STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-VALPARAISO	251 STURDY RD VALPARAISO, IN 46383

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00183681. Complaint IN00183681-Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F323. Survey date: October 7, 2015 Facility number: 000062 Provider number: 155137 AIM number: 100271400 Census bed type: SNF/NF: 79 Total: 79 Census payor type: Medicare: 5 Medicaid: 66 Other: 8 Total: 79 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 26143, on October 13, 2015.	F 0000	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review, and interview, the facility failed to ensure non-pressure related skin areas related to bruises were assessed and monitored for 2 of 3 residents reviewed for non-pressure related skin conditions. (Residents #B & #C) Findings include: 1. On 10/7/15 at 8:50 a.m., Resident #C was observed sitting in her wheelchair. At that time, the resident was observed with a large scabbed abrasion to the center of her forehead as well as blue/green/yellow bruising around the scabbed area. The resident was also observed with a large skin tear to the left hand surrounded by red and purple bruising. There was also a red and purple bruise noted to the resident's right hand. The record for Resident #C was reviewed on 10/7/15 at 9:45 a.m. The resident's	F 0309	1) Residents #B and #C's skin assessments were completed. Areas were measured and addressed. 2) All residents with non-pressure skin areas have the potential to be effected. Skin sheets were reviewed for weekly documentation. 3) A. Nursing staff was in serviced on consistent weekly documentation of non-pressure skin areas. B. Auditing documentation of non-pressure skin areas 5x/week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. 4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting unless further monitoring is deemed necessary. 5) October 23, 2015	10/23/2015

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	diagnoses included, but were not limited to, delusion disorder, anxiety, difficulty walking, epilepsy, macular degeneration, psychotic symptoms, and insomnia. The Significant Change Minimum Data Set (MDS) dated 8/25/15 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 8 indicating the resident was moderately impaired for cognition. The resident needed extensive assist with a two person physical assist for transfers and toilet use. The current plan of care updated on 8/25/15 indicated the resident was at risk for complications related to anticoagulant use. The Nursing approaches were to observe for signs and symptoms of bleeding such as bruising. The wound evaluation form dated 9/25/15 indicated the resident had an abrasion to the forehead which measured 2 centimeters (cm) by 2 cm. The area around the abrasion was pink. There was no documentation regarding any bruising to the forehead. There were no further measurements of the abrasion. Another wound evaluation form dated 9/25/15 indicated the resident had a skin tear to the left hand by the thumb. The area measured 4 cm by 2 cm. The			

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	surrounding skin was pink. There was no documentation regarding the bruising around the skin tear. There were no further measurements of the skin tear. There was no wound evaluation form for the bruise noted on the right hand. Nursing Progress Notes dated 10/2/15 at 3:59 p.m., indicated skin tear and bruising to left hand remains. Blue, green, and yellow bruising with abrasion to forehead. No further skin issues. The new bruise, skin tear, abrasion and bruise to the forehead and left hand were measured on 10/7/15 at 3:45 p.m. The measurements were as follows: A. Left temporal bruise, 4.5 cm by 2 cm. Color was green and yellow. B. Right hand bruise, 2.5 cm by 1.5 cm. Color was purple. C. Left hand skin tear, 4 cm by 1.5 cm. Bruise around skin tear, 1.5 cm by 2 cm. D. Center of forehead abrasion, 1.5 cm by 1 cm. Interview with the DON on 10/7/15 at 3:00 p.m., indicated all non-pressure areas were to be measured weekly until healed. She further indicated the bruise to the right hand was not assessed or measured.			

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	2. On 10/7/15 at 3:50 p.m., Resident #B was observed in her room lying in be. At that time the Unit Manager and LPN #1 indicated a yellow fading bruise to the upper right thigh measured 3.1 centimeters (cm) x 2.6 cm. The Record for Resident #B was reviewed on 10/7/15 at 10:08 a.m. The resident's diagnoses included, but were not limited to, heart failure, dementia, and depression. The Quarterly Minimum Data Set (MDS) assessment dated 7/27/15 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 2 indicating the resident's cognition was severely impaired. The resident needed extensive assist with a two person physical assist for transfers and toilet use. The wound evaluation form dated 9/21/15 indicated the resident had green bruising to the front of the right thigh which measured 3.0 cm. There were no further measurements of the bruise. The Nursing Progress notes dated 9/21/15 indicted, green bruising measuring 3.0 cm to the right front thigh. There was no further documentation of the bruising in the Nursing Progress notes.			

