

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 09/16/2016
--	---	--	---

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

(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 IN00209129 and IN00209323.</p> <p>Complaint IN00209129 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F224, F225, and F226.</p> <p>Complaint IN00209323 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F224, F225, and F226.</p> <p>Survey dates: September 15 & 16, 2016</p> <p>Facility number: 000062 Provider number: 155137 AIM number: 100271400</p> <p>Census bed type: SNF/NF:72 Total:72</p> <p>Census payor type: Medicare: 6 Medicaid: 58 Other: 8 Total: 72</p>	F 0000	F000 - Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in 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 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: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO			STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383		
(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 0223 SS=D Bldg. 00	<p>Sample: 9</p> <p>These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 9/20/16.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure residents remained free of physical, mental, and emotional Abuse related to Staff photographing a cognitively impaired resident for 1 of 2 allegations of Abuse reviewed. (Resident #K)</p> <p>Finding includes:</p> <p>The closed record for Resident #K was reviewed on 9/16/16 at 1:04 p.m. The resident diagnoses included, but were not</p>	F 0223	<p>1. Resident K no longer resides in the facility.</p> <p>2. All residents have the potential to affected by this alleged deficient practice. The DNS/ designee has in-serviced all staff on the new CMS policyfor Reporting and Investigation of Alleged Violations of Federal and State Laws,Involving</p>	10/07/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2016	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO				STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383			
(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>limited to, Alzheimer's disease, dementia, high blood pressure, depressive disorder, and mood disorder.</p> <p>Review of the 6/14/16 MDS (Minimum Data Set) quarterly assessment indicated the resident's cognitive patterns were moderately impaired and the resident displayed both short and long term memory problems.</p> <p>An Incident Report form related to Resident #K was reviewed. The form indicated the Director of Nursing was approached by the contracted Housekeeping Director on 6/21/16. The Housekeeping Director informed the Director of Nursing one of the staff members reported another employee had taken a photograph of a resident. An investigation was initiated and the local Police Department was also notified. The employee who allegedly took the photograph was suspended at the time the occurrence was reported.</p> <p>Interviews were obtained during the facility investigation from contracted Housekeeping staff as follows: 6/23/16- Contracted HK Employee #1's written interview indicated E#2 told Employee #3 about a picture that was taken of Resident #K. Employee #1 then informed her Supervisor.</p>		<p>Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident Property. Also, we will re-educate all staff on the policy of Cell Phone and Cameras in the Work place.</p> <p>ADDENDUM:</p> <p>1.The policy requested is provided for your review. 2.This is a part of the General Orientation the Cell Phone and Cameras in the Work Place, that is contained in the Employee Handbook the employee signs and acknowledges their understanding of the policy. 3.The MOD's have been in-serviced on reporting to the ED immediately any reportable issues that may arise.</p> <p>3. The ED/ DNS are reviewing the daily (Monday thru Sunday 24 hour) nurses progress notes and the DNS/designee will also, review the 24 hour nursing report to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/16/2016
--	---	---	---

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

(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>6/21/16- Contracted HK Employee #2's written statement indicated HK Employee #2 told her about HK Employee #4 taking a picture of Resident #K and she took a picture of the resident "pleasuring himself."</p> <p>When interviewed on 9/15/16 at 11:30 a.m., the facility Administrator indicated the local Police department was called related to the incident and came to the facility to investigate. The Administrator indicated he had not seen the picture and did not know if the picture had been posted on any social media site. The local Police continue to have the case open and reported they had been able to recover the picture on her phone and confirmed there are charges pending against the Employee. The staff member is not longer working at the facility. The Administrator further indicated the other staff members should have immediately informed the Administrator prior to discussing it with each other.</p> <p>The facility policy titled "Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property" was reviewed on 9/15/16 at 9:05 a.m. The policy was last reviewed on 9/7/16. The facility</p>		<p>ensure that any resident concerns are being noted and addressed. Additionally, The (MOD Manager on Duty) for the weekend will contact the ED prior to leaving for the day and provide him with an update on any concerns that may have the potential to be reported the ISDH. The ED and the DNS along with the IDT will audit all verifications of investigations during the daily stand up meeting. An audit tool will be completed by the ED /designee 7 times per week for 4 weeks then 5 X weekly for 4 weeks, weekly for 4 weeks and then monthly for 12 weeks.</p> <p>4. Audit tool will be reviewed monthly for 6 months at our QAPI meeting to track and trend for any concerns. Finding no patterns, we will review quarterly thereafter. Action plans will be developed for any identified concerns.</p>	

