

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 03/17/2016
--	---	--	---

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
F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00195385 and IN00195689.</p> <p>Complaint IN00195385- Substantiated. Federal/State deficiencies related to the allegations are cited at F164, F441, and F465.</p> <p>Complaint IN00195689- Substantiated. Federal/State deficiencies related to the allegations are cited at F323 and 9999.</p> <p>Survey dates: March 15, 16, and 17, 2016</p> <p>Facility number: 000253 Provider number: 155362 AIM number: 100266660</p> <p>Census bed type: SNF/NF: 138 Total: 138</p> <p>Census payor type: Medicare: 10 Medicaid: 102 Other: 26 Total: 138</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.

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 03/17/2016
--	---	--	---

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
F 0164 SS=D Bldg. 00	<p>Sample: 11</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review was completed by 32883 on 3/21/16.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2016
--	---	---	---

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 facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by law; third party payment contract; or the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's privacy during care was maintained during morning care, related to a missing privacy curtain in the middle of the room, which is used to provide privacy to roommates during care when both residents are in the room , for 1 of 3 residents reviewed for resident rights/privacy in a total sample of 11. (Resident #C)</p> <p>Finding includes:</p> <p>During an observation on 03/15/16 at 7:03 a.m. a.m., CNA #1 entered Resident #C's room to assist the resident with morning care. CNA #1 obtained a basin of water from the bathroom, removed the resident's brief, while keeping the resident torso and upper extremities covered with a blanket, and provided incontinent care.</p> <p>During this care, the resident's roommate was lying in the bed by the window. There was no privacy curtain to pull to provide privacy to Resident #C during</p>	F 0164	<p>F 164</p> <p>Corrective Action: The privacy curtain was replaced immediately for the one room identified</p> <p>All Others: Any resident in a double room as the potential to be affected by this deficient practice. A rounding sheet for housekeeping will monitor that all curtains will be in place.</p> <p>No Reoccurrence: Housekeeping staff have been in service regarding the need to immediately replace any curtains that are soiled or taken down for any reason.</p> <p>Housekeeping Manager is to be checking each room for appropriate curtains and identifying any "one offs" immediately to housekeeping services to replace.</p> <p>Monitoring corrective action: A daily duties sheet for all housekeepers has been created to include the monitoring of privacy curtains. The sheets are turned into the Housekeeping Manager and she in turn will bring these to morning meeting on a daily basis x 5 days for 3 months and then weekly for a remaining 3 months. Housekeeping will be responsible to add all findings to QA monthly for 6 months.</p> <p>Date: April 16, 2016</p>	04/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2016
--	---	---	---

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>care.</p> <p>During an interview at the time of the observation, CNA #1 indicated the curtain had been missing for a couple days.</p> <p>During an environmental observation on 03/15/16 from 9:20 a.m. through 9:33 a.m., with the Housekeeping Supervisor, Director of Maintenance, and the Administrator present, Resident #C's room had no middle of the room privacy curtain.</p> <p>During an interview on 03/15/16 at 9:23 a.m., the Housekeeping Supervisor indicated she was unsure when the privacy curtain had been removed.</p> <p>During an observation on 03/15/16 at 11:01 a.m., Resident #C's room was still missing the privacy curtain.</p> <p>Resident #C's record was reviewed on 03/16/16 at 10:14 a.m. The resident's diagnoses included, but were not limited to, dementia.</p> <p>The Quarterly Minimum Data Set assessment, dated 02/25/16, indicated the resident's cognition was severely impaired, required extensive assistance with transfers, and was dependent for</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 03/17/2016
--	---	--	---

