

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155120	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRANDYWINE	STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00206427, Complaint IN00206945 and Complaint IN00207256.</p> <p>Complaint IN00206427 -- Substantiated. Federal/state deficiencies related to the allegations are cited at F309, F323, F354 and F9999.</p> <p>Complaint IN00206945 -- Substantiated. Federal/state deficiencies related to the allegations are cited at F309, F323, F354 and F9999.</p> <p>Complaint IN00207256 -- Substantiated. Federal/state deficiency related to the allegations is cited at F309.</p> <p>Survey dates: August 15, 16, 17 and 18, 2016</p> <p>Facility number: 000050 Provider number: 155120 AIM number: 100266170</p> <p>Census bed type: SNF/NF: 107 Total: 107</p> <p>Census payor type: Medicare: 5</p>	F 0000		
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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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F 0309 SS=E Bldg. 00	<p>Medicaid: 86 Other: 16 Total: 107</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on August 26, 2016</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure adequate staffing to ensure residents had their call lights responded to in a timely manner, were repositioned in a timely manner, supervised a resident on the secured Memory Care Unit (MCU) to prevent the resident from exiting onto the secured courtyard without staff supervision for 4 residents of 6 residents reviewed for care and services. (Resident #B, Resident #C, Resident #D and</p>	F 0309	<p>All four residents identified and reviewed for any injuieres/side effects, none noted.</p> <p>All residents have the potential to be affected by this deficiency. All residents' call lights have been audited for placement within reach. Any call lights not within reach were corrected immediately. All residents dependent on staff for repositioning</p>	09/09/2016

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	<p>Resident #E)</p> <p>Findings include:</p> <p>1. In an interview with a family member of Resident #B on 8-16-16 at 3:12 p.m., he indicated, "Not long ago, mom was turned towards the wall at 10:15 a.m., and at 3:30 p.m., [was] still facing the same direction. That tells me they aren't doing what they should for her. They don't have enough staff to take care of the patients there. They normally just have one aide on each hall and that's not enough. The other day when I was here, there was 6 lights going off down mom's hall. The aide was trying to do what she could, but she can only do so much. I feel sorry for the aides. They are run to death. That's another thing, we have come in several times and found mom's call light where she can't reach it. Have found it on the floor several times. She knows how to use the call light."</p> <p>In observations with Resident #B on 8-17-16 at 9:38 a.m., at 10:15 a.m., at 1:22 p.m., at 2:18 p.m., and at 4:15 p.m., the resident was observed turned to left side, facing the wall. Her call light was observed on the right upper side rail, but not within reach. In interview with Resident #B on 8-17-16 at 1:22 p.m., she indicated she had not been repositioned</p>		<p>were reviewed and turned and repositioned as needed. ACU courtyard door secured per facility plan. Implemented immediately, ACU door checked by nurses at shift change to make sure it is secured.</p> <p>All staff in-serviced on call light placement, call light response time, turning and repositioning per care plan, and securing ACU courtyard door.</p> <p>Leadership team/designee to audit call lights for proper placement 10 times per day for 8 weeks, 5 times per day for 8 weeks, 2 times per day for 4 weeks, and 1 time per day for 4 weeks. DNS/UM/designee to audit 5 dependent residents per day for accurate positioning 3 times per day for 8 weeks, 3 dependent residents per day for accurate positioning 3 times per day for 8 weeks, 2 dependent residents per day for accurate positioning 3 times per day for 4 weeks, and 1 dependent resident per day for accurate positioning 3 times per day for 4 weeks. ACD/designee to ensure ACU courtyard door is secured once per day for 16 weeks.</p> <p>Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based</p>				

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	<p>since the dressing change was conducted that morning at 9:38 a.m.</p> <p>Review of Resident #B's clinical record on 8-16-16 at 4:00 p.m., indicated her diagnoses included, but were not limited to CVA (cerebrovascular accident or stroke) with hemiplegia (one-sided paralysis). Her most recent Minimum Data Set (MDS) assessment, dated 6-8-16, indicated she is moderately cognitively intact, she does not ambulate and she requires extensively assistance of one to two persons with bed mobility and transfers.</p> <p>2. In an interview with a family member of Resident #E on 8-15-16 at 5:35 p.m., she indicated Resident #E often does not have her call light in reach and can't reach it for help. She indicated, " Mom is normally quite sharp, but can sometimes be confused." She indicated, "I have to say, when I came in this evening, I noticed there was a lot more staff and workers here than they normally have around dinner time. Then I found out that State [staff from the Indiana State Department of Health] was in and that explained it."</p> <p>Review of Resident #E's most recent Minimum Data Set (MDS) assessment, dated 7-21-16, indicated she is</p>		<p>on QAPI recommendations. If no trends identified then will review on PRN basis.</p>				

