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 09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-VALPARAISO	251 STURDY RD VALPARAISO, IN 46383

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00182245 and IN00182296. Complaint IN00182245- Substantiated. Federal/State deficiency related to the allegation is cited at F312. Complaint IN00182296- Substantiated. Federal/State deficiencies related to the allegations are cited at F241, F250, F312, F356, F425, and F514. Survey dates: September 20, 21, 22, & 23, 2015 Facility number: 000062 Provider number: 155137 AIM number: 100271400 Census bed type: SNF/NF: 78 Total: 78 Census payor type: Medicare: 4 Medicaid: 66 Other: 8 Total: 78 Sample: 22	F 0000	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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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 26143, on September 27, 2015.			
F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review, and interview, the facility failed to ensure residents dignity was maintained related to staff referring to dependent residents as "feeders"during the observation of a meal service in 1 of 2 Dining areas in the ACU (Alzheimer unit). (Residents #H and #S) (CNA #1) Finding includes: On 9/21/15 at 12:22 p.m., Residents #H and #S were observed sitting at a table in the "Workshop" Dining Room on the ACU unit. Resident #S was feeding him self independently and Resident #H was scraping his plate off. CNA #1 was present in the Dining Room. The CNA	F 0241	Resident #H and #S exhibited no psychosocial effects from being present when assistive dining was referred to as the “feeder room”. All residents have the potential to be affected by referring to the assisted dining room as a “feeder room.” 1. Staff was in-serviced on resident dignity. 2. Random audit of dining rooms, only during meal times, will be performed 5x/week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Meals only occur on the 1st and 2nd shifts. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting unless further monitoring is deemed necessary.	10/22/2015

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	indicated the Dining Room across the hall was the "Feeders" The Alzheimer Care Director was also present at this time and did not intervene or correct the above staff member. The record for Resident #H was reviewed on 9/22/15 at 2:20 p.m. The resident's diagnoses included, but were not limited to, delusional disorder, dementia, and Parkinson's disease. Review of the 7/3/15 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (2). A score of (2) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required assistance of one staff member for eating. The record for Resident #S was reviewed on 9/22/15 at 1:00 p.m. The resident's diagnoses included, but were not limited to, Alzheimer disease, major depression and high blood pressure. Review of the 8/20/15 Minimum Data Set (MDS) quarterly assessment indicated the residents BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were			

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	severely impaired. The assessment also indicted the resident had other behaviors not directed at others daily. When interviewed on 9/22/15 at 1:00 p.m., the Director of Nursing indicated the staff member should not have referred to the residents as "feeders." This Federal tag relates to Complaint IN00182296. 3.1-3(t)			
F 0250 SS=D Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review and interview, the facility failed to ensure behaviors between residents on the Alzheimer secured unit were reported and monitored for 2 of 2 residents reviewed for behaviors in a sample of 22. (Residents #S and #W) (CNA #1) Findings include: On 9/21/15 at 6:35 p.m., Resident #W was observed standing in the hall in front of Resident #S's room. The room door was closed.	F 0250	Resident #W and #S's behaviors were reviewed. (Upon investigation, it was determined that the incident as described had not occurred. The charge nurse had witnessed the interaction between the two residents and, on interview, reported to us that there was no inappropriate touching involved - that is why there was no report or charting that was required. She stated that the CNA that made the comment regarding the two residents had a tendency to be overly dramatic about events. When the CNA was interviewed, she commented that	10/22/2015

