

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401
--	---

(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
F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 3, 4, 5, and 6, 2011</p> <p>Facility number: 000177 Provider number: 155278 AIM number: 100289860</p> <p>Survey team: Melinda Lewis, RN- TC Marla Potts, RN Sharon Whiteman, RN</p> <p>Census bed type: SNF/NF: 137 Total: 137</p> <p>Census payor type: Medicare: 10 Medicaid: 109 Other: 18 Total: 137</p> <p>Sample: 24</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October 12, 2011 by Bev Faulkner, RN</p>	F0000	<p>Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed with this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute and admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filled solely because of the requirements under State and federal law that mandate submission of a Plan of Corrction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. Facility respectfully requests a desk review of the Plan of Correction due to the documentation allegations.</p>	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401
--	---

(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
F0241 SS=D	<p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure a Resident with a MR/DD (Mental Retardation/Developmental Disability) Diagnoses, Resident #78, received care which ensured his specialized needs regarding socialization were met, to prevent decline, for 1 of 1 resident with MR reviewed for services in the sample of 24.</p> <p>Findings include:</p> <p>On the initial tour, on 10/3/11 at 9:45 A.M., LPN # 1 indicated Resident # 78 required extensive assistance with activities of daily living, had cognitive impairment, and was not interviewable.</p> <p>During observation of the locked Advanced Alzheimer's Care Unit (AACU), on 10/4/11 at 11:00 A.M., Resident # 78 was observed to be sitting at the dining room table with his eyes closed with Christmas music playing in</p>	F0241	<p><b>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</b></p> <p><b>The facility has contacted for a referral the BDDS (Bureau of Developmentally Delayed Services) to have R78 assessed for placement in a residential setting appropriate to his diagnosis.</b></p> <p><b>The facility has contacted Stonebelt, an outside agency, to assess the resident for outside services. A habilitation plan has been developed to provide him opportunities in choices of his ADLs. The family has been contacted to set up visits and resident will have a minimum of one activity off the Unit 5 days a week.</b></p> <p><b>Other residents having the potential to be affected by the</b></p>	11/05/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2011
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>the background. There were no staff in the dining room. The unit was observed to be a small unit with the census of 14. There was only one common area observed which was the dining room with four tables. The dining room had only kitchen table chairs. There was no television or radio observed. There was a CD player observed to be on the counter next to the sink that was playing the Christmas music. No one was observed to interact with the resident.</p> <p>On 10/5/11 at 9:30 A.M., there were 11 residents observed to be in the dining room with the AACU Director. There was church music playing and several different items placed on the tables in front of the residents such as books, magazines, beads, puzzles, blocks and plastic pipes. One resident was observed to be looking at a magazine, but the other residents were not interested in the items on the tables. Resident # 78 was observed to be sitting in his wheelchair in his room. The two staff members were assisting Resident # 78's room mate from the bathroom. Resident #78 was not observed to have interaction with anyone nor to have been offered and engaged in anything to do.