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 09/16/2016
--	---	--	---

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

(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 0224	<p>Administrator provided the policy and indicated the policy was current.</p> <p>The policy indicated the facility was required to take steps to prevent the occurrence of abuse, neglect, injury of unknown origin, and misappropriation of resident property. The policy indicated each employee was required to report any allegation of mistreatment, neglect, abuse, or misappropriation of property to the designated supervisor in charge.</p> <p>This Federal tag relates to Complaints IN00209129 and IN00209323.</p> <p>3.1-27(a)(1)</p>			

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 09/16/2016
--	---	--	---

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

(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
SS=D Bldg. 00	<p>PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure resident medications were accounted for and administered only to the resident for whom the Physician ordered them for 1 of 3 residents reviewed for medication reconciliation in a sample of 9. (Resident #H)</p> <p>Finding includes:</p> <p>The record for Resident #H was reviewed on 9/15/16 at 3:40 p.m. The resident's diagnoses included, but were not limited to, dementia with behaviors, anorexia, and encephalopathy. Hospice services were ordered for the resident on 7/11/16. The resident was discharged on 8/12/16.</p> <p>Review of the 9/16/16 Physician Order Statement indicated an order was written on on 7/22/16 for the resident to receive Haldol (an antipsychotic medication) 1 mg (milligram) every eight hours as needed for nausea or delirium.</p> <p>The July 2016 MAR (Medication</p>	F 0224	<p>1. Resident H no longer resides in the facility.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. An audit was conducted for any resident receiving Haldol, no issues were identified.</p> <p>ADDENDUM: An audit of all Controlled substances for misappropriations was completed.</p> <p>3. The DCE has re-educated the Licensed staff on the following policies.1. Medication Administration Preparation and General Guidelines. 2. Controlled Substance Disposal. 3.The DNS or another licensed nurse will complete audits for</p>	10/07/2016

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 09/16/2016	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO				STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383			
(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>Administration Record) was reviewed. The resident received Haldol 1 milligram on 7/17/16 at 8:14 p.m. and 7/19/16 at 8:24 p.m. The August 2016 MAR was reviewed. No Haldol was signed out as given in August 2016.</p> <p>Review of an facility reported Incident Report form indicated the facility Administrator received a telephone call from the Medical Director of the facility. The form indicated the Medical Director notified the Administrator of a phone call he had received from RN #1. The Medical Director indicated the Nurse reported she had witnessed another Nurse giving Haldol to a resident who did not have current Physician orders for the medication. An investigation was initiated.</p> <p>Review of the facility investigation indicated the Administrator interviewed the Director of Nursing after the above phone was received. The Director of Nursing informed the Administrator she had been aware of the incident and did not report the occurrence to the Administrator. Statements were then written by several different staff members.</p> <p>A statement obtained from RN #2 indicated RN #1 approached her</p>				<p>narcotics 5 times weekly for 4 weeks , 5 X weekly for 4 weeks, weekly for 4 weeks then monthly thereafter for 12 weeks.</p> <p>4. Audit tools will be reviewed monthly for 6 months in the facility QAPI meeting to track and trend for any patterns. Finding no identified concerns, the audits will be reviewed quarterly. Actions Plans will be developed for any identified concerns.</p>		

