

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 02/11/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
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F 0000 Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 12/22/15. This visit included the PSR to the Investigation of Complaints IN00187972 and IN00187525 completed on 12/22/15.</p> <p>Complaint IN00187972-corrected Complaint IN00187525-corrected</p> <p>Survey dates: February 10 and 11, 2016.</p> <p>Facility number: 000062 Provider number: 155137 AIM number: 100271400</p> <p>Census bed type: SNF/NF: 76 Total: 76</p> <p>Census payor type: Medicare: 4 Medicaid: 64 Other: 8 Total: 76</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on</p>	F 0000	F000 - Preparation, submission and implementation of this plan of correction does not constitute an admission of 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.	
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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 0225 SS=D Bldg. 00	<p>February 19, 2016.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law</p>						

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	<p>(including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure an injury of unknown origin was thoroughly investigated and reported to the State Agency and Executive Director immediately related to a bruise of unknown origin for 1 of 3 residents reviewed for reportable allegations. (Resident #37)</p> <p>Finding includes:</p> <p>The record for Resident #37 was reviewed on 2/11/16 at 10:47 a.m. The resident's diagnoses included but were not limited to, heart failure and spinal stenosis (narrowing of the spinal canal, to which can cause pain, numbness and loss of motor control).</p> <p>The "Verification of Investigation" report form provided by the Executive Director was reviewed for Resident #37. The "Verification of Investigation" report dated 1/24/16, indicated the incident occurred on 1/22/16. "The Evening nurse was notified by a CNA that she noticed a bruise on resident's arm. Nurse went to assess. Resident was alert and was oriented, but resident did not know what</p>	F 0225	<p>F225 -</p> <p>1) Resident #37 remains in the living center and continues to be monitored for any additional events. Therapy had already completed their investigation/evaluation, and had instituted corrections as needed. Additional therapy will be initiated as appropriate.</p> <p>2) All residents have the potential to be affected by the alleged deficient practice. A review was conducted, by the Executive Director, of investigations completed within the last 30 days to ensure investigations were thorough and that documentation, from interviews with staff (when appropriate), were present. No concerns were noted.</p> <p>3) DNS/designee has in-serviced the staff on identifying and reporting allegations of abuse, and the importance of a timely and thorough investigation. This POC for this tag differs from the previous one, because the DNS/designee and the executive director are reviewing daily (Monday – Sunday; 24-hour) nurses' progress notes, and the DNS/designee is reviewing the 24-hour report, to ensure that all resident concerns are being noted, and are followed up on.</p>	02/29/2016

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	<p>she may have done. Type of injury, on the report, indicated a 11 cm (centimeter) by 7 cm bruise on left upper arm. Immediate action taken, the resident was assessed, contacted MD and family, and initiated investigation. The preventative measures added to be determined after the completion of the investigation. Follow up added on 1/28/16, indicated Therapy evaluated the resident and determined that she transfers without assistance. They worked though what she had been doing and they concluded that she had caused her issues. Contributing factors and observations, indicated the resident was weak on the left side, she may have hit the water shut off when self transferring on the toilet. She may have bumped her upper arm on the wheelchair or chair at bedside. The resident is unable to remember what occurred to cause area. (sic) The report also indicated the Executive Director and the Physician was contacted on 1/22/16 at 10:00 p.m.</p> <p>There was no other written investigation statements from the staff regarding the resident's functional status or mannerisms for the possible cause of the large bruise.</p> <p>The Quarterly MDS (Minimum Data Set (MDS) assessment, dated 12/4/15 indicated the resident had memory</p>		<p>Additionally, the executive director, if not on as the manager-on-duty for a weekend day, is in contact with the manager that is assigned for that day to ascertain if anything unusual has occurred. If there are any concerns, the staff will be directed, if they haven't already done so, to begin an investigation. ED and DNS, along with the IDT, will audit all verifications of investigations in daily stand-up meeting. An audit tool will be completed by the ED /designee 7 times per week for 4 weeks, then 5x per week times for 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks.</p> <p>4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern.</p> <p>5) February 29, 2016</p>				

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	<p>problems.</p> <p>Interview with the Executive Director on 2/11/16 at 11:32 a.m., indicated he was not notified by staff on 1/22/16 as indicated in the report by the RN #1. The Executive Director indicated he could not remember how he found the bruise of unknown origin, whether it was reviewing Nurse Progress notes or if he was notified by staff on 1/24/16. He further indicated, he reported the bruise to the State Department of Health due to the large size of the bruise. The Executive Director indicated he spoke to several CNAs and Nurses regarding the resident, but did not document those interviews and he should have.</p> <p>This deficiency was cited on 12/22/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-28(c) 3.1-28(d)</p>			