</p> <p>On 10/5/11 at 10:30 A.M., during observation of the AACU there were no</p>		<p><b>same deficient practice will be identified and the corrective actions taken are as follows:</b></p> <p><b>Other residents with a MR/DD diagnosis will have care plan reviewed to ensure that their specialized needs regarding socialization are met and outside services will be contacted if indicated.</b></p> <p><b>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</b></p> <p><b>SSD/Designee will review all Level IIs upon 48 hours of documentation arriving in the facility to ensure that if a resident is admitted with a diagnosis of MR/DD that a QMRP assesses the resident.</b></p> <p><b>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b></p> <p><b>ED/Designee will review Level IIs after admission and QMRP notes to ensure that outside services are contacted if indicated.</b></p> <p><b>Any trends or patterns will be reviewed during QA monthly</b></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2011
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401		
(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>nursing staff observed on the unit. The Housekeeping Supervisor stated the nurse had left the unit to go get something and would be right back. There were 9 residents observed to be in the dining room sitting at the tables. There different items on the tables such as books, magazines, puzzles, blocks and plastic pipes. Resident # 78 was observed to be sitting in a wheelchair at the dining room table. Resident # 78 was observed to have his eyes closed, and there was a baggie of toy cars sitting on the table in front of Resident # 78. There was one person observed in the dining room with the residents who identified herself as the nursing scheduler. She stated she had been a CNA in the past but was no longer certified. She indicated she had been requested to assist with activities for the residents. The nurse returned to the unit about 15 minutes later.</p> <p>During observation of the locked AACU, on 10/5/11 at 10:30 A.M., Resident # 78 was observed to be sitting in a wheelchair at the dining room table. Resident # 78 was observed to have his eyes closed, and there was a baggie of toy cars sitting on the table in front of Resident # 78.</p> <p>On 10/6/11 at 9:45 A.M., Resident # 78 was observed to be sitting in his wheelchair at the dining room table. He</p>		meeting.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>was observed to have a racing magazine open on the table in front of him.</p> <p>The clinical record for Resident # 78 was reviewed on 10/4/11 at 10:45 A.M. The record indicated Resident # 78 had diagnoses that included but were not limited to Downs syndrome, depression, anxiety and dementia with behavior disturbances. The MDS [minimum data set] assessment, dated 7/21/11, indicated Resident # 78 had short and long term memory problems. Resident # 78 required extensive assistance of two with transfers and ambulation.</p> <p>The Preadmission Screening Level II Case Analysis, dated 2/4/11, indicated "...He didn't fully understand his purpose of being at the facility, other than his occasional comment, "I make new friends." Prior to his placement on this date at this facility, (Resident # 78) had lived at home with his parents his entire life with only four one-night hospitalizations away from his parents. Until the onset of dementia three years ago he had been a functioning adult with a job and social activities with his family. Increased confusion and advanced dementia became apparent about six months ago. His mother described his most recent daily routine as follows: up from bed around 10:00 a.m.; being with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401
--	---

