

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/28/2015
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00178623.</p> <p>Complaint IN00178623- Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226, F315, and 9999.</p> <p>Unrelated deficiency was cited.</p> <p>Survey dates: July 27 &amp; 28, 2015</p> <p>Facility number: 000253 Provider number: 155362 AIM number: 100266660</p> <p>Census bed type: SNF/NF: 142 Total: 142</p> <p>Census Payor type: Medicare: 12 Medicaid: 98 Other: 32 Total: 142</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		

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>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>			

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	<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 (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 thoroughly investigate allegations of abuse and report allegations of abuse to the Administrator and the Indiana State Department of Health (ISDH), related to allegations of staff to resident abuse, for 2 of 4 residents reviewed for abuse in a total sample of 4. (Resident #B and #E)</p> <p>Findings include:</p> <p>1. Review of a State Reportable Incident and Investigation, dated 06/22/15, indicated an allegation of staff to resident abuse was reported by Resident #E on 06/20/15 (no time documented) to LPN #2. Resident #E indicated a CNA had treated him roughly and used inappropriate language during care. The State Reportable Incident and Investigation report, indicated ISDH (Indiana State Department of Health) was notified by the ADON (Assistant Director of Nursing) on 6/22/15.</p>	F 0225	<p><b>F225</b></p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p><b>Unable to correct the alleged deficient practice for Resident B&amp; E.</b></p> <p>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.</p>	08/27/2015

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	<p>Interview on 7/28/15 at 11:10 a.m. with LPN #1, who was the on-call nursing Supervisor on 6/20/15, indicated LPN #2 had notified her of the allegation. LPN #1 indicated she attempted to notify the ADoN, who was on call for the DoN (Director of Nursing), of the allegation of abuse on 6/20/15. She was unable to reach the ADoN and left a voicemail. LPN #1 further indicated she did not attempt to notify the Executive Director.</p> <p>Interview with the ADoN on 7/28/15 at 11:10 a.m., indicated she was unaware of the allegation or the attempt to notify her until hearing the voicemail from LPN #1 on 6/21/15. She further indicated she did not notify the Executive Director and proceeded to wait until the morning of 6/22/15 to file a report with ISDH.</p> <p>Resident #E's record was reviewed on 07/27/15 at 11 a.m. The resident's diagnoses included, but were not limited to, vascular dementia and hypertension.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 06/30/15, indicated the resident's cognition was intact.</p> <p>2. Resident #B's record was reviewed on 07/27/15 at 11:05 a.m. The resident's diagnoses included, but were not limited to diabetes mellitus and peripheral</p>		<p><b>Residents with new reportable events have the potential to be affected.</b></p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p><b>Management team will be re-educated on the following:</b></p> <p><b>Reportable incident policy and ISDH reportable unusual occurrence policy, Verification of Investigation of Alleged Mistreatment,</b></p> <p><b>Abuse, Neglect, Injuries of Unknown Source and</b></p> <p><b>Misappropriation of Resident/Patient Property Guideline</b></p> <p><b>Which includes investigation and reporting events to the ED.</b></p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</p>	

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	<p>vascular disease.</p> <p>The Quarterly MDS assessment, dated 06/23/15, indicated the resident's cognition was intact.</p> <p>During an interview on 07/28/15 at 10:05 a.m., Resident #B indicated she had been treated roughly by a CNA during care in the past and the CNA had left a bruise on her arm. She indicated she did not know the CNA's name.</p> <p>A State Reportable Incident and Investigation, dated 07/10/15, incident time of 11:20 a.m., indicated a bruise was found on the resident's arm on 07/10/15 at 10:20 a.m. and the resident alleged the bruise was caused by a staff member.</p> <p>The investigation indicated the alleged staff member (CNA #3) had finished her shift and was no longer in the building to interview and CNA #4, who had been in the room with CNA #3 was interviewed about the allegation. The investigation had not indicated CNA #3 had been interviewed.</p> <p>During an interview on 07/28/15 at 11:16 a.m., the ADoN indicated she had not interviewed CNA #3 (CNA allegation was made against). The ADoN indicated she should have interviewed CNA #3.</p>		<p>program will be put into place.</p> <p><b>Reporting and Investigation Audit will be completed monthly for all reportable events. Results will be provided in QAPI monthly for a minimum of six months looking for any trends or patterns.</b></p> <p>By what date the systemic changes will be completed? <b>August 27, 2015</b></p>	

