STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 00 B. WING	05/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN LIVING CENTER-BLOOMINGTON	155 E BURKS DR BLOOMINGTON, IN 47401

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 17, 18, 19, 20, 21 and 24, 2021 Facility number: 000177 Provider number: 155278 AIM number: 100289860 Census Bed Type: SNF/NF: 113 Total: 113 Census Payor Type: Medicare: 8 Medicaid: 94 Other: 11 Total: 113 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on May 27, 2021.	F 0000	The submission of this Plan of Correction does not indicate an admission by Golden Living of Bloomington that the findings and allegations contained herein are an accurate and true depiction of the quality of care and services provided to the residents of Golden Living—Bloomington. The Facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The Facility hereby maintains it is in substantial compliance with the requirements of participation for Comprehensive Health Care Facilities. To this end, this Plan of Correction shall serve as a credible allegation of compliance with all state and federal requirements governing the management of this Facility. It is thus submitted as a matter of statute only. We are respectfully requesting paper compliance for this survey (survey event ID 7UC211). We are requesting a desk review with paper compliance.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility	F 0641	**What corrective action(s) will**	06/17/2021

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	failed to ensure a Minimum Data Set (MDS) assessment was accurately coded for a resident who received an antipsychotic medication for 1 of 23 residents reviewed for accuracy of assessments (Resident 24). Findings include: On 5/23/21 at 10:30 a.m., Resident 24's clinical record was reviewed. Diagnoses included, but were not limited to: anxiety disorder, psychophysiologic insomnia, schizoaffective disorder, and dementia. A review of Resident 24's May, 2021, physician's orders indicated the resident was prescribed Zyprexa (an antipsychotic medication), on 7/13/20. A review of the resident's MAR (medication administration record) indicated the resident received the medication daily at bedtime. Resident 24's annual MDS assessment, dated 5/10/21, indicated the resident did not receive any antipsychotic medication during the look back period. During an interview, on 5/24/21 at 10:25 a.m., the MDS coordinator indicated the resident was taking an antipsychotic during the time frame and the MDS was coded incorrectly. She will have to do a modification. On 5/24/21 at 1:45 p.m., the Director of Nursing provided the facility policy, "Conducting an Accurate Resident Assessment," dated 2020, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... health professionals correctly document the resident's medical ... problems ... to maintain or improve medical status ... nurse will certify the		**be accomplished for those residents found to have been affected by the deficient practice;** It is the policy of Golden Living Bloomington that MDS's are coded correctly. The Resident Assessment Coordinator reviewed Resident 24's MDS. The assessment was modified and resubmitted. See Exhibit A **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;** All residents have the potential to be affected by the alleged deficient practice. Residents prescribed antipsychotics had their MDS reviewed for correctness and no other issues were noted. The Resident Assessment Coordinator and MDS assistant were educated on the policy "Conducting an Accurate Resident Assessment" (see exhibit B) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The MDS staff reviewed the policy "Conducting an Accurate Resident Assessment" (see exhibit B). An	

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	accuracy ... each individual assessor is responsible for certifying the accuracy of responses relative to the resident's condition ..." 3.1-31(d)		audit tool "MDS Accuracy", (see exhibit C), will be utilized to determine the accuracy of antipsychotic coding. The Resident Assessment Coordinator, or designee, will complete random monthly MDS Antipsychotic coding reviews for six (6) consecutive months. Audit results will be reviewed by the Resident Assessment Coordinator and the Quality Assurance Team until such time consistent substantial compliance has been achieved as determined by the QA Team. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **6/17/2021**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment			