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
F 0323 SS=G Bldg. 00	<p>hygiene/bathing.</p> <p>During an interview on 03/16/16 at 1:44 p.m., the Housekeeping Supervisor indicated the privacy curtain had been removed for cleaning on the morning of 03/14/16 and the Housekeeper forgot to replace the curtain.</p> <p>This Federal tag relates to Complaint IN00195385.</p> <p>3.1-(p)(4)</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. Based on record review and interview, the facility failed to ensure a resident received adequate supervision and assistive devices to prevent accidents, which resulted in a fall with an injury requiring sutures for 1 of 4 residents reviewed for falls in a total sample of 11. (Resident #J).</p>	F 0323	<p>F323</p> <p>Whatcorrective action(s) will be accomplished for those residents found to have been affectedby the deficient practice.</p> <p>Unable to correct the alleged deficientpractice for</p>	04/16/2016

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 03/17/2016
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>Finding includes:</p> <p>Resident #J's record was reviewed on 03/16/16 at 1:57 p.m. The resident's diagnoses included, but were not limited to dementia.</p> <p>A Quarterly Minimum Data Set assessment, dated 12/24/15, indicated the resident's cognition was severely impaired, required extensive assistance with all activities of daily living (ADL's) except bathing, was dependent for bathing, and had two falls without injury.</p> <p>A Fall Risk assessment, dated 12/24/15, indicated a score of 14 (total score of 10 or above deems the resident at risk)</p> <p>A care plan, initiated on 07/01/15, indicated the resident was a risk for falls due to history of falls and flailing of arms and legs. The interventions included, bed in low position initiated 07/01/15, floor mat next to the bed initiated 07/01/15, floor mat at the foot of the bed initiated on 09/03/15, and full mattress landing mat next to the bed initiated 11/13/15.</p> <p>A Physician's Order, dated 07/28/15, indicated a easy landing mat next to a full sized mattress.</p>		<p>resident J</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken.</p> <p>All other residents who require supervision and assistive devices to preventaccidents have the potential to be affected by the alleged deficientpractice. No other residents were foundto be affected by the alleged deficient practice.</p> <p>What measureswill be put into place or what systemic changes will be made to ensure that thedeficient practice does not recur.</p> <p>Staff will be re-educated regarding supervisionand safety devices to prevent falls.</p> <p>How thecorrective action(s) will be monitored to ensure the deficient practice willnot recur, i.e., what quality assurance program will be put into place.</p> <p>Unit Rounds/Audit willbe completed 3x weekly x 4 week, 2 x weekly x 4 weeks and then weekly for 4months with</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 03/17/2016
--	---	--	---

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>A Physician's Order, dated 12/14/15, indicated full size mattress next to bed when resident is in bed.</p> <p>A Nurses' Note, dated 02/25/16 at 8:45 p.m., indicated the resident fell out of bed and had a history of falling out of bed. The note indicated the staff had positioned the resident in the bed close to the wall on the resident's left side, then had gone to the resident's bathroom to wet a towel to do the resident's personal care and while in the bathroom the staff heard a, "boom", and found the resident lying on the floor on her right side in a fetal position, with blood on the floor and draining from the resident's left eye and the resident was moaning. The note indicated the resident's bed was waist high and the mattress and mat were not on the floor next to the bed. The resident was assessed to have a laceration above the left eye approximately 0.3 centimeters (cm) by 3.5 cm x 0.1 cm with moderate amount of blood draining from the site and the resident was transferred by Emergency Technicians to the Emergency Room.</p> <p>The Fall Investigation, dated 02/25/16 at 8:45 p.m., indicated the resident was found on the floor in a fetal position, lying on her right side. There was blood on the floor and draining from the</p>		<p>audits covering all unit and shifts to ensure resident's safety devices are in place as per care plan.</p> <p>Results of the audit will be reviewed by the DNS or designee to identify any facility trends or patterns. Results will be submitted to QAPI monthly for 6 months for review and recommendations.</p> <p>By what date the systemic changes will be completed? April 16, 2016</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 03/17/2016
--	---	--	---