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F 0226 SS=D Bldg. 00	<p>This Federal Tag relates to Complaint IN00178623.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p>			

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	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure the facility's abuse policy was followed, related to not immediately reporting allegations of abuse to the Executive Director of the facility, the Indiana State Department of Health (ISDH), and not thoroughly investigating allegations of abuse for 2 of 4 residents reviewed for abuse in a total sample of 4. (Residents #B and #E)</p> <p>Findings include:</p> <p>1. Review of a State Reportable Incident and Investigation, dated 06/22/15, indicated an allegation of staff to resident abuse was reported by Resident #E on 06/20/15 (no time documented) to LPN #2. The reportable indicated ISDH (Indiana State Department of Health) was notified by the ADON (Assistant Director of Nursing) on 6/22/15 (over 24 hours).</p> <p>Interview on 7/28/15 at 11:10 a.m. with LPN #1, who was the on-call nursing Supervisor on 6/20/15, indicated LPN #2 had notified her of the allegation. LPN #1 indicated she attempted to notify the ADoN, who was on call for the DoN</p>	F 0226	<p><b>F226</b></p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p><b>Unable to correct the alleged deficient practice for Resident B&amp; E.</b></p> <p>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.</p> <p><b>Residents with new reportable events have the potential to be affected.</b></p>	08/27/2015

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	<p>(Director of Nursing), of the allegation of abuse on 6/20/15. She was unable to reach the ADoN and left a voicemail. LPN #1 further indicated she did not attempt to notify the Executive Director.</p> <p>Interview with the ADoN on 7/28/15 at 11:10 a.m., indicated she was unaware of the allegation or the attempt to notify her until hearing the voicemail from LPN #1 on 6/21/15. She further indicated she did not notify the Executive Director and proceeded to wait until the morning of 6/22/15 to file a report with ISDH.</p> <p>2. During an interview on 07/28/15 at 10:05 a.m., Resident #B indicated she had been treated roughly by a CNA during care in the past and the CNA had left a bruise on her arm. She indicated she did not know the CNA's name.</p> <p>A State Reportable Incident and Investigation, dated 07/10/15, incident time of 11:20 a.m., indicated a bruise was found on the resident's arm on 07/10/15 at 10:20 a.m. and the resident alleged the bruise was caused by a staff member.</p> <p>The investigation indicated the alleged staff member (CNA #3) was no longer in the building, and CNA #4, who had been in the room with CNA #3 was interviewed about the allegation. The</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p><b>Management team will be re-educated on the following:</b></p> <p><b>Reportable incident policy and ISDH reportable unusual occurrence policy, Verification of Investigation of Alleged Mistreatment,</b></p> <p><b>Abuse, Neglect, Injuries of Unknown Source and</b></p> <p><b>Misappropriation of Resident/Patient Property Guideline</b></p> <p><b>Which includes investigation and reporting events to the ED.</b></p> <p>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.</p> <p><b>Reporting and Investigation</b></p>	

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	<p>investigation had not indicated CNA #3 had been interviewed.</p> <p>During an interview on 07/28/15 at 11:16 a.m., the ADoN indicated she had not interviewed CNA #3 (CNA allegation was made against). The ADoN indicated she should have interviewed CNA #3.</p> <p>A facility policy, dated 01/15/15, received from the Director of Nursing as current on 07/27/15 at 9:40 a.m., titled, "Verification of Investigation of Alleged Mistreatment, Abuse, Neglect, Injuries of Unknown Source and Misappropriation of Resident/Patient Property Guideline", indicated, "...Any employee who suspects an alleged violation immediately notifies the ED (Executive Director), or designee. The ED notifies the appropriate state agency in accordance with state law...The investigation includes interviews of employees...who may have knowledge of the alleged incident..."</p> <p>This Federal Tag relates to Complaint IN00178623.</p> <p>3.1-28(a)</p>		<p><b>Audit will be completed monthly for all reportable events. Results will be provided in QAPI monthly for a minimum of six months looking for any trends or patterns.</b></p> <p>By what date the systemic changes will be completed? <b>August 27, 2015</b></p>				