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	On 9/21/15 at 2:00 p.m., Resident #S was observed sitting in his room. The Alzheimer Unit Director was interviewed on 9/22/15 at 11:00 a.m., related to Behavioral Monitoring of residents on the Alzheimer unit. The Alzheimer Unit Director indicated staff monitor the behaviors of the residents on the unit. The Alzheimer Unit Director indicated staff report and follow up on any behaviors. The Alzheimer Unit Manager was interviewed on 9/22/15 at 11:50 a.m. The Manager provided information regarding a behavior which was reported to her on 9/21/15. The Alzheimer Unit Director indicated CNA #1 informed her on 9/21/15 of an event that occurred between Residents #S and #W on 9/20/15 (Sunday). The CNA informed her the two residents were walking down the hall and Resident #S had urinated in his pants. Resident #W was walking next to him with her hands on his pants in the genital area. The Director indicated she had a call out to the Nurse that was on duty at this time as there was no documentation in either of the resident's records of the above incident. The Director indicated it was not noted on the 24 hour shift to shift report and she		she had not said what was reported by the director of the Alzheimer's unit.) All residents have the potential to be effected. During the in-services, not only was a test administered regarding different scenarios and how to handle them, the staff was asked about behaviors that they may have witnessed and had not been addressed and/or documented. No issues surfaced. 1. Staff was in-serviced on reporting behaviors. Nursing staff was in-serviced on importance of documentation of behaviors. 2. DNS or designee will use an audit tool to review and record that behaviors are being documented. The audit tool will be completed by the DNS/designee 5 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting unless further monitoring is deemed necessary.	

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	wanted to verify the reported incident with the Nurse. The record for Resident #W was reviewed on 9/22/15 at 10:07 a.m. The resident's diagnoses included, but were not limited to, dementia, depression, heart failure, and high blood pressure. Review of the 7/27/15 Minimum Data Set (MDS) significant change assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (5). A score of (5) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident displayed physical and verbal behaviors towards others. The resident's current Care Plans were reviewed. A Care Plan initiated on 9/1/15 indicated the resident exhibited behaviors that were territorial and sexual in nature towards another male resident. Care Plan interventions included, but were not limited to, behavior checks as needed, redirect resident with conversation, going for a walk, and encourage visits from family members. Review of a 9/14/15 Psychiatric Progress Note indicated Nursing and Social Service had reported there had been an increase in depressive symptoms, sexual			

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	verbalizations, interest in one male resident, and had been caught in a male's room undressing. The 9/2015 Progress Notes were reviewed. There was no documentation of behaviors on 9/20/15. The record for Resident #S was reviewed on 9/22/15 at 1:00 p.m. The resident's diagnoses included, but were not limited to, Alzheimer disease, major depression and high blood pressure. Review of the 8/20/15 Minimum Data Set (MDS) quarterly assessment indicated the residents BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The assessment also indicted the resident had other behaviors not directed at others daily. The resident's current Care Plans were reviewed. A Care Plan initiated on 9/1/15 indicated the resident exhibit sexual behaviors and believed that other residents were his girlfriends. Care plan interventions included, but were not limited to, provide 1:1 as needed, redirect the resident to go for a walk, assist with a task, or engage in an activity.			

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	The 9/2015 Progress Notes were reviewed. There was no documentation of resident behaviors on 9/20/15-9/22/15. When interviewed again on 9/22/15 at 1:50 p.m., the Director indicated any behaviors were to be documented in the Progress Notes and passed on in the 24 hour shift to shift report for ongoing monitoring of the residents When interviewed on 9/22/15 at 2:00 p.m., the Director of Nursing indicated she had not been informed of the above incident until this time. The Director of Nursing indicated behaviors should be reported, assessed, and monitored. The facility policy titled "Behavior Management Guideline" was reviewed on 9/22/15 at 2:45 p.m. The policy was dated 2/12/2015. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated a Care Plan was to be developed for resident's exhibiting behaviors and monitoring of the established behaviors, interventions, and medications was to be completed by the interdisciplinary team. This Federal tag relates to Complaint IN00182296.			

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	3.1-34(a)			
F 0312 SS=D Bldg. 00	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 record review and interview, the facility failed to ensure the necessary treatment and services were provided to maintain good personal hygiene related to showers not provided for 1 of 3 dependent residents reviewed for showers in a sample of 22. (Resident #K) Finding includes: The record for Resident #K was reviewed on 9/22/15 at 12:16 p.m. The resident's diagnoses included, but were not limited to, dementia, convulsions, heart failure, stroke, and chronic obstructive pulmonary disease. Review of the 7/27/15 Minimum Data Set (MDS) quarterly assessment indicated the resident required extensive assistance of one staff member for personal hygiene and physical help of one person assist in part of bathing.	F 0312	Resident #K's preference for bathing was reviewed. All residents have the potential to be affected. Resident's bathing preferences were reviewed. 1. Staff was educated on completing shower sheets with showers. 2. DNS or designee will use an audit tool to record documentation of showers using shower sheets. The audit tool will be completed by the DNS/designee 5 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting unless further monitoring is deemed necessary.	10/22/2015