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>resident's left eye and the resident was moaning during the assessment and was moving her body. Pressure was applied to the site and the bleeding would not stop. The resident was transported to the hospital for treatment and evaluation. The "Causal/Contributing Factor" for the fall, indicated, "Staff member was still providing care and had walked to the bathroom while CNA was in bathroom res (resident) fell out of bed".</p> <p>The Summary and Outcome of the investigation indicated, "Resident was put into bed by CNA and CNA was getting ready to provide care. Resident fell while CNA was in the bathroom getting ready to complete care. Mattress was not in place due to the same reason staff member still providing care..."</p> <p>The Interview Summary of the Fall Investigation indicated, "Staff stated when he put resident in bed, he position (sic) her close to the wall and was not aware that she has a history of rolling out of bed." The Possible Causal factor indicated the bed was not at the lowest position.</p> <p>The Hospital History and Physical, dated 02/25/16, indicated the resident had a bleeding laceration on the left forehead and the laceration was sutured and the</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 03/17/2016
--	---	--	---

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>CT scan of the brain showed no hemorrhage. The resident was admitted to the hospital and placed on stroke protocol.</p> <p>A Hospital Neurological Examination, dated 02/28/16, indicated, "...Patient did hit her head and has a laceration above the left eyebrow with no active bleeding...the daughter who states patient has been recently falling out of bed at the nursing home. The daughter also states patient is bed bound and is not able to walk...also admits the patient is restless and is (sic) usually moves around in bed a lot..."</p> <p>During an interview on 03/16/16 at 2:55 p.m. the Director of Nursing (DON) indicated the CNA had left the resident's bedside to walk into the bathroom and came back and the resident had fallen out of bed. She indicated the CNA had not put the mattress down beside the bed because the resident's care had not been completed. She indicated the CNA could not stand on the mattress while providing care. The DON indicated the resident had full body movement but could not follow directions for movement.</p> <p>This Federal tag relates to Complaint IN00195689.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2016
--	---	---	---

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
F 0441 SS=E Bldg. 00	<p>3.1-45(a)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2016
--	---	---	---

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>a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to ensure the residents had a sanitary environment to help prevent the transmission of disease and infection, related to storage of items used for personal care on a contaminated surface and using personal care items for more than one resident on the D-Wing, which had the potential to effect 55 residents who resided on the D-Wing.</p> <p>Finding includes:</p> <p>During an observation on 03/15/16 at 5:09 a.m., CNA #3 was in the hallway pushing a container which contained soiled linen and trash. Stored on top of the container lids were an open bag of incontinent briefs, washcloths, two bottles of shampoo/bodywash, and a tube of skin moisturizer.</p> <p>During an interview at the time of the</p>	F 0441	<p>F441</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>On 3/15/16 CNA #3 was immediately redirected and all personal care items that were stored on a contaminated surface were disposed.</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>All other residents on the D wing have the potential to be affected by the alleged deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that</p>	04/16/2016

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 03/17/2016
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>observation, CNA #3 indicated she took the shampoo/bodywash and the skin moisturizer into the residents rooms and used them. CNA #3 indicated she used the items for more than one resident. CNA #3 indicated there was no other cart to use so she used the soiled linen and trash cart to carry the items.</p> <p>During an interview on 03/15/16 at 5:18 a.m., the Director of Nursing indicated the items should not be stored on top of the soiled linen and trash cart and should not be used for more than one resident.</p> <p>This Federal tag relates to Complaint IN00195385.</p> <p>3.1-18(a)</p>		<p>thedeficient practice does not recur.</p> <p>Staff re-education will be completed regarding personal care items being single patient use and cannot be stored or transported on top of contaminated surfaces.</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>Unit Rounds/Audit will be completed 3x weekly x 4 week, 2 x weekly x 4 weeks and then weekly for 4 months with audits covering all unit and shifts.</p> <p>Results of the audit will be reviewed by the DNS or designee to identify any facility trends or patterns. Results will be submitted to QAPI monthly for 6 months for review and recommendations.</p> <p>By what date the systemic changes will be completed? April 16, 2016</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 03/17/2016
--	---	--	---