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F 0315 SS=G Bldg. 00	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on interview and record review the facility failed to assess a resident who was continent of urine, and became incontinent of urine for potential causes of the incontinence and the need for an individual toileting program and also failed to assess another resident for causes of incontinence and a toileting program for the incontinence, for 2 of 3 residents reviewed for urinary incontinence in a total sample of 4. (Residents #B and #C)</p> <p>Findings include:</p> <p>1. During an interview on 07/27/15 at 8:55 a.m., LPN #5 indicated Resident #C was alert and oriented to person, place, and time, required assistance with care, and was incontinent of urine.</p>	F 0315	<p><b>F315</b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. <b>Resident's B &amp; C had a bladder assessment completed and an individualized toileting plan has been developed</b> 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. <b>Residents who are incontinent have the potential to be affected by the alleged deficient practice. Residents will have their most recent MDS reviewed, to determine if any decline has occurred. Any residents noted with a decline will have bladder assessment completed and need for a toileting plan assessed.</b></p>	08/27/2015

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	<p>During an interview on 07/27/15 at 8:58 a.m., Resident #C indicated the staff do not check him for incontinence. He indicated he has to use his call light to let them know when he needs to use the toilet or after he has already been incontinent. He indicated he knew when he needed to void.</p> <p>During an interview on 07/27/15 at 11:12 a.m., CNA #4 indicated she would check with Resident #C, "but he knows when he is wet."</p> <p>During an interview on 07/28/15 at 9:41 a.m., Resident #C indicated he had been incontinent since he fractured his arm (07/01/15), and the staff placed him in a wheelchair. He indicated he used to use a walker to ambulate and could take himself to the bathroom. He indicated he now wore an incontinent brief. He indicated the staff informed him he could call for assistance to the bathroom, but by the time the staff answer the call light, he had already been incontinent. He indicated he could not wait long for the bathroom. He indicated the staff do not come in before or after meals to ask him if he needed the bathroom. He indicated it had not bothered him to be incontinent, he stated, "I adapt."</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. <b>Nurse Management will be re-educated regarding Incontinence Management / Bladder Function Guideline. Bladder Evaluation form will be completed by Nurse manager with the initial MDS and reviewed Quarterly to evaluate the effectiveness of the current plan of care. Nursing Staff will be re-educated regarding reporting changes in function or incontinence to nurse manager. Nursing staff will be re-educated regarding following toileting plans as care planned.</b> 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. <b>Quarterly MDS Audit will be completed weekly for any recent MDS' completed to ensure Bladder Evaluation Form was completed and reviewed for continued effectiveness. Audit will be completed for a minimum of 6 months. DNS or designee will review results of audits and bring trends or patterns to QAPI meeting monthly for 6 months. Date of Compliance: August 27, 2015</b> We respectfully request an IDR for this tag. We appreciate the opportunity to</p>				

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	<p>Resident #C's record was reviewed on 07/28/15 at 8:55 a.m. The resident's diagnoses included, but were not limited to, prostate cancer and congestive heart failure.</p> <p>A Clinical Health Status form, dated 06/05/15, indicated the resident was continent of urine.</p> <p>A Significant Change Minimum Data Set (MDS) assessment, dated 07/10/15, indicated the resident's cognition was intact, required minimal assistance with transfers, extensive assistance with toileting, and was occasionally incontinent.</p> <p>The Care Area Assessment (CAA), dated 07/10/15, indicated the resident had urinary urgency, became dependent up on staff for assistance with toileting and transfers, was occasionally incontinent of bladder, received a diuretic daily, and the resident was rendered incontinent care daily and as needed.</p> <p>The care plan, dated 01/21/15, indicated the resident had an alteration in elimination of bowel and bladder. The interventions included, call light within in reach and reminders to use as needed, discuss medications with physicians which may be contributing to</p>		<p>present information and documentation that will lower the scope and severity or eliminate the tag. Thank you in advance for your time and consideration in this matter.</p>	

