

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  09/16/2015
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
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F 0000  Bldg. 00	<p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00180090 completed on August 18, 2015 which cited unrelated deficiencies.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00178623 completed on July 28, 2015 which cited unrelated deficiencies.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00181676 and IN00181862.</p> <p>Complaint IN00180090- Not corrected.</p> <p>Survey dates: September 14, 15, &amp; 16, 2015.</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: 14</p>	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0241 SS=E Bldg. 00	<p>Medicaid: 97 Other: 27 Total: 138</p> <p>Sample: 15</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on September 23, 2015.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents dignity was maintained related to staff placing and removing clothing protectors, transferring residents, providing incontinence care, and repositioning resident's chairs without explaining the care to the residents, and not changing a resident's stained clothing for 4 of 5 residents reviewed for dignity during random observations in a sample of 15. (Residents #F, #J, #L, &amp; #N ) (CNA's #1 &amp; #2)</p>	F 0241	<p>F241 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p><b>Unable to correct the alleged deficient practice for residents #F, #J, #L, #N. CNA #1 &amp; CNA #2 were re-educated at the time of the event.</b> How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Other residents on the B wing have the potential to be affected by the same deficient practice. Rounds were completed</p>	10/16/2015

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	<p>Findings include:</p> <p>1. On 9/14/15 at 1:04 p.m. Resident #F was observed sitting in a high back wheel chair at a table in the B-wing dining room. CNA #1 approached the resident from behind and removed the resident's clothing protector which was snapped around the resident's neck in the back. The CNA did not speak to the resident to explain what she was doing before, during, or after removing the clothing protector.</p> <p>On 9/15/15 at 11:05 a.m., the resident was observed sitting up in high back wheel chair in the unit Dining Room. There was dried food on the front of the resident's shirt near her lower abdominal area. The resident did not have any lap blanket or other clothing covering the area. Activity staff was present next to the resident. The lunch meal had not been served.</p> <p>On 9/15/15 at 12:26 p.m., the resident was observed sitting up in a high back wheelchair in the unit Dining Room. The resident's shirt had not been changed.</p> <p>On 9/15/15 at 1:25 p.m., the resident was observed sitting in her chair in her room. The resident was not receiving care from any staff members at this time. The</p>		<p>on the B wing to identify other residents. Residents found to have soiled clothing had their clothing changed. CNA staff member was immediately called and re-educated. No other staff members were identified as lacking communication with the residents during care. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p><b>Facility staff will be re-educated regarding F241 Dignity; focusing on communication- explaining care to the residents and changing of soiled clothing.</b></p> <p>Facility ACE members will include dignity question, "Do staff treat you with respect and dignity?" as part of their facility rounds. Residents will be interviewed during ACE rounds to ensure the deficient practice does not recur.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p><b>During rounds on all three shifts unit managers will audit residents to ensure residents dignity is being maintained. Rounds will be completed 5x week for 4 weeks, 2x week x 4 weeks and then weekly for a total of 6 months. DNS will bring results of audits and ACE rounds to QAPI for 6 months</b></p>				

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	<p>resident's shirt had not been changed.</p> <p>The record for Resident #F was reviewed on 9/15/15 at 11:44 a.m. The resident's diagnoses included, but were not limited to, edema (swelling) shortness of breath, congestive heart failure, and dementia.</p> <p>Review of the 6/9/15 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (9). A score of (9) indicated the resident's cognitive patterns were moderately impaired. The assessment also indicated the resident required extensive assistance (resident involved in activity with staff providing weight bearing support) of one staff member for dressing and personal hygiene.</p> <p>2. On 9/14/15 at 1:04 p.m., Resident #N was observed sitting in a wheel chair in the unit Dining Room. CNA #1 approached the resident from behind and removed the resident's clothing protector which was snapped around the resident's neck in the back. The CNA did not speak to the resident to explain what she was doing before, during, or after removing the clothing protector.</p> <p>The record for Resident #N was reviewed on 9/15/15 at 11:10 a.m. The resident's</p>		<p><b>identifying any trends or patterns.</b> By what date the systemic changes will be completed? October, 16, 2015</p>	