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
--------------------	--	---------------	---	----------------------

F 0465 SS=E Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, record review, and interview, the facility failed to provide a safe, sanitary, and comfortable environment for residents, related to broken blinds, soiled floors, walls, curtains, trash cans, feeding pumps and poles, linen, storage of wash basins and commode buckets, chipped paint, tiles, and counters, soiled chairs, dirty shower rooms, curtains off the hooks and missing privacy curtains for 4 of 4 units.</p> <p>(B-Wing, C-Wing, D-Wing, and AACU (Advanced Alzheimer's Care Unit) Wing)</p> <p>Findings include:</p> <p>1. During the initial tour of the C-Wing on 03/15/16 at 3:38 a.m. through 4:32 a.m., the following was observed:</p> <p>a. There were broken window blinds on the window of room and a wash basin stored on the floor in the bathroom of 208. (two residents shared the room)</p> <p>b. There was an accumulation of a dried beige substance on the tube feeding pole and cord of the feeding pump and an unfolded towel left in the chair in room</p>	F 0465	<p>F465</p> <p>Corrective Action: The broken blinds, soiled floors, walls, curtains, trash cans, feeding tube pump/pole, linen, and chairs, chipped paint, tiles, and countertops, dirty shower rooms, curtains off hooks and missing privacy curtain were immediately corrected. The wash basins/commode buckets were immediately disposed of and floor staff has been serviced to place all wash basins in proper storage areas.</p> <p>All Others: All residents have the potential to be affected by this deficient practice. Housekeeping and Maintenance have added line items to their daily work sheets to ensure these items are appropriate. Unit Managers/ACE members have been serviced on their unit rounds to include monitoring wash basins/commode buckets 3 times a week for 4 weeks, 2 x a week for 4 weeks and then weekly for 4 months.</p> <p>No Recurrence: Maintenance has added line items to their daily rounding sheet to include monitoring broken blinds in rooms, chipped paint, tiles and counter tops. Housekeeping has added to their daily work sheet the need for focused attention to soiled floors, walls, curtains, trash cans, and</p>	04/16/2016
----------------------------	--	--------	--	------------

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 03/17/2016
--	---	--	---

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>211. (one resident in the room)</p> <p>c. The two privacy curtains in room 215 were not attached and hanging down from the curtain hooks and tracks. (one resident in the room)</p> <p>d. There was an unfolded towel lying across the back of a high back chair which was sitting outside of room 220.</p> <p>e. There were several areas of a white substance on the privacy curtain in room 220. (Two residents resided in the room.)</p> <p>f. There was a trash can which was filled and overflowing with trash and a sheet on the floor under the bed by the door in room 221. (Two residents resided in the room.)</p> <p>g. There was a commode pan stored uncovered on the floor in the bathroom of room 201. (One resident resided in the room.)</p> <p>h. There were chips out of the floor and strips of a grayish color substance on the floor in the bathroom of 223. Behind the entry door of room 223, there was a foam wedged stored on the floor. (One resident resided in the room.)</p> <p>i. There were two bath basins stacked</p>		<p>linens, soiled chairs cleaning shower rooms and monitoring privacy curtainsfor "off the hook" and missing. Nursing staff have been in serviced to monitorfeeding tube poles/pumps, and attending to proper storage of washbasins/commodos buckets.</p> <p>Monitoring Corrective Action: Housekeeping will bemonitoring the enhanced sheets daily with rounding to ensure all items are attendeand in place; these findings will be brought to morning meeting daily x 5 daysfor 3 months and the weekly for 3 additional months. Maintenance will monitordaily the daily rounding sheet and bring findings to morning meeting daily x 5days for 3 months and then weekly for 3months. Nursing will monitor wash basins/ commode buckets 3 times a week for 4 weeks, 2 x a weekfor 4 weeks and then weekly for 4 months. All findings from Housekeeping, Maintenanceand Nursing will be brought to QA for 6 months. Date: April 16, 2016</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 03/17/2016
--	---	--	---