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	155137		09/23/2015

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	The 8/2015 and 9/2015 Bathing Detail Reports and Shower Sheets were reviewed. The report indicated the resident was to be given showers on Wednesdays and Saturdays. The report indicated the resident did not receive showers on 8/12/15, 8/15/2015, 8/19/2015, 8/22/15, 8/29/15, 9/5/15, and 9/9/15 which were her scheduled days for showers. When interviewed on 9/22/15 at 1:57 p.m., the Director of Nursing indicated the resident's schedule shower days were Wednesdays and Saturdays. The Director of Nursing also indicated the Shower Sheets and Bathing reports should have all showers documented. This Federal tag relates to Complaints IN00182245 and IN00182296. 3.1-38(a)(3)(A)			
F 0356 SS=C Bldg. 00	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:			

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	- Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation and interview, the facility failed to ensure the daily staffing pattern was posted throughout the facility. Finding includes: During Orientation Tour on 9/20/15 at 3:50 a.m. through 8:50 a.m., no daily Staffing Sheets identifying the actual number of RN's , LPN's, CNA's working each shift were observed throughout the facility. On 9/21/15 no Staffing Sheets were	F 0356	No residents were affected. Residents and visitors have the potential to be affected. ED or designee will use an audit tool to record that the Nurse Staffing form is posted daily. The audit tool will be completed by the ED/designee 5 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting unless further monitoring is deemed necessary.	10/22/2015

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	observed throughout the building on the day shift from 8:00 a.m.- 3:30 p.m.. On 9/2/15 no Staffing Sheets were observed at 6:30 p.m. on the Evening shift. On 9/21/15 at 8:00 a.m., no Staffing Sheets were noted. When interviewed on 9/22/15 at 8:30 a.m. the Director of Nursing indicated the Staffing Sheets were to be posted on the wall across from her office daily. The Director of Nursing indicated the signs had not been posted as required. This Federal tag relates to Complaint IN00182296. 3.1-17(a)			
F 0425 SS=E Bldg. 00	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,			

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	dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review, and interview, the facility failed to ensure medication were destroyed as per the Pharmacy and facility in 2 of 2 Medication Rooms observed for medication storage. (The South and ACU units) Findings include: 1. The Medication Room on the ACU unit was observed on 9/21/15 at 11:20 a.m. with LPN #2. There were medications for a resident who had been discharged from the facility in July 2015. The medications had not been destroyed. When interviewed at this time, LPN #2 indicated the midnight shift Nurses were responsible for destroying medication that were not being used. 2. The Medication Room on the South unit was observed on 9/21/15 at 11:35 a.m.- 12:05 p.m., with the Director of Nursing present. The following was observed:	F 0425	No residents were adversely affected. All residents have the potential to be affected. 1. Staff was in-serviced on appropriate medication disposition procedure. 2. DNS or designee will use an audit tool to record that appropriate medication disposition procedure is performed. The audit tool will be completed by the DNS/designee 5 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting unless further monitoring is deemed necessary	10/22/2015

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	a. There was a large clear plastic bag on the counter top. There were numerous rolls of pre- filled plastic strips of medications in the bag. The Director of Nursing indicated there had been a malfunction with the dispensing machine and the technician had been out to repair the machine. The machine dispensed two sets of all the 9/12/15 medications for all the residents in the facility. The Director of Nursing indicated these were the second set of medications. b. There were several boxes and Pharmacy totes in the Medication Room. One box was filled with medication punch cards for multiple residents. There were unused pills in the punch cards. Thirty two punch cards were counted with additional ones noted. Eighty two individual plastic strip packets of medications were counted with some having multiple pills in them. Several additional packets were noted in other boxes, on the counter top, and on the floor. Dates on some of the packets and punch cards were dated 10/2014, 3/14/15, 5/16/15, 7/8/15, 8/1/15, and 9/12/15. When interviewed on 9/21/15 at 12:05 p.m., the Director of Nursing indicated several of the medications observed had been for residents who were no longer in			