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	<p>moderately cognitively intact and requires moderate to extensive assistance of one to two persons with bed mobility and transfers. It indicated she ambulates with supervision and uses a wheelchair for mobility.</p> <p>3. In a confidential interview with an interested party of Resident #D 8-15-16, this person indicated the family was notified by phone on 7-7-16 at 7:25 a.m., that Resident #D "had gotten out in the courtyard during the night and [was] found lying on the grass. They were unsure how long she had been there, but was it was long enough her back was wet...It worries me that for one thing that they didn't know she had gotten out at all at a door that should have been locked. She would have had no idea how to get back in." He indicated, "...seem to have less workers here...I expect them to have enough staff to take care of each patient in here properly and I don't think they have nearly enough staff." He indicated he visits on a regular basis. He continued, "Of an evening, it's normally only one aide, one nurse, for this unit. When I got here [this evening]...I noticed there was a lot more people here working than normal. I know in May and June when the State [staff from the Indiana State Department of Health] was here, there seemed to more people working</p>			

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	<p>then, too. Then when they left, it went back to normal, which isn't nearly enough people to take care of all the patients."</p> <p>Resident #D's clinical record was reviewed on 8-17-16 at 3:50 p.m. It indicated her diagnoses included, but were not limited to, dementia with behavioral disturbances. The admission Minimum Data Set (MDS) assessments, dated 2-15-16 and a quarterly MDS assessment, dated 8-10-16, indicated she has short term and long term memory problems and is severely cognitively impaired. Both MDS assessments indicated she is ambulatory with supervision and uses no mobility devices for assistance with ambulation.</p> <p>4. In an observation of Resident #C on 8-17-16 at 2:25 p.m., the resident was seated in a wheelchair in her room. Her call light was observed to be lying on top of 2 pillows on a chair, located behind the wheelchair and out of the resident's reach, prior to care being provided to the resident.</p> <p>Review of Resident #C's clinical record on 8-16-16 at 11:50 a.m. Her diagnoses included, but were not limited to, dementia with behavioral disturbances. Her most recent Minimum Data Set (MDS) assessment, dated 6-15-16,</p>			

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F 0323 SS=D Bldg. 00	<p>indicated she is severely cognitively impaired, requires extensive assistance of one person with bed mobility and transfers, does not ambulate and uses a wheelchair for mobility.</p> <p>5. In interview with the Director of Nursing (DON) on 8-17-16 at 11:17 a.m., she indicated nursing staffing at the facility, "has been a big problem." She indicated the nursing management team has been stepping in for any vacant spots on the nursing schedule in whatever capacity is needed, from working in the capacity of a CNA to passing medications or filling in as the floor nurse.</p> <p>This Federal tag relates to Complaint IN00206427, Complaint IN00206945 and Complaint IN00207256.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident</p>			

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	<p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a resident with severe cognitive impairment did not exit the secured Memory Care Unit (MCU) into the secured courtyard after bedtime without the staff's knowledge. (Resident #D)</p> <p>Findings include:</p> <p>In a confidential interview with an interested party of Resident #D 8-15-16, this person indicated the family was notified by phone on 7-7-16 at 7:25 a.m., that Resident #D "had gotten out in the courtyard during the night and [was] found lying on the grass. They were unsure how long she had been there, but it was long enough her back was wet...Normally, the door is locked and alarmed. Never got any feedback except the one phone call. To the best of my knowledge, she had never done anything like this before.... It worries me that for one thing that they didn't know she had gotten out at all at a door that should have been locked. She would have had no idea how to get back in." He indicated, "...seem to have less workers here...I expect them to have enough staff to take care of each patient in here</p>	F 0323	<p>Resident identified and reviewed with no injuries noted.</p> <p>All residents residing on ACU have the potential to be affected by this deficiency. ACU courtyard door secured per facility plan. Implemented immediately, ACU door checked by nurses at shift change to make sure it is secured.</p> <p>All staff in-serviced on securing ACU courtyard door.</p> <p>ACD/designee to ensure ACU courtyard door is secured once per day for 16 weeks.</p> <p>Results of these audits will be taken to QAPI x 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.</p>	09/09/2016

