Review of the 8/7/12 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident was frequently incontinent of urine and required staff assistance with toilet use, personal hygiene, and transfers.<br><br>A care plan initiated on 11/30/11 and last revised on 9/5/12 indicated the resident was at risk for alteration in elimination of | | | |

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| | bowel and bladder and was occasionally incontinent of urine, and had a history of a urinary tract infection. Interventions included for the resident to use briefs and pads for incontinence protection.<br><br>When interviewed on 9/26/12 at 5:25 a.m., CNA #2 indicated she this is the unit she usually works on. The CNA indicated she had just come to help with care this morning.<br><br>When interviewed on 9/26/12 at 5:15 a.m. CNA #1 indicated this was not the unit she normally was assigned to work on. The CNA indicated she started work at 3:00 a.m. this morning. The CNA indicated an orientating CNA from the other unit came down to help around 4:00 a.m.. The CNA indicated when she arrived the previous staff told her who had been wet and who they had done rounds on. The CNA indicated she had not checked the above residents since she had started her shift at 3:00 a.m. The CNA indicated residents were to be checked and changed every two hours.<br><br>When interviewed on 9/17/12 at 10:20 a.m., the Director of Nursing indicated resident's should be checked for incontinence every two hours.<br><br>This federal tag relates to Complaint | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 09/27/2012 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO | | STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383 | |

| (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 |
|---|---|---|---|---|
| | IN00116734.<br><br>3.1-38(a)(3)(A) | | | |