(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>his parents and accompanying them on their activities such as shopping or church; when at home watching favorite television shows such as Dukes of Hazard, or Bonanza; bedtime around 10:00 p.m....(Resident # 78) is assigned to a shared room on a secure unit of this nursing care facility....(Resident # 78) will not have freedom to move about to other units in this facility, unless accompanied by staff or family. He will continue to make choices about his television programs, what he wished to eat or wear...Recommendations: 1. (Resident # 78) needs a residential setting that is able to provide 24-hour nursing assistance and monitoring. He needs to be fully assisted in completing self-care tasks, with mobility, medical and safety needs. 2. (Resident # 78) needs the opportunity to make choices, when provided with concrete options, to increase his ability to express his wants and needs. 3. (Resident # 78) may benefit from participating in meaningful and varied day activities within the nursing facility. 4. (Resident # 78) would benefit from reminders about his personal information, routine, and activities...8. (Resident # 78) needs access to opportunities to participate in social and leisure activities within his facility and with his family outside the facility."</p> <p>In an interview with the Director of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2011
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	Nursing and the Alzheimer's Unit Director, on 10/4/11 at 1:35 P.M., they indicated they were unaware Resident # 78 had a diagnoses of mental retardation. They indicated Resident # 78 was placed on the secured AACU due to his diagnosis of dementia. They indicated there would be too many people out and about on the other hallways.  3.1-3(t)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0323 SS=E	<p>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> <p>Based on observation, interview and record review, the facility failed to ensure residents on the Advanced Alzheimer's Care Units (AACU) were provided with staff supervision to provide for residents safety. This affected 1 of 13 residents reviewed for supervision and falls ( Resident # 105) in the sample of 24, and 1 random observation involving Resident #52. The AACU was observed to have only two caregivers scheduled for each shift, with residents requiring both staff to provide personal care allowing the other residents to sit for long periods and wander about the unit without supervision.</p> <p>Findings include:</p> <p>1. On 10/03/11 at 10:20 a.m., LPN #2</p>	F0323	<p><b>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: R 52 and R105 had their care plans for falls reviewed and updated as indicated. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: AACU floor plan was reviewed and program room will be added to Unit. TV was purchased and mounted in dining room. Staff re-educated on programming of the residents on the Unit. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: ACUD or Unit Manager will assist with the Unit. Program theme boxes were established with written</b></p>	11/05/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2011	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>and CNA #1, the only 2 staff members on the unit, were observed in Resident #52's room with the door closed. LPN #2 and CNA #1 were observed to provide incontinence care for Resident #52. Resident #52 resided on the Alzheimer locked unit. During the time care was provided for Resident #52, 10 other residents who resided on the Alzheimer unit remained seated in the dining room and two other residents were resting in there beds and one resident was seated in a wheelchair in the hall. Resident #105 was observed resting in her low bed. Resident #105's walker was across the room approximately 7 feet from her bed.</p> <p>During observation of the locked Advanced Alzheimer's Care Unit (AACU), on 10/4/11 at 11:00 A.M., Resident # 78 was observed to be sitting at the dining room table with his eyes closed with Christmas music playing in the background. There were no staff in the dining room. The unit was observed to be a small unit with the census of 14. There was only one common area observed which was the dining room with four tables. The dining room had only kitchen table chairs.</p> <p>On 10/4/11 at 12:10 P.M., during observation of the AACU dining room, there were 7 residents seated at the tables.</p>		<p><b>program descriptions for staff to utilize to meet sensory and tactile stimulation. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: The ED/Designee will observe programming Monday through Friday to ensure programming is being carried out, 3 x a week for 4 weeks, 2 x week for 4 weeks and then weekly Any concerns or trends will be discussed at monthly QA meetings and appropriate action plans will be written and implemented.</b></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2011
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>Five of the 7 residents had their lunch trays. There were three family members observed to be feeding 3 of the 7 residents. The two staff members on the unit were observed to assist a resident from the hall to the dining room about every 5 minutes until 12:40 P.M., when all the residents but one were observed in the dining room. When a staff member would bring a resident to the dining room they would give the resident their lunch tray. Three residents were observed to be sitting with their lunch tray on the table in front of them but they made no attempts to eat. When the two staff members would bring another resident into the dining room they would give 1 or 2 of the residents requiring assistance with eating a bite then leave the room to get another resident up for lunch. Resident # 61 was observed to have had a divided plate. She was observed to eat all the food out of one section, but could not get any of the food out of the other two sections of her plate to her mouth without dropping the food from the fork.</p> <p>On 10/04/11 at 5:15 p.m., Resident #52 was observed to wander up and down the hall on the Advanced Alzheimer's unit. Three staff were observed to be present in the dining room on the Advanced Alzheimer's unit. Resident #52 was observed to walk into Resident #11's</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>room. Resident #11 was observed to be resting on her bed with her eyes closed. Resident #52 was observed to walk over to Resident #11's window and turned around and walked back out of the room and down the hall. Resident #11's room was observed to be at the far/opposite end of the hall from the dining room.</p> <p>On 10/04/11 at 5:20 p.m., Resident #52 was observed to wander back into Resident #11's room and turn around and walk back down the hall.</p> <p>During interview of LPN #4 (LPN working on the advanced Alzheimer's unit) on 10/04/11 at 5:22 p.m., the LPN indicated Resident #52 "wanders." LPN #4 indicated Resident #52 occasionally wandered in other resident's rooms. LPN #4 indicated that this behavior did not seem to bother the other residents.</p> <p>On 10/5/11 at 10:30 A.M., during observation of the AACU there were no nursing staff observed on the unit. The Housekeeping Supervisor stated the nurse had left the unit to go get something and would be right back. The only CNA scheduled for the unit was also off the unit. There were 9 residents observed to be in the dining room sitting at the tables. There different items on the tables such as books, magazines, puzzles, blocks and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401
--	---

