

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 07/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
---	---

(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 the Investigation of Complaints IN00110979 and IN00111280.</p> <p>Complaint IN00110979-Substantiated. No deficiencies related to the allegation are cited.</p> <p>Complaint IN00111280-Substantiated. Federal/state deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: July 9, 10, 11, 2012</p> <p>Facility number: 155362 Provider number: 000253 Aim number: 100266660</p> <p>Survey team: Janet Adams, RN</p> <p>Census bed type: SNF/NF: 151 Total: 151</p> <p>Census payor type: Medicare: 24 Medicaid: 104 Other: 23 Total: 151</p>	F0000		

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: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/11/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
---	---

(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>Sample: 7</p> <p>This deficiency reflects state finding cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 7/12/12 Cathy Emswiller RN</p>			

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 07/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
---	---

(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=D	<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> <p>Based on observation, record review, and interview, the facility failed to ensure fall risk preventions devices were on as ordered for 1 of 3 residents reviewed for falls in the sample of 7. (Resident #H)</p> <p>Findings include:</p> <p>On 7/10/12 at 7:50 a.m., Resident #H was observed in bed. There was an alarm box on the overbed table next to the resident's bed. The on/off black button was down in the "off" position. There was a black mat on the floor next to the resident's left side. There was no alarm box connected to the floor mat. No staff members or visitors were in the room. There was a blue bed bolster wedge cushion in place to the left side of the bed against the 1/4 side rail. There was no wedge bolster cushion the right side. There were no staff members or visitors in the room at this time.</p> <p>On 7/10/12 at 8:45 a.m., the resident was observed in bed. The alarm box was still</p>	F0323	<p><i>F 323 It is the practice of this facility to 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. · Resident H was reviewed by the IDT team on 7-10-12 for need of fall prevention interventions. Resident is a hospice patient whose condition is now in the later stages and no longer is a high fall risk. Interventions for bed bolster and alarming floor mat were discontinued. Bed alarm continued and was verified that alarm was on and functioning appropriately. 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. · Any resident who is at risk for falls and who have "fall prevention" interventions implemented per their individual plan of care, are at risk to be effected by the alleged deficient</i></p>	07/27/2012

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 07/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
---	---

(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>on the overbed table next the resident's bed. The black button was still in the "off" position. The one bed bolster remained on the resident's left side. There was no alarm box attached to the call light or the floor mat. No staff members were in the room at this time.</p> <p>On 7/10/12 at 8:55 a.m. CNA#1 took the resident's breakfast meal tray into his room. The CNA started feeding the resident some liquids.</p> <p>On 7/10/12 at 9:45 a.m. the resident was observed in bed. The resident was awake. The alarm box that had been present on the over bed table was now attached to the lower bed rail. The button on the box was still in the "off" position. No alarm was attached to the black floor mat. There were no staff in the room.</p> <p>On 7/10/12 at 11:50 a.m., the resident was observed in bed. The alarm box remained off.</p> <p>On 7/10/12 at 12:02 p.m., LPN # 1 entered the resident's room. The resident's alarm box was in the off position at this time. During interview at that time, LPN # 1 indicated she was assigned to care for the resident. LPN#1 indicated the alarm box was in the "off" position and it should have been on.</p>		<p><i>practice. · Any resident who has had a fall within the past 3 months will have their plan of care reviewed for fall interventions to ensure that all interventions are in place and functioning. · Any resident with an order/plan of care for the use of any type of alarming system will have their plan of care reviewed to ensure that alarms are appropriate and are in place and functioning. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur · Nursing staff will be re-in-serviced on the practice of checking that fall interventions/alarms are in place and functioning at the beginning of each shift and visually verifying that alarms are on through out the shift. · Nurses will document on the TAR each shift that they have verified alarms are in place and functioning. · ACE team members (Guardian Angels) have been given education on verifying that fall interventions/alarms are in place and functioning when they do their daily rounds. · C.N.A resident information sheets includes identification of those residents who have fall interventions/alarms in place. These sheets will be used by staff and ACE members to monitor resident's interventions. How the corrective action(s) will be</i></p>	