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	remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on observation, interview, and record review, the facility failed to provide supervision to prevent repeated falls for a resident assessed to be at risk for falls that resulted in falls with bruises for 1 of 5 residents reviewed for accidents (Resident 74) and, the facility failed to ensure a remote control cord for a bed was free from disrepair for 1 of 1 randomly observed resident. (Resident 104) Findings include: 1. On 5/18/21 at 11:47 a.m., Resident 74 was ambulating with staff. She was observed to have a green colored bruise under her right eye. On 5/19/21 at 11:21 a.m., Resident 74 was resting in her bed. She was observed to have a green colored bruise on her right temple with steri-strips (thin adhesive bandages used to close small wounds) applied, and a green colored bruise on the right side of her chin. An interview, at that time, she indicated the bruises were from a fall. She had, "a lot of falls." On 5/21/21 at 10:51 a.m., Resident 74 was resting in her bed. She was observed to have a green colored bruise on the right side of her forehead. During an interview on, 5/19/21 at 12:55 p.m., Resident 74's family member indicated Resident 74 had fallen quite often. She fell a month or so ago and broke her hip. She was not to be up ambulating without supervision. Resident 74 had	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The Director of Nursing, Director of Education, and the Resident Assessment Instrument Coordinator met with the nursing and care staff. Safety and fall risk assessments were completed for resident # 74 (see exhibit A). Appropriate revisions were made to the care plans (see exhibit B) to reflect all current safety interventions. The revised assessments and care plans were reviewed with staff involved in the care resident #74. **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;** The nursing management team reviewed the MDS Assessments for residents who have been identified as having a potential risk for falls. Fall and Safety risk assessments are complete and interventions currently In place are	06/17/2021

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	dementia and required reminders to have supervision when ambulating, to use a call light, and to use her walker. On 5/21/21 at 4:08 p.m., Resident 74's clinical record was reviewed. The diagnoses included, but were not limited to, left femur fracture, dementia, anxiety, Alzheimer's disease, unsteadiness on feet, and muscle weakness. The quarterly Minimum Data Set (MDS) assessment, dated 12/18/20, indicated Resident 74 had severe cognitive impairment; required supervision of one person for transfer and walking in her room; required limited assistance of one for walking in the corridor and toilet use; was not steady when moving from a seated to a standing position; was not steady while walking, was not steady when moving on and off the toilet; was not steady with surface transfers; had one fall with no injury; and had one fall with injury. The quarterly Minimum Data Set (MDS) assessment, dated 3/18/21, indicated Resident 74 had severe cognitive impairment; required extensive assistance of one person for transfer, walking in her room, walking in the corridor, and toilet use; was not steady when moving from a seated to a standing position; was not steady while walking, was not steady when moving on and off the toilet; was not steady with surface transfers; had one fall with no injury; and had two or more falls with injury. A care plan, initiated on 3/31/21 and current through 7/7/21, for Resident 74 indicated: "...Focus...At risk for falls related to: has cognitive impairments DX [diagnosis] Dementia, HX [history] of FX [fracture] L [left] femur...Goal: No Fall related injuries...Interventions...1/2 rail on (L)		appropriate. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing staff will be inserviced on the facility policy for Accidents and Supervision (see exhibit C). Fall reports will be reviewed during the clinical meeting by the nursing management team to ensure appropriate implementation of safety interventions including updating plans of care. This review will be documented on the "Audit Form—Accidents and Supervision Interventions to minimize Falls/Accidents" (see exhibit D). **How the corrective actions will be monitored to ensure the practice will not recur:** The nursing management team will review each fall report during clinical meetings to ensure appropriate interventions are implemented and updated on the Plan of Care. The Director of Nursing, or designee, will review all fall reports to ensure that appropriate interventions have been put in place to reduce the risk of resident falls and that care plans and have been updated to reflect these interventions during clinical meetings. Audits will be	