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	<p>incontinence, and evaluate frequency/timing of incontinence episodes.</p> <p>The Continance Daily Report, dated 07/01/15 through 07/27/15, indicated the resident was continent on 07/01/15, (the resident was in the hospital from 07/01/15 to 07/06/15), was incontinent at least 2-4 times daily 07/07/15 through 07/27/15, with one continent episode on July 8, 11, 13, 15, and 20, 2015.</p> <p>During an interview on 07/28/15 at 8:25 a.m., CNA #3 indicated when reporting bladder functioning on the Continance Daily Report, they can only document each shift if the resident was incontinent or continent, and they can not document how many times the resident was incontinent.</p> <p>The record indicated the resident's incontinence had not been evaluated for frequency and timing of incontinence, reasons for the increased incontinence, and for an individualized toileting plan.</p> <p>During an interview on 07/28/15 at 1:13 p.m., the ADoN (Assistant Director of Nursing), indicated there had not been an urinary incontinence assessment completed on the resident with the change in bladder function.</p>			

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	<p>2. During an interview on 07/27/15 at 8:55 a.m., LPN #5 indicated Resident #B was alert and oriented to person, place, and time, required assistance with care, and was incontinent of urine.</p> <p>During an interview on 07/27/15 at 8:12 a.m., Resident #B indicated she knew when she was wet and she called for the staff to come change her. She indicated sometimes she was sitting in a wet brief for long periods of time. She indicated she cannot feel the urge to void but she felt the wetness after she voided in her briefs.</p> <p>During an interview on 07/27/15 at 11:12 a.m., CNA #4 indicated Resident #B knew when she was incontinent and used the call light to let the staff know.</p> <p>Resident #B's record was reviewed on 07/27/15 at 11:05 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and peripheral vascular disease.</p> <p>The Quarterly MDS assessment, dated 06/23/15, indicated the resident's cognition was intact, required extensive assistance of two staff for transfers, extensive assistance of one for toileting, and was always incontinent of bladder.</p>			

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	<p>There was no bladder assessment located in the resident's medical record.</p> <p>A CAA, dated 04/16/15, indicated the resident had restricted mobility, had urinary urgency and needed assistance in toileting, the resident was frequently incontinent of bowel and bladder, briefs were worn and incontinence care was rendered as needed.</p> <p>The Continence by Day Report, dated 07/01/15 through 07/15/15 and 07/21/15 through 07/27/15, indicated the resident was incontinent multiple times daily.</p> <p>A care plan, dated 04/24/15, indicated the resident had an alteration in elimination of the bladder, the interventions included, call light in reach and reminders to use as needed, check and change as needed, provide assistance to toilet, use of briefs/pads for incontinence protection.</p> <p>During an interview on 07/28/15 at 1:13 p.m., the ADoN indicated a bladder assessment had not been completed for Resident #B.</p> <p>A facility policy, dated 06/09/15, received from the ADoN as current on 07/28/15 at 8:36 a.m., titled, "Incontinence Management/Bladder</p>			

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F 0323 SS=D Bldg. 00	<p>Function Guideline", indicated, "...Upon admission (if the resident has a history of incontinence) complete the Bowel and Bladder Tracking Tool. Completed to identify any trends or patterns that the resident may have in relation to incontinence...Complete the Bladder Evaluation Form...Upon completion of this evaluation as well as the Tracking Tool, the toileting/bladder program can be determined..."</p> <p>This Federal Tag relates to Complaint IN00178623.</p> <p>3.1-41(a)(1) 3.1-41(a)(2)</p> <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>	F 0323		08/27/2015

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	<p>Based on interview and record review, the facility failed to ensure a resident was free of accidents and had an assistive device in place, related to a fall for 1 resident reviewed for a fall in a total sample of 4. (Resident #D)</p> <p>Findings include:</p> <p>Resident #D's record was reviewed on 07/28/15 at 10 a.m. The resident's diagnoses included, but were not limited to dementia and hypertension.</p> <p>A Medicare Minimum Data Set assessment, dated 06/11/15, indicated the resident's cognition was impaired, and required extensive assistance for bed mobility and transfers.</p> <p>A Fall Risk Assessment, dated 06/08/15, indicated the resident was a risk for falls.</p> <p>A care plan, dated 05/20/11, indicated the resident was a risk for falls and had a history of falls. The interventions included, perimeter mattress, initiated on 08/15/12.</p> <p>A Fall Investigation, dated 07/16/15 at 2 p.m., indicated the resident was found lying on her right side on her bedroom floor, and the resident stated she tried to roll over in bed and rolled right off.</p>		<p><b>F323</b></p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p><b>At the time of the fall 7/16/15 resident D's mattress was changed to a perimeter mattress as ordered.</b></p> <p>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.</p> <p><b>An order audit was completed for all residents to identify those residents who are to have a perimeter mattress in place. All residents with orders for perimeter mattresses were audited to ensure perimeter mattresses are in place.</b></p> <p>What measures will be put into</p>	