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	<p>properly and I don't think they have nearly enough staff."</p> <p>In an interview with the Executive Director on 8-18-16 at 12:21 p.m., she indicated it is not unusual for residents to go in and out of the door to go out into the courtyard. She indicated, "The courtyard door is not alarmed since you can get to the exterior of the building from the courtyard."</p> <p>In an interview with the Clinical Educator on 8-18-16 at 12:21 p.m., she indicated she was working with the MCU manager, who was new to the manager position, on evening of 7-6-16. She recalled, "Around 8:00 p.m., my kids came on to the unit and she [Resident #D] was very interested in them. I was supervising the kids and [name of Resident #D]. [Name of Resident #D] was talking with them and playing with toys with them. She stayed close to them and seemed interested in them the entire time we were there...We left between 10:15 and 10:20 pm. She was at the nurse's station when I left. [Name of the MCU Manager] was in the nurse's station with her when I left. There were 2 CNA's working the 6p-6a shift, but can't recall their names. [Name of QMA #1] came on duty at 10 pm to relieve the nurse, [name of the MCU</p>						

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	<p>Manager]...Didn't see any attempts of her going out to the courtyard."</p> <p>In interview with the Executive Director on 8-18-16 at 2:20 p.m., she indicated she had spoken to QMA #1 that afternoon to clarify some information regarding Resident #D on the evening of 7-6-16. She indicated he clarified, "He told me they started the routine every two hour rounds around 11:30 p.m. At 11:35 p.m., they did not find [name of Resident #D] in her bed. They started looking all over the unit and then out into the courtyard. They found her laying on the ground, looking up at the sky. He thought they finished report around 10:45 p.m...they did not alert anybody else because they found her pretty quick. They did have one of the nurses come over and check her out and she was not injured, she was okay."</p> <p>In an interview with the Executive Director on 8-18-16 at 10:40 a.m., "We did not file a reportable [incident for an unusual occurrence with the Indiana State Department of Health] about her being found out in the courtyard since there was no injury. Since the area is secured, she couldn't have gone anywhere. We did conduct a post fall investigation...The AACU [also known as the Memory Care Unit] Manager the time this went on is no</p>			

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F 0354 SS=F Bldg. 00	<p>longer with us."</p> <p>Resident #D's clinical record was reviewed on 8-17-16 at 3:50 p.m. It indicated her diagnoses included, but were not limited to, dementia with behavioral disturbances. The admission Minimum Data Set (MDS) assessments, dated 2-15-16 and a quarterly MDS assessment, dated 8-10-16, indicated she has short term and long term memory problems and is severely cognitively impaired. Both MDS assessments indicated she is ambulatory with supervision and uses no mobility devices for assistance with ambulation.</p> <p>This Federal tag relates to Complaints IN00206427 and IN00206945.</p> <p>3.1-45(b)(2)</p> <p>483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p>			

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	<p>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>Based on interview and record review, the facility failed to ensure a registered nurse was physically present in the facility for a minimum of eight hours each day for the dates work schedules were reviewed in the last month. This deficient practice has the potential to adversely affect all residents.</p> <p>Findings include:</p> <p>On 8-15-16 at 7:05 p.m., the Executive Director provided a copy of the "as worked" nursing schedule for multiple dates for the last month. Review of these dates indicated on 7-31-16, the facility failed to have a Registered Nurse (RN) physically present in the facility for a minimum of eight hours on that date.</p> <p>In an interview on 8-16-16 at 2:02 p.m., the Executive Director indicated there was not an RN in the building, however an RN was on call and available as needed for 7-31-16.</p> <p>This Federal tag relates to Complaints IN00206427 and IN00206945.</p> <p>3.1-17(b)(3)</p>	F 0354	<p>No residents identified.</p> <p>All residents have the potential to be affected by this deficiency.</p> <p>In-service the Staffing Coordinator/Management Team on 8 hour per day, 7 days per week RN coverage.</p> <p>ED/DNS/designee to ensure daily RN coverage by reviewing the nursing schedule daily.</p> <p>Results of these audits will be taken to QAPI x 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.</p>	09/09/2016