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 09/16/2016
--	---	--	---

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

(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>approximately 1 1/2 weeks prior and stated she had observed another Nurse administer Haldol to a resident who did not have a Physician's order for Haldol. RN #2's statement indicated she instructed RN #1 to report the occurrence to the Director of Nursing. RN #2's statement also indicated LPN #2 had told her she heard LPN #3 looking for Haldol to give to another resident.</p> <p>When interviewed on 9/15/16 at 2:10 p.m., the facility Administrator indicated RN #1 had spoken to the Director of Nursing on 7/31/16 and informed her residents were receiving Haldol without an MD order. The Administrator indicated he was not informed of the above allegation until the day the Medical Director phoned him. The Administrator indicated he then spoke with the Director of Nursing and she informed him she had completed a medication count which was correct. The Director of Nursing did not inform the Administrator at the time of the above.</p> <p>Continued interview with the Administrator indicated Resident #H had been receiving Hospice Care during the above time and had Physician orders to receive Haldol. The Administrator indicated the Director of Nursing stated she completed a narcotic count and no</p>			

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 09/16/2016
--	---	--	---

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

(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>discrepancies were found. The Administrator indicated statements were obtained from staff members. RN #1 indicated she observed LPN #3 take medications out of her (RN #1) cart and place them in a plastic bag and go into a resident's room.</p> <p>The Administrator indicated the Haldol medication for Resident #H was provided from Hospice and no medication reconciliation or count forms were completed for the Haldol. The Administrator indicated she spoke with the Hospice Service who verified a total of (10) Haldol pills were provided for Resident #H. In the facility investigation (4) Haldol pills were found in the medication bag. The Administrator was informed only (2) doses of Haldol were signed out on the Medication Records between July and August 2016. The Administrator indicated there would have been (4) other Haldol pills which were not accounted for or signed out.</p> <p>The facility policy titled "Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property" was reviewed on 9/15/16 at 9:05 a.m. The policy was last reviewed on 9/7/16. The facility</p>			

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 09/16/2016
--	---	--	---

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

(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 0225 SS=D Bldg. 00	<p>Administrator provided the policy and indicated the policy was current.</p> <p>The policy indicated the facility was required to take steps to prevent the occurrence of abuse, neglect, injury of unknown origin, and misappropriation of resident property.</p> <p>This Federal tag related to Complaints IN00209129 and IN00209323.</p> <p>3.1-27(a)(3)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or</p>			

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 09/16/2016
--	---	--	---

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

(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>abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure allegations of Misappropriation of Property and abuse were reported to the Administrator immediately and were thoroughly investigated related to an allegation of missing medications and photographing a cognitively impaired resident without consent. (Residents #K and #H)</p> <p>Findings include:</p> <p>1. The record for Resident #H was reviewed on 9/15/16 at 3:40 p.m. The</p>	F 0225	<p>1. Resident K and H no longer are residing in the facility.</p> <p>2. All resident have the potential to be affected by this alleged deficient Practice. The ED/ DNS or designee are reviewing the daily nurses progress notes (Monday – Sunday) as well as the 24 hour report to ensure that any incidents that may have the potential to be reportable</p>	10/07/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO			STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383		
(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 diagnoses included, but were not limited to, dementia with behaviors, anorexia, and encephalopathy. Hospice services were ordered for the resident on 7/11/16. The resident was discharged on 8/12/16.</p> <p>Review of the 9/16/16 Physician Order Statement indicated an order was written on on 7/22/16 for the resident to receive Haldol (an antipsychotic medication) 1 mg (milligram) every eight hours as needed for nausea or delirium.</p> <p>The July 2016 MAR (Medication Administration Record) was reviewed. The resident received Haldol 1 milligram on 7/17/16 at 8:14 p.m. and 7/19/16 at 8:24 p.m. The August 2016 MAR was reviewed. No Haldol was signed out as given in August 2016.</p> <p>Review of a facility reported Incident Report form indicated the facility Administrator received a telephone call from the Medical Director of the facility on 8/15/16. The form indicated the Medical Director notified the Administrator of a phone call he had received from RN #1. The Medical Director indicated the Nurse reported she had witnessed another Nurse giving Haldol to a resident who did not have current Physician orders for the</p>		<p>to the ISDH and are completed timely, and thoroughly investigated as per policy.</p> <p>3. The DCE has completed an in- service for staff on Verification of Investigation Process Emphasizing the importance of reporting all Investigations to the Executive Director as well as to the state agencies as required by Federal and /or State law. Additionally, the Manager on Duty (MOD) for the weekend will contact the ED prior to leaving for the day and provide him with an update on any concerns that may have the Potential to be reportable to the ISDH . The ED and the DNS along with the IDT will audit all verifications of investigations during the daily stand up meeting. An audit tool will be completed by the ED /designee 7 times per weekly for 4 weeks then 5 X weekly for 4 weeks , weekly for 4</p>		