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	<p>An Interdisciplinary Team Progress Note, dated 07/20/15 at 3:15 p.m., indicated, "... the resident had a recent room move and it was noted that the resident did not have her perimeter mattress (sic) in place to her bed..."</p> <p>During an interview on 07/28/15 at 11:20 a.m., the Assistant Director of Nursing indicated the mattress should have been transferred with the bed transfer. She indicated the fall occurred due to the perimeter mattress was not on the bed.</p> <p>3.1-45(a)(2)</p>		<p>place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p><b>Management team will be re-educated that when a resident is moved their mattress is to move with them to avoid the alleged deficient practice from reoccurring.</b></p> <p>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.</p> <p><b>When a resident has an internal transfer the room will be audited by the unit manager or designee to ensure the resident has the correct mattress in place.</b></p> <p><b>All residents with orders for perimeter mattresses will be audited monthly x 6 months by the DNS or designee to ensure mattresses remain in place and the deficient practice does not reoccur</b></p>	

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F 9999  Bldg. 00	<p>3.1-13 Administration and management</p> <p>The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any:</p> <p>(A) epidemic outbreaks;</p> <p>(B) poisonings;</p>	F 9999	<p><b>DNS or designee will bring results of the audit to QAPI for 6 months looking for trends and patterns.</b></p> <p>By what date the systemic changes will be completed?</p> <p><b>Completed by August 27, 2015</b></p> <p><i>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.</i></p> <p>·All incidence of unusual occurrence will be reported to the Indiana State Department of Health immediately, within 24 hours, adhering to the guidelines of the State Department and the Golden Living.</p>	08/27/2015

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	<p>(C) Fires; or (D) major accidents.</p> <p>This State Rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to report an unusual occurrence within 24 hours, to the Indiana State Department of Health (ISDH), related to a resident with a large bruise, for 1 of 4 residents reviewed for abuse/unusual occurrences in a total sample of 4. (Resident #D)</p> <p>Finding includes:</p> <p>Resident #D's record was reviewed on 07/28/15 at 10 a.m. The resident's diagnoses included, but were not limited to dementia and hypertension.</p> <p>A Medicare Minimum Data Set assessment, dated 06/11/15, indicated the resident's cognition was impaired, and required extensive assistance for bed mobility and transfers.</p> <p>An Investigation of a skin tear to the left shin, dated 07/07/26 at 6:40 a.m., indicated the resident had received a skin tear to the left shin, which measured 0.3 cm (centimeters) by 1.5 cm with bruising which measured 29 cm x 26 cm. The</p>		<p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</i></p> <ul style="list-style-type: none"> <li>·Director of Clinical Education did an in-service and education with all management staff to ensure the proper knowledge of the timely reporting of any unusual occurrences</li> </ul> <p><i>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.</i></p> <ul style="list-style-type: none"> <li>·All unusual occurrences will immediately be reported to the ED/DNS to ensure the proper timeline in notification to the State.</li> <li>·All unusual occurrence reports to the State will be brought to QA monthly to monitor as an ongoing process.</li> </ul> <p><i>By what date the systemic changes will be completed.</i></p> <ul style="list-style-type: none"> <li>·8/27/15</li> </ul>		

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	<p>Investigation indicated the Assistant Director of Nursing had been notified on 07/07/15 at 7 a.m. The Investigation did not indicate the ISDH had been notified of the bruising.</p> <p>An Incident Reportable to the ISDH, indicated the incident occurred on 07/08/15 at 4:30 p.m. The statements on the report indicated a date of 07/09/15.</p> <p>A facility policy, dated 01/15/15, received from the Director of Nursing as current on 07/27/15 at 9:40 a.m., titled, "Verification of Investigation of Alleged Mistreatment, Abuse, Neglect, Injuries of Unknown Source and Misappropriation of Resident/Patient Property Guideline", indicated, "...The ED (Executive Director) notifies the appropriate state agency in accordance with state law..."</p> <p>This Federal Tag relates to Complaint IN00178623.</p> <p>3.1-13(g)(1)</p>			

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

PRINTED: 08/26/2015

FORM APPROVED

OMB NO. 0938-0391

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