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>inside each other stored on the bathroom floor in room 224. (Two residents resided in the room.)</p> <p>j. There were commode buckets and a urine collection container stored uncovered in the bathroom and trash on the floor in room 226. The trash can did not have a trash bag and there were brownish/beige substance on the inside of the trash can. (Two residents resided in the room.)</p> <p>k. The tube feeding pole and electrical strip had an accumulation of a beige substance on them, in room 230. (Two residents resided in the room.)</p> <p>l. There was a bath basin stored uncovered on the floor of the bathroom and an unfolded towel draped over the corner of the sink in room 232. (Two residents resided in the room.)</p> <p>m. There were cracked, loose, and chipped flooring, and broken tiles in the Shower Room.</p> <p>n. There were chipped walls, missing tiles, build up of dirt and hair on the drain cover, dirty green mesh chair, brown substance on two of two shower curtains, and a maroon colored chair with a dark substance on the seat, in the Tub Room.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2016
--	---	---	---

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>During an interview on 03/15/16 at 4:02 a.m., LPN #2 indicated the Shower Room and the Tub Room were both used by the residents on the C-Wing. There were 38 residents on the C-Unit.</p> <p>2. During the initial tour of the D-Wing on 03/15/16 at 4:46 a.m. through 5:14 a.m., the following was observed:</p> <p>a. There were crumbs and a dried brown substance on the floor and the mat against the wall was torn in room 309. (Two residents resided in the room.)</p> <p>b. There were two bath basins stacked and stored uncovered on top of the paper towel holder and there were areas of a white substance on the curtain between the two beds in room 307. (Two residents resided in the room.)</p> <p>c. The corners of the Dining Room had an accumulation of dirt and crumbs. (8-12 residents eat in the dining room)</p> <p>d. The computer outlet was pulled from the wall and a brown substance was on the floor in the resident lounge</p> <p>e. There was a bag of towels stored on the floor, several paint chips on the floor and wall, and a white dried substance on</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 03/17/2016
--	---	--	---

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 floor in the Shower Room. (52 of 55 residents used the shower room.)</p> <p>f. The bathroom floor was dirty with a brown substance on the floor, two wet washcloths on the side of the sink and the trash can was dirty in the bathroom of 310. (Two residents resided in the room.)</p> <p>g. There was a wet washcloth draped on the side of the sink and a wet washcloth in the sink in the bathroom of 322. (Two residents resided in the room.)</p> <p>h. Resident #J's high back wheelchair had a plastic tray, which had foam tearing off from the edge closest to the resident, the plastic was rough and sharp.</p> <p>i. There was a wash basin stored uncovered on the bathroom floor, and the floor behind the toilet had an accumulation of dirt and small white paper substance, gloves on the floor and the wall had brown splatters in the bathroom of 324. (Two residents resided in the room.)</p> <p>3. During the initial tour of the B-Wing on 03/15/16 at 5:21 a.m. through 5:35 a.m., the following was observed:</p> <p>a. There was a towel and washcloth on the floor wrapped around the base of the</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 03/17/2016
--	---	--	---

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>water cooler.</p> <p>b. There were chips out of the counter, accumulation of crumbs and dirt in the corner by the end of the counter in the Dining Room. The microwave had a large amount of food accumulation and a black substance on the floor of the oven.</p> <p>c. The wall covering was torn, loose cove base and dirty floor in the bathroom located in the resident lounge.</p> <p>d. There were chipped areas out of the floor tile, brown substance on the floor, a plastic back of a patch or dressing, dated 01/19/16 was stuck to the floor of the shower, and chipped wall tiles in the Shower Room.</p> <p>e. There was a brown substance on the curtain between the beds in room 17. (Two residents resided in the room.)</p> <p>There were 31 residents on the B-Wing.</p> <p>4. During the initial tour of the AACU (Advanced Alzheimer's Care Unit) on 03/15/16 at 5:39 p.m. through 5:41 a.m., the following was observed:</p> <p>a. The privacy curtain was off the hooks of the door bed in room 21. (Two residents resided in the room)</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 03/17/2016
--	---	--	---