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F 0226 SS=D Bldg. 00	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure the facility's policy was followed for a thorough investigation and reported to the State Agency and Executive Director immediately related to a bruise of an injury of unknown for 1 of 3 residents reviewed for reportable allegations. (Resident #37)</p> <p>Finding includes:</p> <p>The record for Resident #37 was reviewed on 2/11/16 at 10:47 a.m. The resident's diagnoses included but were not limited to, heart failure and spinal stenosis (narrowing of the spinal canal, to which can cause pain, numbness and loss of motor control).</p> <p>The "Verification of Investigation" report form provided by the Executive Director was reviewed for Resident #37. The</p>	F 0226	<p>F226 - 1) Resident #37 remains in the living center and continues to be monitored for any additional events. Therapy had already completed their investigation/evaluation, and had instituted corrections as needed. Additional therapy will be initiated as appropriate. 2) All residents have the potential to be affected by the alleged deficient practice. A review was conducted, by the Executive Director, of investigations completed within the last 30 days to ensure investigations were thorough and that documentation, from interviews with staff (when appropriate), were present. No concerns were noted. 3) DNS/designee has in-serviced the staff on identifying and reporting allegations of abuse, and the importance of a timely and thorough investigation. This POC for this tag differs from the previous one, because the</p>	02/29/2016

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	<p>"Verification of Investigation" report dated 1/24/16, indicated the incident occurred on 1/22/16. "The Evening nurse was notified by a CNA that she noticed a bruise on resident's arm. Nurse went to assess. Resident was alert and was oriented, but resident did not know what she may have done. Type of injury, on the report, indicated a 11 cm (centimeter) by 7 cm bruise on left upper arm. Immediate action taken, the resident was assessed, contacted MD and family, and initiated investigation. The preventative measures added to be determined after the completion of the investigation. Follow up added on 1/28/16, indicated Therapy evaluated the resident and determined that she transfers without assistance. They worked though what she had been doing and they concluded that she had caused her issues. Contributing factors and observations, indicated the resident was weak on the left side, she may have hit the water shut off when self transferring on the toilet. She may have bumped her upper arm on the wheelchair or chair at bedside. The resident was unable to remember what occurred to cause area. (sic) The report also indicated the Executive Director and the Physician was contacted on 1/22/16 at 10:00 p.m.</p> <p>There was no other written investigation</p>		<p>DNS/designee and the executive director are reviewing daily (Monday – Sunday; 24-hour) nurses' progress notes, and the DNS/designee is reviewing the 24-hour report, to ensure that all resident concerns are being noted, and are followed up on. Additionally, the executive director, if not on as the manager-on-duty for a weekend day, is in contact with the manager that is assigned for that day to ascertain if anything unusual has occurred. If there are any concerns, the staff will be directed, if they haven't already done so, to begin an investigation. ED and DNS, along with the IDT, will audit all verifications of investigations in daily stand-up meeting. An audit tool will be completed by the ED /designee 7 times per week for 4 weeks, then 5x per week times for 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks. 4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern. 5) February 29, 2016</p>	

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	<p>statements from the staff regarding the resident's functional status or mannerisms for the possible cause of the large bruise.</p> <p>The Quarterly MDS (Minimum Data Set (MDS) assessment, dated 12/4/15 indicated the resident had memory problems.</p> <p>Interview with the Executive Director on 2/11/16 at 11:32 a.m., indicated he was not notified by staff on 1/22/16 as indicated in the report by the RN #1. The Executive Director indicated he could not remember how he found the bruise of unknown origin, whether it was reviewing Nurse Progress notes or if he was notified by staff on 1/24/16. He further indicated, he reported the bruise to the State Department of Health due to the large size of the bruise. The Executive Director indicated he spoke to several CNAs and Nurses regarding the resident, but did not document those interviews and he should have.</p> <p>The policy titled, " Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation," was provided by the Administrator on 2/11/16 at 9 a.m. This current policy indicated, "Policy Statement: It is the responsibility of all employees to immediately report any alleged violation</p>			

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	<p>of abuse, neglect injuries of unknown source...injuries of unknown source ...are reporting immediately to the executive director of the center...The center investigates each such alleged violation thoroughly and reports the result of all investigations to the executive director or his or her designee, as well as to state agencies as required by state and federal law...Investigations:...The investigations includes interviews of employees...When written statements are required by the state agency summarize or assist the interviewee to complete a written statement and sign it...Federal law requires the center to have evidence of investigations of alleged violations...."</p> <p>This deficiency was cited on 12/22/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-28(a)</p>			

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

PRINTED: 03/16/2016

FORM APPROVED

OMB NO. 0938-0391

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