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	[Left] side of bed for support...Appropriate footwear...assess dining room chair...assess dining room seating arrangement...bright color added to call light...clutter removed from bedside...colored walker... continue with PT [physical therapy]...contrast color added to chair in room...Demonstrated entering/exiting recliner et [and] raising/lowering feet of recliner...Dining room chair glides removed from chair to prevent chair from sliding too quickly when she stands... [Medical Doctor's name] examined right wrist. New order to x-ray...(negative for acute fx)... [Medical Doctor's name] notified of BP [blood pressure]....Dycem [non-slip material for improving grip] added under recliner to prevent sliding...to follow up regarding irritation with husband...Instructed nursing to assess for s/s [signs/symptoms] of dysuria [painful or difficulty with urination] and update M.D. if clinically indicated...instructed staff of toileting schedule...instructed staff to remind [Resident's name]... to ambulate with distance between them while ambulating...night light in bedroom...placed a colored x on the floor to help cue area for shoe placement...PT eval [evaluation] et treat...Resides on ...well lit, clutter free environment...silent bed alarm...standard chair removed from room..." The care plan lacked documentation of intervention for Resident 74 to be up by herself and/or supervision of staff. A care plan, initiated on 3/31/21 and current through target date 7/7/21, for Resident 74 indicated:"...Focus...I am at risk for falls related to: Dizziness, history of falls and Alzheimer's disease, HX [history] of falls, HX of FX [fracture] left hip/femur...Goal...I will remain free from fall related injuries...INTERVENTIONS...Assess me for pain...Monitor my restorative programs for effectiveness...Place my call light light or personal		completed weekly x 4 weeks, bi-monthly for 2 months, monthly for 3 months, and quarterly for 2 quarters. The audits will be submitted to the Quality Assurance Team to monitor that compliance has been achieved as determined by the QA Team. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **6/17/2021** **F 689** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** It is the policy of Golden Living Bloomington to provide a	

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	items available and in easy reach or provide reacher...provide me with 1/2 rail on (L) [left] side of bed for support...Provide/make sure that I have proper footwear on to prevent slipping...Refer me to therapy as needed...toilet schedule...Provide verbal cues/reminders and physical assist with toileting before meals, after meals, at HS [bedtime] and x 2 during the night shift and as needed. Assist with peri-care as needed. Prompt to wash hands...." The care plan lacked documentation of intervention for Resident 74 to be up by herself and/or supervision of staff. Resident 74's Fall Risk Evaluation indicated the following: -On 2/16/21, Resident 74 was disoriented times 3 at all times, had 3 or more falls in the past 3 months, was ambulatory, was incontinent, had a balance problem while walking, required use of assistive devices, took 3-4 medications within the last 7 days, and was at risk for falls. -On 3/18/21 at 11:58 a.m., Resident 74 had intermittent confusion, had 1-2 falls in the past 3 months, was ambulatory, was incontinent, had a balance problem while standing and walking, required use of an assistive device, took 3-4 medications within the last 7 days, and was at risk for falls. -On 3/26/21 at 11:07 a.m., Resident 74 had intermittent confusion, had 3 or more falls in the past 3 months, was ambulatory, was incontinent, had a balance problem while standing and walking, required use of an assistive device, took 3-4 medications within the last 7 days, and was at risk for falls. -On 4/10/21 at 1:00 p.m., Resident 74 had intermittent confusion, had 3 or more falls in the past 3 months, was ambulatory, was incontinent, and was at risk for falls. -On 4/25/21 at 2:00 p.m., Resident 74 had		preventative maintenance program that will minimize or prevent the risks of accidents. The bed remote control and cord for Resident 104 was replaced with a brand new remote control and cord. See Exhibit E **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;** All residents have the potential to be affected by the alleged deficient practice. Bed controls throughout the building were assessed and it was determined they were all in good repair. No other issues were noted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance department has reviewed the Policy for Preventative Maintenance (see exhibit F) and no changes were made. The Maintenance staff were re-educated on the Preventative Maintenance policy. **How the corrective actions will be monitored to ensure the practice will not recur:**	