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>b. There was no trash bag in the trash can and the trash can had brown substances on the sides and bottom of the container. There was no curtain in the middle of the room between the door and window bed and there was a brown substance on the privacy curtain by the wall of the door bed in room 28. (Two residents resided in the room)</p> <p>c. An observation of the AACU Shower Room on 03/15/16 at 6:53 a.m., indicated there was dried food and crumbs on the floor, brown stains on the toilet, the linen cart cover had a white stain on it, there were unfolded towels in an open hamper, a towel on the seat of a geri-chair stored in the Shower Room, trash cans were dirty, a brown ring around the inside of the toilet bowl, chipped tiles on the walls, a broken electric razor and two disposable razors stored on top of the partial wall. The disposable razors had a build up of hair on the blades, there were no resident names on the razors, there was a green mesh chair with brown stains, and a metal cabinet on the wall, which was dirty on the inside and contained three bottles of deodorant without a resident's name, a disposable razor, and six unmarked bottles of moisturizers.</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 03/17/2016
--	---	--	---

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>During an interview at the time of the observation, CNA #1 indicated the shower room was used for all the residents on the unit. (12 residents resided on this unit)</p> <p>During an interview on 03/15/16 at 8:26 a.m., D-Wing Unit Manger indicated there were three residents on the wing who did not use the shower room because they preferred bedbaths instead.</p> <p>A second tour of the AACU, B, C, and D-wings were completed on 03/15/16 with the Administrator, the Housekeeping Supervisor, and the Maintenance Director at 8:35 a.m. through 9:33 a.m. During interviews at the time of the observations, the Housekeeping Supervisor indicated they were suppose to clean the feeding tube poles when the room was cleaned daily. The Administrator indicated the microwave in the B-Wing dining room was used for staff only and needed to be thrown away. The Administrator, Housekeeping Supervisor, and the Maintenance Director acknowledged the above observations.</p> <p>During an observation on 03/16/16 at 2:41 p.m., there were 2 pillows which had shredded plastic covers in room 225, which were being used by the resident.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2016
--	---	---	---

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
F 9999 Bldg. 00	<p>During an interview on 03/16/16 at 2:46 p.m., the Director of Nursing indicated the CNA who made the resident's bed should have seen the shredded plastic covers on the pillow.</p> <p>An undated cleaning procedure, received from the Housekeeping Supervisor on 03/15/16 at 9:43 a.m., indicated shower rooms, dining rooms, resident rooms, and common areas were to be cleaned daily.</p> <p>This Federal tag relates to Complaint IN00195385.</p> <p>3.1-19(f)</p> <p>3.1-13 Administration and management</p> <p>The responsibilities of the administrator</p>	F 9999	F9999 Corrective Action: ED and DNS were educated on the State's interpretation of the regulations. All Others: All	04/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2016
--	---	---	---

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>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; (B) poisonings; (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 to the Indiana State Department of Health (ISDH), related to improper care techniques for a resident who was a fall risk, was left unattended without fall interventions in place, and fell from the bed, requiring sutures to a laceration above the left eye, for 1 of 1 residents reviewed for an unusual occurrence in a total sample of 11. (Resident #J)</p> <p>Finding includes:</p> <p>Resident #J's record was reviewed on 03/16/16 at 1:57 p.m. The resident's</p>		<p>residents with injury needing more than first aid or an ER doctor's evaluation will be reported to the State. Monitoring: ED and DNS have been educated to follow the guidelines set out by the State of Indiana regulations. Sustainability: ED/DNS will monitor all DQI's/SBAR on injuries daily x5 days for 4 weeks, 3 x daily x 4 weeks and then weekly thereafter for 4 months Findings will be brought to QA for 6 months Date: April 16, 2016</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 03/17/2016
--	---	--	---