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	<p>diagnoses included, but were not limited to, dementia, high blood pressure, and glaucoma.</p> <p>Review of the 6/25/15 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (15). A score of (15) indicated the resident's cognitive patterns were intact.</p> <p>Review of the Resident Report Sheet for Resident #N indicated the resident was legally blind and needed assistance with meals.</p> <p>3. On 9/14/15 at 11:52 a.m., Resident #L was observed seated in a high back specialty chair in the unit Dining Room. CNA #1 approached the resident and reclined her chair. The CNA then pushed the chair and then pulled the chair backward and placed the resident in a different direction in the Dining Room. The CNA did not speak to resident or attempt to explain to the resident what was being done at this time.</p> <p>On 9/14/15 at 1:27 p.m., the resident was observed in the unit Dining Room. CNA #1 approached the resident and pushed her in her chair into her room without speaking to the resident. CNA #2 entered the room. The two CNA's attached the</p>			

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	<p>strips of the Marissa lift (a mechanical lift device) to the sling pad. The CNA's transferred the resident into her bed. CNA #1 turned the resident to her right side and removed her pants and incontinence brief and began to provide incontinence care. The CNA's did not explain the above events to the resident prior to or during the above care.</p> <p>The record for Resident #L was reviewed on 9/15/15 at 11:20 a.m. The resident's diagnoses included, but were not limited to, depressive disorder, dementia, high blood pressure, and anxiety state.</p> <p>Review of the 8/16/15 Minimum Data Set (MDS) quarterly assessment indicated the resident's cognitive skills were severely impaired. The assessment also indicated the resident required extensive assistance of two staff members for bed mobility and was dependent on staff for dressing, eating, transfers, and personal hygiene. The assessment also indicated the resident was dependent on two staff members for transfers.</p> <p>The Resident Report Sheet for Resident #L was reviewed. The sheet indicated staff were to lay the resident down after meals.</p>			

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	<p>4. On 9/14/15 at 11:52 a.m., Resident #J was observed seated in a specialty chair in the unit Dining Room. CNA #1 approached the resident and placed a clothing protector on his chest and around his neck. The CNA did not speak to the resident to explain what she was doing at this time.</p> <p>The record for Resident #J was reviewed on 9/15/15 at 2:00 p.m. The resident's diagnoses included, but were not limited to, dementia, convulsions, and hearing loss.</p> <p>Review of the 8/24/15 Minimum Data Set (MDS) significant change assessment indicated the resident's cognitive skills for decision making were severely impaired. The assessment also indicated the resident was dependent on staff for bed mobility and transfers. The assessment also indicated the resident required extensive assistance of one staff member for eating, dressing, and personal hygiene.</p> <p>When interviewed on 9/15/15 at 2:30 p.m., the Director of Nursing indicated the the staff should have spoken with the residents to explain care.</p> <p>This deficiency was cited on 8/18/15. The facility failed to implement a</p>			

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F 0465 SS=E Bldg. 00	<p>systemic plan of correction to prevent recurrence.</p> <p>3.1-3(t)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the resident's environment remained sanitary related to dirty seat belts, floors, chairs, walls, bed rails on 2 of 3 Wings. (The B and C Wings)</p> <p>Findings include:</p> <p>1. During Orientation Tour on 9/14/15 at 8:30 a.m. the following was observed on the C-wing:</p> <p>a. There floor in front of the Nursing Station was dirty. There were dried red spots on the floor. There was dried spillage on the base board. The floor tiles around the water cooler next to the Station were dirty.</p> <p>b. There was dried tan colored spillage on the bed rails and frame in Room 221-1. Two residents resided in this</p>	F 0465	<p>F465</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p><b>Resident D had self-releasing alarming belt changed out for a new belt on 9/16/15.</b></p> <p><b>Food tray was removed from the B wing dining room.</b></p> <p><b>Maintenance and Housekeeping immediately started working on cleaning and repairing the facility areas found deficient.</b></p>	10/16/2015