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 09/16/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO			STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383		
(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>medication. An investigation was initiated.</p> <p>Review of the facility investigation indicated the Administrator interviewed the Director of Nursing after the above phone was received. The Director of Nursing informed the Administrator she had been aware of the incident and did not report the occurrence to the Administrator. Statements were then written by several different staff members.</p> <p>A statement obtained from RN #2 indicated RN #1 approached her approximately 1 1/2 weeks prior and stated she had observed another Nurse administer Haldol to the resident who did not have a Physician's order for Haldol. RN#2's statement indicated she instructed RN #1 to report the occurrence to the Director of Nursing. RN #2's statement also indicated LPN #2 had told her she heard LPN #3 looking for Haldol to give to another resident.</p> <p>When interviewed on 9/15/16 at 2:10 p.m., the facility Administrator indicated RN #1 had spoken to the Director of Nursing on 7/31/16 and informed her residents were receiving Haldol without an MD order. The Administrator indicated the was not informed of the</p>		<p>weeks and then monthly for 12 weeks.</p> <p>ADDENDUM: The MOD'S have been in-serviced on reporting immediately to the ED on any Reportable issue that may arise.</p> <p>4. Audit tools will be reviewed monthly for 6 months at our monthly QAPI meeting to track and trend for any concerns identified. Finding no pattern the audits will then reviewed quarterly thereafter. Action Plans will be developed for any identified concerns.</p>		

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 09/16/2016
--	---	--	---

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

(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>above allegation until the day the Medical Director phoned him. The Administrator indicated he then spoke with the Director of Nursing and she informed him she had completed a medication count which was correct. The Director of Nursing did not inform the Administrator of the above.</p> <p>Continued interview with the Administrator indicated Resident #H had been receiving Hospice Care during the above time and had Physician orders to receive Haldol. The Administrator indicated the Director of Nursing stated she completed a narcotic count and no discrepancies were found. The Administrator indicated statements were obtained from staff members. RN #1 indicated she observed LPN #3 take medications out of her (RN #1) cart and place them in a plastic bag and go into a resident's room.</p> <p>The Administrator indicated the Haldol medication for Resident #H was provided from Hospice and no medication reconciliation or count forms were completed for the Haldol. The Administrator indicated he spoke with the Hospice Service who verified a total of (10) Haldol pills were provided for Resident #H. In the facility investigation (4) Haldol pills were found in the bag.</p>			

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 09/16/2016
--	---	--	---

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

(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 Administrator was informed only (2) doses of Haldol were signed out on the Medication Records between July and August 2016. The Administrator indicated there would have been (4) other Haldol pills which were not accounted for or signed out.</p> <p>2. The closed record for Resident #K was reviewed on 9/16/16 at 1:04 p.m. The resident diagnoses included, but were not limited to, Alzheimer's disease, dementia, high blood pressure, depressive disorder, and mood disorder.</p> <p>Review of the 6/14/16 MDS (Minimum Data Set) quarterly assessment indicated the residents cognitive patterns were moderately impaired and the resident displayed both short and long term memory problems.</p> <p>An Incident Report form related to Resident #K was reviewed. The form indicated the Director of Nursing was approached by the contracted Housekeeping Director on 6/22/16. The Housekeeping Director informed the Director of Nursing one of the staff member reported another employee had taken a photograph of a resident. An investigation was initiated and the local Police Department was notified. The employee who allegedly took the</p>			