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 07/11/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410			
(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>The clinical record for Resident #H was reviewed on 7/10/12 at 2:00 p.m. The resident's diagnoses included, but were not limited to, acute pain, memory loss, dementia, and depressive disorder.</p> <p>The current Physician orders included an order for bed bolster to the bed. This order was initially written on 5/15/12. There also orders for an alarming floor mat to be in place next to the bed and for a call light bed alarm to be used. The order for the alarming floor mat was initially written on 5/17/12. The order for the call light bed alarm was initially written on 4/4/12.</p> <p>The 4/12/12 MDS (Minimum Data Set) significant change assessment indicated the BIMS (Brief Interview for Mental Status) score was 9. This indicated the resident's cognitive patterns were moderately impaired.</p> <p>The residents current plans initiated on 8/1/2011 indicated the resident was at risk for falls related to a diagnoses of high blood pressure, anemia, congestive heart failure, dementia, rheumatoid arthritis, and a history of falls. The most recent target date on the care plan was 8/22/12. Care plan interventions included for bed</p>		<p><i>monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. · Nursing Management and ACE members will complete audits daily (M-F) x 4 weeks and then 3 times a week x 4 weeks and then weekly there after indefinitely as it will be a permanent piece of the monthly QA; this will verify that fall interventions /alarms are in place and functioning . · The weekend nursing supervisor will complete audit (Sat and Sun) to verify that fall interventions/alarms are in place and functioning. · Audits will be completed weekly for review of TAR's to verify that Nurses are checking interventions/alarms and documenting that they are in place and functioning. · Results of audits will be reviewed at the Monthly QA&A meeting x 3 months or until in substantial compliance. · This process will be overseen by the Director of Nursing and the Executive Director. By what date the systemic changes will be completed.</i></p> <p><i>·July 27, 2012</i></p> <p>F 323 Audit related to Complaint Survey July 2012 It is the practice of this facility to 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. · Nursing</p>				

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 07/11/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410			
(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>bolster, alarming floor mat beside the bed, bed to be in the lowest position, and a call light alarm to the bed.</p> <p>An IDT (Inter-Disciplinary Team) note dated 7/2/12 indicated the resident had falls on 6/30/12 at 11:15 p.m. and on 7/1/12 at 10:30 p.m. The note indicated on 6/30/12 the resident was observed on the floor next to wheel chair and no injures were noted. The note also indicated on 7/1/12 the resident was observed kneeling on the floor next to his bed and no injuries were observed.</p> <p>A change of condition note was entered on 7/2/12 at 7:20 a.m. This note indicated the resident was found kneeling on the floor at the bedside. A change of condition note entered on 6/3/12 at 5:15 p.m. indicated the resident was found on the floor next to the bed and no injuries were noted.</p> <p>When interviewed on 7/10/12 at 12:00 p.m., CNA #1 indicated she was aware the resident was a fall risk and was to have low bed. The CNA indicated she did not have a sheet listing the devices to be used for the resident. The CNA indicated they "pass it on in report" if the resident is getting out of bed.</p> <p>When interviewed in the resident's room</p>		<p>Management and ACE members will complete audits daily (M-F) x 4 weeks (July 23 through August 17) o The weekend nursing supervisor will complete audit (Sat and Sun) to verify that fall interventions/alarms are in place and functioning. · and then 3 times a week x 4 weeks (August 20 through September 14) · and then weekly there after as on going process, to verify that fall interventions /alarms are in place and functioning . · Audits will be completed 3 times a week x 3 months for review of TAR's to verify that Nurses are checking alarms and documenting that they are in place and functioning (July 23 through end of October) · Results of audits will be reviewed at the Monthly QA&A meeting x 3 months or until in substantial compliance.</p> <p>Room Resident Name Intervention and/or Tar Review Date and comments Date and comments Date and comments Date and comments</p> <p>Week of: _____ Signature/Title:_____</p>				

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 07/11/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410		
(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>on 7/10/12 at 12:25 p.m., the Unit Manager indicated the bed alarm box should have been on. The Unit Manager also indicated she was informed about a week ago that the resident's call light alarm was not working and she instructed staff to use the bed alarm. The Unit Manager indicated the resident did not have an alarm to the floor mat as per the Physician orders.</p> <p>This federal tag relates to Complaint IN00111280.</p> <p>3.1-45(a)(2)</p>				