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	intermittent confusion, had 3 or more falls in the past 3 months, was ambulatory/incontinent, had a balance problem while standing and walking, required use of an assistive device, took 1-2 medications within the last 7 days, and was at risk for falls. -On 5/11/21 at 8:30 a.m., Resident 74 had 3 or more falls in the past 3 months, was ambulatory, was incontinent, had a balance problem while walking, required use of an assistive device, and was at risk for falls. Resident 74's 5 Post Fall Evaluations indicated the following: -On 2/16/21 at 11:19 p.m., Resident 74 fell in her room attempting to take herself to the bathroom. The fall was not witnessed. -Resident 74's SBAR (Situation, Background, Assessment, and Response) - Change of Condition progress note, dated 2/17/21 at 1:36 a.m., indicated she was found sitting on the floor beside her bed. The certified nursing assistant (CNA) was informed by Resident 74's husband. Resident 74 did not remember how she fell from her bed to the floor. She had an abrasion and bruising to her left outer wrist. She was incontinent of urine and indicated she needed to go to the bathroom. The SBAR-Change of Condition progress note lacked documentation of a staff intervention to prevent Resident 74 from attempting to take herself to the bathroom without supervision. -On 2/20/21 at 11:01 a.m., Resident 74 fell in her room. Her injury was a "raised area scalp." The fall was not witnessed. -Resident 74's progress notes, dated 2/20/21 at 11:57 a.m., indicated Resident 74 was found sitting on the bathroom floor. She was leaning to the right with her back against the door. She was		The Maintenance Director, or Designee will review work orders on a daily basis to determine what submissions need immediate attention. The Maintenance Director, or designee, will audit Bed remote controls and cords Bi-monthly for 2 months, monthly for 4 months, and then quarterly for 2 quarters (see exhibit G). Audited records will be reviewed by the Quality Assurance Team until such time consistent substantial compliance has been achieved as determined by the QA Team. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **6/17/2021**	

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	assisted to her bed, and had ice applied to a raised area on the back of her left scalp. -Resident 74's progress notes, dated 2/22/21 at 10:46 a.m., indicated Resident 74 was in her bathroom floor. She had increased confusion. She had a raised area to the back of her left side of scalp. She had diagnoses which impact her risk for falls. The progress note lacked documentation of a staff intervention to prevent Resident 74 from attempting to take herself to the bathroom without supervision. -On 3/26/21 at 7:18 p.m., Resident 74 fell in the bathroom while transferring herself to the the toilet. She was found on the floor in the bathroom by her husband. Her husband notified the staff she was on the floor. She was complaining of left hip and leg pain. She was sent the emergency room as a result of the fall. The fall was not witnessed. -Resident 74's SBAR - Change of Condition, dated 3/26/21 at 7:20 p.m., indicated Resident 74's husband informed staff she was on the floor in the bathroom. She was sitting on the floor with her knees bent under her. Her husband's walker was outside the bathroom. She had history of falls and had already fallen earlier in the day. She was complaining of left leg and left hip pain. The nurse practitioner ordered her to go to the emergency room. -Resident 74' progress notes, dated 3/26/21 at 11:15 p.m., indicated Resident 74 was admitted to the hospital with a left hip fracture and a left pulmonary contusion. -Resident 74's Inpatient Hospital Discharge Instructions, dated 3/26/21, indicated the reason for the visit was a fall. Her diagnosis was age-related osteoporosis with current pathological fracture of the femur. -Resident 74's IDT (interdisciplinary team) note,			

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	dated 3/29/21 at 11:16 a.m., indicated she was sent to the emergency room and was admitted to the hospital with a hip fracture. -Resident 74's progress notes, dated 4/7/21 at 9:37 a.m., indicated she was encouraged to use her walker while ambulating at all times. She often forgets to utilize her call light for assistance related to her cognition. The SBAR-Change of Condition progress note and the progress notes lacked documentation of a staff intervention to prevent Resident 74 from attempting to take herself to the bathroom without supervision. -On 4/25/21 at 2:00 p.m., Resident 74 fell in her room while attempting to take herself to the bathroom without help. The fall was not witnessed. -Resident 74's SBAR - Change of Condition, dated 4/25/21 at 2:33 p.m., indicated she fell while trying to go to the bathroom by herself. -Resident 74's progress note, dated 4/26/21 at 10:11 a.m., indicated she was in her room beside her bed. She indicated she was going to the bathroom. She had diagnoses which impact her risk for falls. Her new interventions were to instruct staff to toilet before meals, after meals, at bedtime, and two times during the night as needed. Staff were to provide verbal cues, reminders, and physical assist with toileting. -On 5/11/21 at 8:30 a.m., Resident 74 fell in her room while attempting to take herself to the bathroom with a laceration and contusion to right temple. The fall was not witnessed. -Resident 74's SBAR - Change of Condition, dated 5/11/21 at 8:30 a.m., indicated staff heard a loud noise coming home her room. A CNA found Resident 74 lying on the floor next to a chair. She had blood coming from her head. She had a laceration (deep tear in the skin) on her right side			