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 09/16/2016
--	---	--	---

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

(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>photograph was suspended at the time the occurrence was reported.</p> <p>Interviews obtained during the facility investigation from contracted Housekeeping staff as follows: 6/23/16- Contracted HK Employee #1's written interview indicated E#2 told Employee #3 about a picture that was taken of Resident #K. Employee #1 then informed her Supervisor. 6/21/16- Contracted HK Employee #2's written statement indicated HK Employee #2 told her about HK Employee #4 taking a picture of Resident #K and she took a picture of the resident "pleasuring himself."</p> <p>When interviewed on 9/15/16 at 11:30 a.m., the facility Administrator indicated the local Police department was called related to the incident and came to the facility to investigate. The Administrator indicated he had not seen the picture and did not know if the picture had been posted on any social media site. The local Police continue to have the case open and reported they had been able to recover the picture on her phone and confirmed there are charges pending against the Employee. The staff member is no longer working at the facility. The Administrator further indicated the other staff members should have immediately</p>			

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 09/16/2016
--	---	--	---

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

(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 0226 SS=D Bldg. 00	<p>informed him Administrator prior to discussing it with each other first.</p> <p>This Federal tag relates to Complaints IN00209129 and IN00209323.</p> <p>3.1-28(c) 3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure all allegations of abuse and misappropriation were reported to the Administrator immediately and investigations were initiated at the time for 2 of 2 allegations of Abuse reviewed. (Residents #H and #K)</p> <p>Findings include:</p> <p>1. The closed record for Resident #K was reviewed on 9/16/16 at 1:04 p.m. The resident diagnoses included, but were not limited to, Alzheimer's disease,</p>	F 0226	<p>1. Resident K no longer is residing at this facility.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. The DNS/ designee has in-serviced all staff on the new CMS policy for Reporting and Investigation of Alleged Violations of Federal and State Laws, Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident property. Also, we will re-educate all staff on the policy of Cell Phone and Cameras in the Work Place.</p>	10/07/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/16/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>dementia, high blood pressure, depressive disorder, and mood disorder.</p> <p>An Incident Report form related to Resident #K was reviewed. The form indicated the Director of Nursing was approached by the contracted Housekeeping Director on 6/22/16. The Housekeeping Director informed the Director of Nursing one of the staff member reported another employee had taken a photograph of a resident. An investigation was initiated and the local Police Department was notified. The employee who allegedly took the photograph was suspended at the time the occurrence was reported.</p> <p>Interviews were obtained during the facility investigation from contracted Housekeeping staff as follows: 6/23/16 - Contracted HK Employee #1's written interview indicated E#2 told Employee #3 about a picture that was taken of Resident #K. Employee #1 then informed her Supervisor. 6/21/16 - Contracted HK Employee #2's written statement indicated HK Employee #2 told her about HK Employee #4 taking a picture of Resident #K and she took was a picture of the resident "pleasuring himself."</p> <p>When interviewed on 9/15/16 at 11:30</p>		<p>ADDENDUM: 1. This is a part of the General Orientation the policy on Cell Phone and Cameras in the Workplace that is contained in the Employee Handbook the employee sign and acknowledges their understanding of the policy.</p> <p>2. The MOD's have been in-serviced on reporting to the ED immediately any reportable issues that may arise.</p> <p>3. The ED/ DNS are reviewing the daily (Monday thru Sunday 24 hour) nurses progress notes and the DNS/designee will also, review the 24 hour nursing report to ensure that any resident concerns are being noted and addressed. Additionally, The (MOD Manager on Duty) for the weekend will contact the ED prior to leaving for the day</p>	
--	--	--	--	--