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	<p>room.</p> <p>c. There was dried tan colored spillage on the floor in Room 222. One resident resided in this room.</p> <p>2. The following was observed in the Dining Room on the unsecured section of B- wing on 9/14/15 at 11:40 a.m.:</p> <p>a. There was a food tray on the counter top. The lid was not covering the tray. Servings of ground meat and a hot cereal were uncovered.</p> <p>b. There was spillage on the sides of the garbage can.</p> <p>c. There was dried spillage on the side of the counter top and along the base board of the counter. A door was missing to one of the shelves in the counter.</p> <p>d. There was spillage on the lower sections of the wall to the left of the entrance and the wall with the television.</p> <p>e. There was an accumulation of dirt and debris on the floor along the base board under the window.</p> <p>f. Food crumbs and debris were observed under a table next to the stove.</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p><b>Other residents with self releasing belts have the potential to be affected. Rounds were completed on 9/16/15 and one additional belt was changed out for a new belt.</b></p> <p><b>Other residents who eat in the dining rooms have the potential to be affected by the alleged deficient practice.</b></p> <p><b>All residents who reside on C and B wing have the potential to be effected by the spillage on floors, baseboards, bedrails, garbage cans, countertops, walls, and on curtains.</b></p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p>	

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	<p>g. There was dried spillage under the counter by the stove.</p> <p>h. The base of the standing fan was dirty. There was an accumulation of dust on the fan blades.</p> <p>i. There was an accumulation of dirt along the bottom of the exit door.</p> <p>j. There was dried spillage on the wall just outside of the entrance.</p> <p>3. The following was observed on 9/15/15 at 10:00 a.m. in the Dining Lounge area on secured section of the B-wing:</p> <p>a. There was dried spillage on the wall under the hand sanitizer pump.</p> <p>b. There was an accumulation of dirt and dust on the floors along the walls by the desk and counter areas.</p> <p>c. There was a drawer missing on the desk.</p> <p>d. There was dried dirt and spillage along the base board under the window.</p> <p>e. There was a dark stain on a window curtain.</p>		<p><b>Staff will be re-educated regarding cleaning self releasing belts when soiled.</b></p> <p><b>Staff will be re-educated to ensure all food trays are removed from dining rooms prior to the start of the next meal.</b></p> <p><b>Housekeeping staff will be re-educated regarding spillage and stains along with appropriate cleaning of floors, rooms, bathrooms and walls.</b></p> <p><b>Housekeeping Manager was replaced and new manager is in house and working on the POC as of 9-25-15.</b></p> <p><b>Maintenance will be re-educated about facility rounding to include the condition of cabinets in facility.</b></p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p>	

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	<p>f. The dark blue chair in the corner had stains on the arms and lower section under the seat.</p> <p>4. On 9/14/14 at 9:14 a.m., Resident #D was observed sitting in a wheel chair in the Dining Room on the unsecured hall of the B-wing. There was an accumulation of dried spillage on the resident's self release alarming belt.</p> <p>When interviewed on 9/14/15 at 2:30 p.m. the Director of Nursing indicated the resident rooms and dining areas should have been cleaned.</p> <p>This deficiency was cited on 8/18/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(f)</p>		<p><b>During rounds on all three shifts unit managers will audit residents to ensure residents are wearing clothing protectors as care planned and clothing is clean and dry. Rounds will be completed 5x week for 4 weeks, 2x week x 4 weeks and then weekly for a total of 6 months.</b></p> <p><b>DNS or designee will bring results of audits to QAPI for 6 months to identify any trends or patterns.</b></p> <p><b>Housekeeping will be rounding daily for 5 weeks for 4 weeks, then 2 x a week for 4 weeks and then weekly for a total of 6 months. Housekeeping will be bringing all audits and findings to QAPI for 6 months.</b></p> <p><b>Maintenance will monitor the cabinet condition 5 x a week for 4 weeks, x 2 weeks for 4 weeks and then weekly for a total of 6 months. Maintenance will bring audits to QAPI for 6</b></p>	

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			months.  Date of Compliance  October 16, 2015		