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	the facility or were medications that could have been discontinued or refused. The Director of Nursing indicated Pharmacy staff came to the facility daily, usually on the Evening or Night shifts. The Director of Nursing indicated the midnight shift Nurses were responsible for destroying any oral medications in punch cards that had been opened and all the unused medications that came in the sleeves. The Director of Nursing indicated this was to be done every day. The facility Pharmacist was interviewed by telephone on 9/21/15 at 3:35 p.m. The Pharmacist indicated the facility was responsible for destroying unused pills from the plastic strip sleeves and and from opened punched cards. The Pharmacist also indicated the medications should not have been left in the Medication Rooms. The Pharmacist indicated the Pharmacy staff that come to the facility do not destroy any medications. The facility policy titled " Disposal of Medication" was reviewed on 9/21/15 at 3:13 p.m. The policy was dated 12/08/2014. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated medications which did not qualify for return to the pharmacy were to be			

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	removed from the supply in a timely manner. This Federal tag relates to IN00182296. 3.1-25(o)			
F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, record review, and interview, the facility failed to ensure side rails assessments were completed for 2 of 3 residents reviewed for side rails in a sample of 22. (Residents #J and #Z) Findings include: 1. On 9/22/15 at 1: 35 p.m., Resident #Z was observed in bed. The resident was laying on his right side. Quarter side rails were in place the middle of the both sides of the bed. The rails were in the up	F 0514	Residents #Z and #J's side rail assessments were reviewed. No adverse affects were noted to residents #Z and #J. All residents have the potential to be affected. All residents with side rails were reviewed to ensure side rail assessments were present. 1. Nurses were educated on when to complete side rail assessments. 2. DNS or designee will audit side rail assessments based on MDS schedule for those residents with side rails. The audit tool will be completed by the DNS/designee	10/22/2015

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	position. The record for Resident #Z was reviewed on 9/22/15 at 2:30 p.m. The resident's diagnoses included, but were not limited to, peripheral neuropathy, chronic airway obstruction, and gastritis. Review of the 8/31/15 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (15). A score of (15) indicated the resident's cognitive patterns were intact. The assessment also indicated the resident required extensive assistance of two or more staff members for bed mobility and transfers. The residents quarterly side rail assessments were reviewed. The most recent side rail assessment was completed on 8/1/2014. When interviewed on 9/22/15 at 1:45 p.m., the Director of Nursing indicated the resident had side rails in place for an extended period of time. The Director of Nursing indicated side rail assessments were to be completed quarterly and there were no further assessments for the resident.		5 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting unless further monitoring is deemed necessary The facility respectfully requests that paper compliance be given consideration for these tags.	

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	2. On 9/22/15 at 2:00 p.m. Resident #J was observed in bed. There were short side rails in place in the middle of bed on both sides. The record for Resident #J was reviewed on 9/22/15 at 2:30 p.m. The resident's diagnoses included, but were not limited to, Alzheimer disease and obstructive hydrocephalus. Review of the 8/27/15 Minimum Data Set (MDS) significant change assessment indicated the resident required extensive assistance of two or more staff for bed mobility. A Clinical Health Status assessment was completed on 8/27/15. The assessment indicated side rails were used. The assessment also indicated a Restraint/Side Rail assessment was to be completed if side rails were used. No Side Rail assessment was completed on 8/27/15. No other 2015 Side Rail assessments were provided by the facility. When interviewed on 9/22/15 at 3:00 p.m. , the Director of Nursing indicated no recent Side Rail assessment could be located. The Director of Nursing indicated Side Rail assessment should have been completed quarterly.			

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	The facility policy titled "Side Rail Guideline" was reviewed on 9/22/15 at 12:15 p.m. The policy had a revised date of 2013. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated side rail assessment were to be completed and documented at least quarterly. This Federal tag relates to Complaint IN00182296. 3.1-50(a)(1)			