(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>plastic pipes. There was one person observed in the dining room with the residents who identified herself as the nursing scheduler. She stated she had been a CNA in the past but was no longer certified. She indicated she had been requested to assist with activities for the residents. The nurse returned to the unit about 15 minutes later, at approximately 10:45 A.M.</p> <p>On 10/06/11 at 9:40 a.m., two nursing staff and the Advanced Alzheimer's Unit Director were observed in the dining room area assisting residents with activities. Resident #52 was not observed in the area. Resident #52's room was located at the end of the hall. The resident's door was closed and a rubbing sound could be heard outside the door. Upon knocking on the door, the resident indicated "I am in here." A rubbing sound could still be heard. The door partially opened, but would not open all the way. CNA #2 approached and entered the resident's room through the bathroom. The resident had removed one of the closet doors and had it partially against the closet and partially against the door of the room. CNA#2 redirected the resident and said would get maintenance to take care of the door.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401
--	---

(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>2. During initial observation tour of the advanced Alzheimer unit on 10/03/11 at 9:15 a.m., Resident #105 was identified by LPN #1 as being cognitively impaired, as having a history of falls, and as requiring extensive assistance of staff for all activities of daily living. Resident #105 was observed to be seated at the dining room table. A dark scabbed area was observed on the back of the resident's head and a fading bruise was observed underneath the resident's right eye.</p> <p>On 10/04/11 at 12:30 p.m., Resident #105 (who resided on the advanced Alzheimer unit) was observed to be resting on her bed with her eyes closed. The bed was observed to be in low position and a protective mat was in place beside the bed. The resident's walker was observed to have been placed beside the bed and on the protective mat. Housekeeper #1 was observed to be mopping the resident's floor. The floor was observed to be visibly wet and the Housekeeper indicated the floor was wet and caution should be taken. A "Caution Wet Floor" sign was placed in the door way of the room.</p> <p>On 10/04/11 at 12:40 p.m., LPN #2 was observed to enter Resident #105's room and indicated she was going to get the resident up for lunch. The floor was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2011
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401		
(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>observed to still be slightly damp. LPN #2 was observed to remove the resident's gripper socks and put shoes on the resident's feet and indicated she didn't want the resident to get her socks wet. LPN #2 told the resident that the floor was a little damp and they "would have to be careful." LPN #2 was observed to assist the resident up from the bed and to grab hold of the back of the resident's slacks and assisted the resident to walk to the dining room with the assist of a rolling walker while holding onto the back of the resident's slacks.</p> <p>Interview of CNA #1 on 10/04/11 at 10:30 a.m., indicated "on a good day" Resident #105 could sit up on the edge of the bed and pull herself up to her walker. CNA #1 indicated Resident #105 walked independently with supervision.</p> <p>Interview of LPN ##2 on 10/04/11 at 10:35 a.m., indicated the LPN tried to watch the resident closely "I stick with her when she's up" due to the resident's history of falls.</p> <p>Review of Resident #105's clinical record on 10/03/11 at 12:05 p.m., indicated the following:</p> <p>Resident #105 had diagnoses which included, but were not limited to,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401
--	---

(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>Dementia with behavioral disturbances, pacemaker, unspecified Psychosis, dizziness and giddiness.</p> <p>A PT (Physical Therapist) Plan of Treatment, with a start of service date of 05/24, indicated, "Pt [Resident #105] was admitted to Alzheimer's unit from another...due to increase in dementia sx [symptoms]. Pt has had 3 falls on unit (5/19, 20, 21) with 1 fall causing significant scalp laceration on back of head. Falls were unwitnessed but appear to all be backwards. PT may help improve balance, strength, and/or environment to decrease fall risk. The Plan of Treatment indicated nursing fall screen for the resident indicated the resident was a high risk for falls during this assessment period.</p> <p>A "Brief Cognitive Rating Scale," dated 05/19/11, indicated Resident #105 required assistance with feeding, toileting, bathing, or walking.</p> <p>An admission MDS [Minimum Data Set] assessment, dated 05/19/11, and a quarterly MDS, dated 08/10/11, indicated Resident #105 had severe cognitive impairment, required extensive assistance with transfers and walking, and had fallen during the time period of both assessments.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401
--	---