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>diagnoses included, but were not limited to dementia.</p> <p>A Quarterly Minimum Data Set assessment, dated 12/24/15, indicated the resident's cognition was severely impaired, required extensive assistance with all activities of daily living (ADL's) except bathing, was dependent for bathing, and had two falls without injury.</p> <p>A Fall Risk assessment, dated 12/24/15, indicated a score of 14 (total score of 10 or above deems the resident at risk).</p> <p>A care plan, initiated on 07/01/15, indicated the resident was a risk for falls due to history of falls and flailing of arms and legs. The interventions included, bed in low position initiated 07/01/15, floor mat next to the bed initiated 07/01/15, floor mat at the foot of the bed initiated on 09/03/15, and full mattress landing mat next to the bed initiated 11/13/15.</p> <p>A Physician's Order, dated 07/28/15, indicated a easy landing mat next to a full sized mattress.</p> <p>A Physician's Order, dated 12/14/15, indicated full size mattress next to bed when resident is in bed.</p> <p>A Nurses' Note, dated 02/25/16 at 8:45</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 03/17/2016
--	---	--	---

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>p.m., indicated the resident fell out of bed and had a history of falling out of bed. The note indicated the staff had positioned the resident in the bed close to the wall on the resident's left side, then had went to the resident's bathroom to wet a towel to do the resident's personal care and while in the bathroom the staff heard a, "boom", and found the resident lying on the floor on her right side in a fetal position, with blood on the floor and draining from the resident's left eye and the resident was moaning. The not indicated the resident's bed was waist high and the mattress and mat was not on the floor next to the bed. The resident was assessed to have a laceration above the left eye approximately 0.3 centimeters (cm) by 3.5 cm x 0.1 cm with moderate amount of blood draining from the site and the resident was transferred by Emergency Technicians to the Emergency Room.</p> <p>The Fall Investigation, dated 02/25/16 at 8:45 p.m., indicated the resident was found on the floor in a fetal position, lying on her right side. There was blood on the floor and draining from the resident's left eye and the resident was moaning during the assessment and was moving her body. Pressure was applied to the site and the bleeding would not stop. The resident was transported to the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2016
--	---	---	---

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>hospital for treatment and evaluation. The "Causal/Contributing Factor" for the fall, indicated, "Staff member was still providing care and had walked to the bathroom while CNA was in bathroom res (resident) fell out of bed".</p> <p>The Summary and Outcome of the investigation indicated, "Resident was put into bed by CNA and CNA was getting ready to provide care. Resident fell while CNA was in the bathroom getting ready to complete care. Mattress was not in place due to the same reason staff member still providing care..."</p> <p>The Interview Summary of the Fall Investigation indicated, "Staff stated when he put resident in bed, he position (sic) her close to the wall and was not aware that she has a history of rolling out of bed." The Possible Causal factor indicated the bed was not at the lowest position.</p> <p>The Hospital History and Physical, dated 02/25/16, indicated the resident had a bleeding laceration on the left forehead and the laceration was sutured and the CT scan of the brain showed no hemorrhage. The resident was admitted to the hospital and placed on stroke protocol.</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 03/17/2016
--	---	--	---

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>During an interview on 03/16/16 at 2:55 p.m. the Director of Nursing (DON) indicated the fall had not been reported to the ISDH because the facility knew how the resident fell and how the resident received the injuries. She indicated the CNA had left the resident's bedside to walk into the bathroom and came back and the resident had fallen out of bed. She indicated the CNA had not put the mattress down beside the bed because the resident's care had not been completed.</p> <p>This State tag relates to Complaint IN00195689.</p>			