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	Interview with the Unit Manager on 10/7/15 at 3:55 p.m., indicated it was the facilities policy for the Nursing staff to monitor and measure bruising weekly. The current Skin Integrity Guideline policy provided by the DON on 10/7/15 at 2:30 p.m., indicated, licensed nurse to document weekly on identified wounds using the "Wound Evaluation Flow Sheet". This Federal tag relates to Complaint IN00183681. 3.1-37(a)			
F 0323 SS=G Bldg. 00	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 observation, record review, and interview, the facility failed to ensure each resident was free from accidents related to assisting a resident during a transfer with one person rather than two persons which resulted in a fall with a fracture (Resident #B) and leaving a	F 0323	1) At the time of the incidents, teachable moments had been given to staff members who were involved with residents #B and #C. 2) All residents have the potential to be affected by the alleged deficient practice. Resident Care Plan sheets were reviewed and updated as needed.	10/23/2015

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	resident with a history of falls on the toilet unsupervised which resulted in a fall (Resident #C) for 2 of 3 residents reviewed for accidents. (Residents #B and #C) Findings include: 1. On 10/7/15 at 8:50 a.m., Resident #B was observed in her room laying in bed. At that time, the resident was observed with a right arm sling in place. The Record for Resident #B was reviewed on 10/7/15 at 10:08 a.m. The resident's diagnoses included, but were not limited to, heart failure, right sided paralysis, dementia, and depression. The Quarterly Minimum Data Set (MDS) dated 7/27/15 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 2 indicating the resident's cognition was severely impaired. The resident needed extensive assist with a two person physical assist for transfers. The Fall Risk Assessment dated 11/8/14 indicated the resident was at risk for falls. The current and updated plan of care dated 8/27/15 indicated the resident was at risk for falls related to the need for		3) Nurse's and CNA's were in-serviced on following Resident Care Plan sheets for proper transfers and safety interventions. Staff will be observed and audited randomly on all shifts for proper transfers according to Resident Care Plan sheets. Transfer and Safety Intervention Audit tool will be completed by the DNS/designee 9 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. 4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting. 5) October 23, 2015	

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	extensive assist with transfers as well as right sided paralysis. The Nursing approaches included, but were not limited to, two person assist for all transfers. Nursing Progress Notes dated 9/21/15 at 4:27 p.m., indicated the resident was lowered to the floor during a transfer. The verification of an investigation form dated 9/21/15 provided by the Director of Nursing (DON) was reviewed on 10/7/15 at 3:50 p.m. The detailed description of the event indicated the resident was lowered to the floor during a transfer after her leg gave out. The intervention recommended to prevent further occurrence was for the resident to be assisted by two staff at all times. Nursing Progress notes dated 9/22/15 at 10:28 p.m., indicated resident noted to have a bruise to her right upper extremity (RUE) measuring 5 centimeters (cm) by 5 cm purple in color. Continued review indicated the following: -9/23/15 at 8:16 a.m., RUE swollen with bruise -9/23/15 at 8:38 a.m., medication administration due to discomfort -9/23/15 at 2:27 p.m., noted swelling to right upper arm and shoulder area, resident guarding area and would not move arm....bruising noted to arm pit			

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	area.....resident assessed by Medical Doctor (MD)....stat x-ray ordered. MD notified of results....resident sent to emergency room (ER). -9/23/15 at 9:02 p.m., resident returned from the ER with an immobilizer in place to be worn at all times. The Radiology Report dated 9/23/15 indicated, There was a mildly displaced fracture through the surgical neck of the proximal right humerus (upper arm). Interview with the DON on 10/7/15 at 2:04 p.m., indicated the resident had a fall resulting in a fracture during a one person assisted transfer and the resident was to be transferred by two staff at all times. Interview with CNA #2 on 10/7/15 at 2:55 p.m., indicated the resident was a two person assist with transfers and now requires a Hoyer lift during transfers. Interview with the Physical Therapy Director on 10/7/15 at 2:55 p.m., indicated the resident has always been care planned as a two person assist with transfers.2. On 10/7/15 at 8:50 a.m., Resident #C was observed sitting in her wheelchair. At that time, the resident was observed with a large scabbed			