(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>A "PT - Therapist Progress Report and Discharge Summary" with an end of care date of 06/22/11 indicated at the time of discharge from services, Resident #105 had improved safety at the time of discharge from PT services with "Mod(I) (S) on unit for amb [walking]/mobility.</p> <p>Interview of Physical Therapist (PT) #1 on 10/04/11 at 9:55 a.m., indicated "Mod(I)" meant the use of an assistive device and (S) meant supervision. PT #1 indicated the definition of supervision was "within line of sight."</p> <p>Fall Risk Assessments, dated 09/19/11, 09/02/11 and 08/31/11, indicated Resident #105 was a high fall risk.</p> <p>A progress note, dated 05/13/11 at 2:47 p.m., indicated,"Res [Resident #105] has been pleasant and coop [cooperative] with staff...Transfers per self and ambulates [walks] with a slow unsteady gait, use of a rolling walker &amp; stand by assistance...."</p> <p>A progress note, dated 05/19/11 at 3: 56 p.m., indicated, " Res. was found sitting in the floor on her buttocks in the kitchen with her walker at her side ROM [range of motion] and VS [vital signs] are WNL [within normal limits]...Res denies pain (sic) she was also wet with proper ft [foot]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>wear on, no trash noted or fluids on the floor. Res was ambulated to her rest rm [room] &amp; changed.</p> <p>A progress note, dated 05/19/11 at 9:06 p.m., indicated, Resident remains on 15 minute tracking,, et neurochecks from previous fall....No s/s [signs or symptoms] of distress. No c/o[complaints of] voiced."</p> <p>A progress note, dated 05/20/11 at 5:59 p.m., indicated, "Resident remained on 15 minute location tracker till 3:30 a.m. (sleeping quietly till that time) when this writer heard bump/thud...found resident lying on back (sic) perpendicular to her room in main corridor with feet facing back outside door and walker in front of her. Resident unable to state why she was in hall, but c/o back of head pain (moved arm to point to where it hurt. (sic) This writer and another staff member assisted resident to stand after verifying full ROM [range of motion], PERRLA (sic) [pupils equal and reactive to light], no change in mental acuity and after cleansing nickel sized diameter...raised area on back of head with superficial bright red blood that stopped when pressure applied to site. Resident had no other injuries noted or symptoms of, was able to stand with assist of two and walk to bed where she was examined again and laid down on bed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2011
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401		
(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>with towel under head to note if bleeding restarted....continued to c/o headache to back of head....Resident transferred via ambulance to (local hospital) after explaining to resident dr [Doctor] wanted her to be seen to check out her head...."</p> <p>A progress note, dated 05/20/11 at 10:22 a.m., indicated, "Regarding falls on 5/19/11 and 5/20/11: Threshold to room to be checked by maintenance to possibly change color of it. Shoes checked by writer et are appropriate. Walker to be checked by maintenance. Staff to call pacemaker clinic to possibly get appt [appointment] scheduled sooner. Bathroom door to be left partially open at noc [night] with light on. Sign placed on bathroom door indicating that it is a bathroom. Staff to put non-skid socks on resident when she goes to bed if she is compliant. Will stop 15 minute checks. No other changes at this time."</p> <p>A progress note, dated 05/20/11 at 3:05 p.m., indicated, "...Res returned this am @ 7:40 a.m., with 2 staples to the occipital (sic) scant amt [amount] of blood PERRL [pupils equal and reactive to light], grips are + [positive]....Res has been transferring herself and ambulating with assistance of hr walker &amp; stand by assistance of 1...."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>A progress note, dated 05/21/11 at 7:30 a.m., indicated, "15 min. [minute] checks have been DC'd. Res to wear slipper socks when in bed if compliant. BR [Bathroom] door to be left sl [slightly] open with the light on and a sign has been placed on the door stating womens (sic) restroom that the res. read to this writer. Shoes also proper fit."</p> <p>A progress note, dated 06/20/11 at 4:12 p.m., indicated, "Resident sustained fall in common dining area of unit. Resident attempting to sit down in chair an (sic) landed between two chairs up against wall air conditioning unit. No visible injuries at this time. Will continue to monitor resident with neuro checks per facility protocol. Will recheck resident for bruising prior to HS [hour of sleep] along with checking for any pain or mobility changes. Resident has attempted to ambulate without assistance an (sic) resistant to assistance with ambulation (sic) acts out with agitation an (sic) mumbles screams which is usally (sic) for resident when she is frustrated...."</p> <p>A progress note, dated 06/20/11 at 11:04 a.m., indicated, "Regarding fall on 6/20/11: Staff to keep chairs out from in front of patio door in dining room. Resident is on optometry list. Request MD for labs. Will stop 15 min [minute]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>checks. No other changes at this time.</p> <p>Progress notes, dated 06/21/11, indicated Resident #105 had labs drawn and reported to physician with no new orders.</p> <p>A progress note, dated 07/01/11 at 5:05 a.m., indicated, "Situation: Resident found in bathroom face up with head under sink, feet facing her door, pull-ups around knees. Background: Hx [History] of falls, on toileting program. Walker within reach, not used by resident. Assessment: Has 8 x [by] 2 x 1 cm [centimeter] pink area without skin breakdown; denies c/o pain....able to ambulate with walker with no change from pre-fall. Ice pack applied for 2 minutes to back of head before resident tore it off..."</p> <p>A progress note, dated 07/01/11 at 12:34 p.m., indicated,"Regarding fall this a.m.: Non-skid strips to be put in front of toilet. 11p - 7a staff to check on resident Q [every] hour. Seeing optometrist today. Will stop 15 min checks. No other changes at this time."</p> <p>A progress note, dated 07/12/11 at 2:27 p.m., indicated, "Situation: Res fell in the pt [patient] dining area while walking with use of her walker falling to the (R) [right] landing on her (R) side. Noted tear</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401
--	---