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	of head above her eyebrow. She had impaired safety awareness and a history of falls. -Resident 74's progress notes, dated 5/12/21 at 11:29 a.m., indicated she was in her room on the floor. She had a laceration on her right side of her head above her eyebrow. She often will forget to utilize her call light despite frequent reminders and cues. She required assistance with toileting and ambulation. During an interview on, 5/21/21 at 2:42 p.m., Licensed Practical Nurse (LPN) 2 Resident 74 had history of falls with injuries. She had bruises to her face and a fracture left hip from her falls. She would get up without staff assistance and take herself to the bathroom. She required supervision to ambulate with cues and reminders to use her walker. During an interview on, 5/24/21 at 11:54 a.m., Occupational Therapist (OT) 1 indicated Resident 74 required supervision and cues to use a walker when she ambulated and required supervision and cues when she needed to go to the toilet. On 5/24/21 at 12:59 p.m., Physical Therapist (PT) 1 indicated Resident 74 required supervision with ambulation. She needed cues to use a walker and to ask for assistance of staff to ambulate. On 5/24/21 at 3:15 p.m., Qualified Medication Aide (QMA)1 indicated Resident 74 has had history of falls. She required supervision and assistance with toileting. She would take herself to the bathroom unassisted but required assistance with changing incontinent clothes. On 5/24/21 at 3:00 p.m., the Director of Nursing provided the facility's policy. "Fall Prevention Program," undated, and indicated this was the			

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	155278	A. BUILDING 00 B. WING	05/24/2021

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	policy currently being used by the facility. A review of the policy indicated, "...Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls...." 2. During an interview, on 5/18/2021 at 2:57 p.m., Resident 104 indicated the remote control cord, which operated the bed, had exposed wires and he had been concerned it would cause a fire. The cord had been that way for several months. The facility had fixed it a couple of times with electrical tape but, the tape kept coming off. The cord "bites" him at times but, he had been told by the facility maintenance man that a little shock would not hurt him. The Quarterly Minimum Data Set assessment, dated 4/28/2021, indicated Resident 104 was interviewable and cognitively intact. On 5/18/2021 at 3:00 p.m., an observation of the remote control cord indicated 10 different colored wires approximately 10 inches in length with old, torn off electrical tape in the middle at the point where the cord no longer contained the wires. On 5/18/2021 at 3:23 p.m., an observation of the remote control cord indicated the cord plugged into a transformer box under the bed frame and the transformer box plugged into the electrical outlet on the wall. On 5/18/2021 at 3:36 p.m., the remote control cord for Resident 104 was observed with the Maintenance Director (MD). The MD indicated the remote control cord needed to be fixed. He had not been aware there was an issue with the remote control cord and a service order had not been put through to his office. He would order a new			

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	remote and fix the current cord right away. On 5/18/2021 at 4:00 p.m., MD was observed putting a temporary casing over the wire on the remote control cord and wrapping it with electrical tape. During an interview, on 5/18/2021 at 3:25 p.m., Licensed Practical Nurse (LPN) 1 indicated Resident 104 utilized the bed remote all the time. The remote cord was "frayed" (unraveled or worn at the edge). The cord had been that way for awhile. During an interview, on 5/19/2021 at 10:02 a.m., a service technician from (bed company name) indicated the remote control cord needed to be replaced right away because it could cause the bed to move up and down erratically. It would not cause a fire nor shock the resident in his opinion. During an interview, on 5/19/2021 at 11:08 a.m., the Maintenance Technician indicated he had taped the remote control wire a few months ago. He did not know the resident had complained of being shocked or he would have taken care of that right away. On 5/24/2021 at 1:45 p.m., the Director of Nursing provided the facility's policy, "Preventative Maintenance Program" undated, and indicated this was the policy currently being used by the facility. A review of the policy did not indicate keeping a remote control cord for a bed free from disrepair. 3.1-45(a)(1) 3.1-45(a)(2)			