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	abrasion to the center of her forehead as well as blue/green/yellow bruising around the scabbed area. The resident was also observed with a large skin tear to the left hand surrounded by red and purple bruising. The record for Resident #C was reviewed on 10/7/15 at 9:45 a.m. The resident's diagnoses included, but were not limited to, delusion disorder, anxiety, difficulty walking, epilepsy, macular degeneration, psychotic symptoms, and insomnia. The Significant Change Minimum Data Set (MDS) dated 8/25/15 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 8 indicating the resident was moderately impaired for cognition. The resident needed extensive assist with a two person physical assist for transfers and toilet use. The fall risk assessment dated 8/25/15 indicated the resident was at risk for falls. The current and updated plan of care dated 8/25/15 indicated the resident was at risk for falls related to difficulty walking and with transfers as well as increased weakness. The Nursing approaches were to position the bed low, keep the call light in reach, wheelchair for mobility and the use of proper			

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	footwear. Nursing Progress Notes dated 9/12/15 at 3:15 p.m., indicated the resident was found on the floor by a CNA. The verification of investigation form dated 9/12/15 provided by the Director of Nursing (DON) was reviewed on 10/7/15 at 2:45 p.m. The detailed description of the event indicated the resident fell while transferring herself from her wheelchair to the stationary chair in the dining room. The interventions recommended to prevent further occurrence was for the resident to be encouraged to attend activities or stay in sight of staff when up in the wheelchair. Nursing Progress Notes dated 9/25/15 at 3:59 p.m. indicated the resident was found on the floor on both of her knees in front of her wheelchair. The resident was bleeding from her forehead and sustained a left hand skin tear. The facility called 911 and the resident was sent to the hospital. The resident returned from the hospital at 8:50 p.m. The hospital report indicated the resident had a Cat Scan (CT) of her right hip which indicated a minimally displaced comminuted fracture involving the greater trochanter proximal to the right femur.			

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	The verification of investigation form dated 9/25/15 provided by the DON was reviewed on 10/7/15 at 2:45 p.m. The detailed description of the event indicated the resident was found on the floor on her knees. The resident's wheelchair was behind her next to the dining table and window wall. It had appeared the resident was leaning over to reach for something. The interventions recommended to prevent occurrence was for the resident's call light to be in reach and not to lean forward in her wheelchair. Nursing Progress Notes dated 9/26/15 at 7:13 p.m., indicated the resident was found on the floor by nurse. The verification of investigation form dated 9/26/15 provided by the DON was reviewed on 10/7/15 at 2:45 p.m. The detailed description of the event indicated the resident had just finished eating dinner and had asked the CNA to transport her to the restroom. The resident asked the CNA to get her a clean pair of pants out of the closet. When the CNA turned around, the resident fell on the bathroom floor. The interventions recommended to prevent occurrence was for the resident to stay with staff when up in the wheelchair. Interview with CNA #1 on 10/7/15 at			

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	12:23 p.m., indicated the staff were to keep a close watch on the resident but it was hard at times due to the resident was able propel her wheelchair by herself. Interview with LPN #2 on 10/7/15 at 3:40 p.m., indicated the resident self propels herself in the wheelchair, but "We try to keep a close eye on her." Interview with the DON on 10/7/15 at 3:00 p.m., indicated the resident had a fall with a fracture on 9/25/15 and fell again the next day on 9/26/15. She indicated on 9/26/15 the CNA had placed the resident on the toilet and left her there to get something for the resident out of the closet. She further indicated the CNA was not in sight of the resident and should not have left the resident on the toilet by herself especially with a history of falls. This Federal tag relates to Complaint IN00183681. 3.1-45(a)(2)			