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 09/16/2016
--	---	--	---

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

(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.m., the facility Administrator indicated the local Police department was called and related to the incident and came to the facility to investigate. The Administrator indicated he had not seen the picture and did not know if the picture had been posted on any social media site. The local Police continue to have the case open and reported they had been able to recover the picture on her phone and confirmed there are charges pending against the Employee. The staff member is not longer working at the facility. The Administrator further indicated the other staff members should have immediately informed him Administrator prior to discussing it with each other.</p> <p>2. The record for Resident #H was reviewed on 9/15/16 at 3:40 p.m. The resident's diagnoses included, but were not limited to, dementia with behaviors, anorexia, and encephalopathy. Hospice services were ordered for the resident on 7/11/16.</p> <p>The July 2016 MAR (Medication Administration Record) was reviewed. The resident received Haldol 1 milligram on 7/17/16 at 8:14 p.m. and 7/19/16 at 8:24 p.m. The August 2016 MAR was reviewed. No Haldol was signed out as given in August 2016.</p>		<p>and provide him with an update on any concerns that may have the potential to be reported the ISDH. The ED and the DNS along with the IDT will audit all verifications of investigations during the daily stand up meeting. An audit tool will be completed by the ED /designee 7 times per week for 4 weeks then 5 X weekly for 4 weeks, weekly for 4 weeks and then monthly for 12 weeks.</p> <p>4. Audit tool will be reviewed monthly for 6 months at our QAPI meeting to track and trend for any concerns. Finding no patterns, we will review quarterly thereafter. Action plans will be developed for any identified concerns.</p>	

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 09/16/2016
--	---	--	---

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

(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>Review of an facility reported Incident Report form indicated the facility Administrator received a telephone call from the Medical Director of the facility. The form indicated the Medical Director notified the Administrator of a phone call he had received from RN #1. The Medical Director indicated the Nurse reported she had witnessed another Nurse giving Haldol to a resident who did not have current Physician orders for the medication. An investigation was initiated.</p> <p>Review of the facility investigation indicated the Administrator interviewed the Director of Nursing after the above phone call was received. The Director of Nursing informed the Administrator she had been aware of the incident and did not report the occurrence to the Administrator. Statement were then written by several different staff members.</p> <p>When interviewed on 9/15/16 at 2:10 p.m., the facility Administrator indicated RN #1 had spoken to the Director of Nursing on 7/31/16 and informed her residents were receiving Haldol without an MD order. The Administrator indicated the was not informed of the above allegation until the day the</p>			
--	--	--	--	--

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 09/16/2016
--	---	--	---

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

(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>Medical Director phoned him. The Administrator indicated he then spoke with the Director of Nursing and she informed him she had completed a medication count which was correct. The Director of Nursing did not inform the Administrator of the above.</p> <p>Continued interview with the Administrator indicated Resident #H had been receiving Hospice Care during the above time and had Physician orders to receive Haldol. The Administrator indicated the Director of Nursing stated she completed a narcotic count and no discrepancies were found. The Administrator indicated statements were obtained from staff members. RN #1 indicated she observed LPN #3 take medications out of her (RN #1) cart and place them in a plastic bag and go into a resident's room.</p> <p>The Administrator indicated the Haldol medication for Resident #H was provided and from Hospice and no medication reconciliation or count forms were completed for the Haldol. The Administrator indicated she spoke with the Hospice Service who verified a total of (10) Haldol pills were provided for Resident #H. In the facility investigation (4) Haldol pills were found in the bag. The Administrator was informed only (2)</p>			

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 09/16/2016
--	---	--	---

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

(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>doses of Haldol were signed out on the Medication Records between July and August 2016. The Administrator indicated there would have been (4) other Haldol pills which were not accounted for or signed out.</p> <p>The facility policy titled "Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property" was reviewed on 9/15/16 at 9:05 a.m. The policy was last reviewed on 9/7/16. The facility Administrator provided the policy and indicated the policy was current. The policy indicated the facility was required to take steps to prevent the occurrence of abuse, neglect, injury of unknown origin, and misappropriation of resident property. The policy indicated each employee was required to report any allegation of mistreatment, neglect, abuse, or misappropriation of property to the designated supervisor in charge</p> <p>This Federal tag relates to Complaints IN00209129 and IN00209323.</p> <p>3.1-28(a)</p>			