(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>@ (R) temple 0.4 cm in length well approximated, bruising (R&amp;L) hands. No other injury noted at present....Assessment: Skin tear (R) outer eyebrow well approximated. Neuro checks anitiated (sic) as well as 15 min. checks."</p> <p>A progress note, dated 07/12/11 at 10:29 p.m., indicated, "Resident continues on antibiotic for UTI...Res is s/p [status post] fall with continued intermittent ambulation w/out [without] using walker..reinforcement of need to use the walker and emotional support given....Steristrips (sic) to R temple are clean, dry, intact. Resident able to ambulate with assist...."</p> <p>A progress note, dated 07/14/11 at 9:54 p.m., indicated, " Resident remains on location tracking et 15 minute checks d/t '[due to] recent fall...."</p> <p>A progress note, dated 07/16/11 at 12:17 a.m., indicated, " resident completed neurochecks and 15 minute checks on evening shift 7/15/11 with no deficits. Intermittent c/o soreness to R [right] arm and shoulder (no chest pain, no jaw pain) where bruising s/p fall 3 days ago on R side remain. New orders received for icy hot (medication to treat sore muscles) cream prn [as needed] to Right</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2011
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401		
(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>shoulder...."</p> <p>A progress note, dated 07/19/11 at 1:46 p.m., indicated, "Skin assessment as follows:....Has an (sic) tear (R) of (R) eyebrow obscured (sic) by steri strips post fall (7-12) bruising as follows: (R) cheek 6.2 x 6.6 yellowing under (R) eye (sic) 5.2 x 3.6 purple bruise (R) shoulder 3 areas noted proximal to chest...6.4 x 6.0 cm purple proximal B [bruise] neck on shoulder (sic) spotting (sic) red scattered spotting ea. [each] 5.5 cm x 5.0 cm (R) trochanter (thigh/hip area) 7.8 cm x 6.8 cm purple bruise, (L) inner knee 9.2 cm x 9.8 cm lt [light] purple bruise."</p> <p>A progress note, dated 07/21/11 at 4:09 p.m., indicated, "Res fell to the floor (sic) lowered by care giver...who states she didn't (sic) hit her head (sic) the res stood from sitting leaned to (R)...ROM [range of motion] to all extrim. [extremities] without diff [difficulty]...."</p> <p>A progress note, dated 07/22/11 at 2:09 p.m., indicated, "....Resident to be added to audiologist list...Ortho/hypo [sit/stand] BP's [blood pressures] Q shift for 72 hours. MD to be asked about possible med [medication] for vertigo [dizziness]. Will stop 15 min checks...."</p> <p>A progress note, dated 08/08/11 at 2:56</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>p.m., indicated, "Late entry for 8/3/11 (sic) Weekly skin assessment. Has fading bruising noted to extremities and right side and chest. No new skin issues noted at this time...."</p> <p>A progress note, dated 08/11/11 at 5:31 a.m., indicated, "Situation: Noted (R) hip has a swollen firm to touch area approx 14 cm x 10 cm and raised...Assessment: Res had a fall 7/21 and a bruise was noted to (R) hip it is noted to be larger (sic) she takes 325 mg [milligrams] ASA EC [enteric coated] QD [every day], ROM wasn't painful and the res ambulated per self without diff [difficulty]...."</p> <p>A progress note, dated 08/12/11 at 2:20 p.m., indicated, "Situation: (R) hip &amp; femur Xray negative (sic) MD informed. Background: Has hjad [had] freq [frequent] falls (sic) last 7/21 (R) side. Assessment: Large firm to the touch area (R) hip, when palpated decreases without pain to the res...."</p> <p>A progress note, dated 08/16/11 at 2:17 p.m., indicated, "...Has fading bruising noted to extremities and right side and chest...."</p> <p>A progress note, dated 08/23/11 at 3:40 p.m., indicated, "Res. found lying in the floor beside her bed on her (R) side. Res.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2011
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401		