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F 9999 Bldg. 00	<p>Based on interview and record review, the facility failed to report an unusual occurrence of a resident with severe cognitive impairment, residing on the secured Memory Care Unit (MCU) of the facility, wandering out into the courtyard of the unit without the knowledge of the staff to the Indiana State Department of Health. The resident was unseen by staff for approximately 1 to 1 and one-half hours, but located within approximately 15 minutes of being identified as not being accounted for by staff. (Resident #D)</p> <p>Findings include:</p> <p>In a confidential interview with an interested party of Resident #D 8-15-16, this person indicated the family was notified by phone on 7-7-16 at 7:25 a.m., that Resident #D "had gotten out in the courtyard during the night and [was] found lying on the grass. They were unsure how long she had been there, but it was long enough her back was wet...Normally, the door is locked and alarmed. Never got any feedback except the one phone call. To the best of my knowledge, she had never done anything like this before.... It worries me that for</p>	F 9999	<p>Resident identified and reviewed with no injuries noted.</p> <p>All residents that reside on the ACU have the potential to be affected by this deficiency. Facility immediately implemented nursing staff to check ACU courtyard door is secured at shift change, approximately 6pm.</p> <p>All staff educated on securing the ACU courtyard door at shift change. Day shift nurse to sign off on securing door daily prior to shift ending.</p> <p>ACD/designee to ensure ACU courtyard door is secured prior to shift end.</p> <p>Will report findings monthly at QAPI meetings x 6 months. The QAPI committee will evaluate compliance with F9999</p>	09/09/2016

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRANDYWINE	STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140
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(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
	<p>one thing that they didn't know she had gotten out at all at a door that should have been locked. She would have had no idea how to get back in." He indicated, "...seem to have less workers here...I expect them to have enough staff to take care of each patient in here properly and I don ' t think they have nearly enough staff."</p> <p>In an interview with the Executive Director on 8-18-16 at 12:21 p.m., she indicated it is not unusual for residents to go in and out of the door to go out into the courtyard. She indicated, "The courtyard door is not alarmed since you can't get to the exterior of the building from the courtyard."</p> <p>In an interview with the Clinical Educator on 8-18-16 at 12:21 p.m., she indicated she was working with the MCU manager, who was new to the manager position, on evening of 7-6-16. She recalled, "Around 8:00 p.m., my kids came on to the unit and she [Resident #D] was very interested in them. I was supervising the kids and [name of Resident #D]. [Name of Resident #D] was talking with them and playing with toys with them. She stayed close to them and seemed interested in them the entire time we were there...We left between 10:15 and 10:20 pm. She was at the</p>			

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	<p>nurse's station when I left. [Name of the MCU Manager] was in the nurse's station with her when I left. There were 2 CNA 's working the 6p-6a shift, but can't recall their names. [Name of QMA #1] came on duty at 10 pm to relieve the nurse, [name of the MCU Manager]...Didn't see any attempts of her going out to the courtyard."</p> <p>In interview with the Executive Director on 8-18-16 at 2:20 p.m., she indicated she had spoken to QMA #1 that afternoon to clarify some information regarding Resident #D on the evening of 7-6-16. She indicated he clarified, "He told me they started the routine every two hour rounds around 11:30 p.m. At 11:35 p.m., they did not find [name of Resident #D] in her bed. They started looking all over the unit and then out into the courtyard. They found her laying on the ground, looking up at the sky. He thought they finished report around 10:45 p.m... they did not alert anybody else because they found her pretty quick. They did have one of the nurses come over and check her out and she was not injured, she was okay."</p> <p>In an interview with the Executive Director on 8-18-16 at 10:40 a.m., "We did not file a reportable [incident for an unusual occurrence with the Indiana State</p>			

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	<p>Department of Health] about her being found out in the courtyard since there was no injury. Since the area is secured, she couldn't have gone anywhere. We did conduct a post fall investigation...The AACU [also known as Memory Care Unit] Manager the time this went on is no longer with us."</p> <p>Resident #D's clinical record was reviewed on 8-17-16 at 3:50 p.m. It indicated her diagnoses included, but were not limited to, dementia with behavioral disturbances. The admission Minimum Data Set (MDS) assessments, dated 2-15-16 and a quarterly MDS assessment, dated 8-10-16, indicated she has short term and long term memory problems and is severely cognitively impaired. Both MDS assessments indicated she is ambulatory with supervision and uses no mobility devices for assistance with ambulation.</p> <p>This Federal tag relates to Complaints IN00206427 and IN00206945.</p> <p>3.1-13(g)(1)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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