(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>was assisted to a sitting position after ROM without pain. Res. also denied pain and was assisted up and ambulated to the DR." The progress note indicated neuro checks were within normal limits and the only injury the resident sustained was a hematoma to her right outer upper eye.</p> <p>A progress note, dated 08/23/11 at 10:42 a.m., indicated, "Regarding fall on 8/23/11: Contour mattress to be ordered for bed. Non-skid strips to be placed at bedside. Will stop 15 min checks. No other changes at this time.</p> <p>A progress note, dated 08/24/11 at 2:58 p.m., indicated, "Weekly skin assessment. Has fading bruising to extremities and right side and chest. Raised area firm to the touch (R) outer hip measures 10.0 x 8.0 cm with fading bruise. New purple bruising at (R) outer eye from fall 8/23....</p> <p>A progress note, dated 08/29/11 at 8:35 a.m., indicated, "Resident was in dining room attempting to rise from chair at table and fell on left side....Range of motion in all extremities WNL [within normal limits] and resident denies pain. Hematoma 12 mm in diameter on back left side of head noted; tender to touch...."</p> <p>A progress note, dated 08/30/11 at 4:16 p.m., indicated, "15 min checks were DC</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>[discontinued] (sic) res to have CBC, CMP in am...."</p> <p>A progress note, dated 08/30/11 at 4:37 p.m., indicated, "Called to res room at 335 pm. Writer noted res to be sitting on floor parrell [sic] with bed. Res with ST [skin tear] to right hand measuring 1.2 x 0.1 x &lt; [less than] 0.1 cm....Moves all ext [extremities] without difficulty per normal for res. Denies pain...."</p> <p>A progress note, dated 09/01/11 at 7:15 p.m., indicated, "Heard noise from residents (sic) room. This nurse (sic), et day nurse entered rm [room], along with Cna [CNA], et resident was on (sic) laying on floor beside bed. Resident unable to tell staff what happened to cause fall d/t cognitive status. Upon assessment, noted 1 cm laceration on R hand pinky finger. No other injuries noted. Resident MAE [moving all extremities] well....15 minute checks initiated...Neuro checks WNL...."</p> <p>A progress note, dated 08/31/11 at 11:00 a.m., indicated, "Resident had a fall on 8/29/11 labs were ordered CBC and CMP...Has a hx [history] of falls. Was on Antivert [medication often used to treat dizziness] x 7 days and during that time she had no falls....New orders noted for UA [urinalysis] and Antivert 12.5 mg</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2011
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401		
(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>[milligrams] tab one tab po [by mouth] bid [twice daily]...."</p> <p>A progress note, dated 09/01/11 at 3:05 p.m., indicated, "Regarding fall on 8/30/11: Resident to be in high/low bed with mat @ bedside. Was started on routine Antivert. Regarding fall on 8/31/11: Table et lamp removed from bedside. Will stop 15 min checks. No other changes at this time."</p> <p>A progress note, dated 09/02/11 at 2:58 p.m., indicated, "Res. was found on the floor on a blue mat beside her bed on her (R) hip with her (R) arm under her (sic) noted (R) great toe posterior scraped and bleeding...."</p> <p>A progress note, dated 09/02/11 at 4:16 p.m., indicated, "UA with culture pending reported to MD."</p> <p>A progress note, dated 09/05/11 at 2:19 p.m., Resident remains on antibiotic for UTI with no c/o...She remains on neurochecks and location tracker secondary to fall 9/2/11. Resident able to ambulate with walker and standby assist to bathroom with slightly unsteady balance. She denies c/o pain."</p> <p>A progress note, dated 09/06/11 at 1:37 p.m., indicated, "Regarding fall 9/2/11:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2011
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>Resident high/low bed replaced. Will stop 15 min checks. No other changes at this time."</p> <p>A care plan with initiated date of 05/16/11 and most recent goal date of 11/22/11 indicated, "I have a DX [diagnosis] Dementia that makes my balance off sometimes. I also take psychotropic medications that causes me to have a higher risk for falling. The care plan indicated the resident had a history of hypotension [low blood pressure] and tachycardia [rapid heart rate] and behavioral disturbance.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>				

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

PRINTED: 11/01/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2011
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	

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

PRINTED: 11/01/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2011
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	

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

PRINTED: 11/01/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2011
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	