

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155264		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/19/2016	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-GOLDEN RULE				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 STRAIGHT LINE PIKE RICHMOND, IN 47374			
(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 a Recertification and State Licensure Survey.</p> <p>Survey dates: December 12, 13, 14, 15, 16, and 19, 2016</p> <p>Facility number: 000165 Provider number: 155264 AIM number: 100288220</p> <p>Census bed type: SNF/NF: 106 Total: 106</p> <p>Census payor type: Medicare: 8 Medicaid: 82 Other: 16 Total: 106</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on December 22, 2016</p>			F 0000			
F 0278	483.20(g)-(j)						

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2017

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155264		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/19/2016	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-GOLDEN RULE				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 STRAIGHT LINE PIKE RICHMOND, IN 47374			
(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><b>ASSESSMENT</b> <b>ACCURACY/COORDINATION/CERTIFIED</b> (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.</p> <p>(h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>(i) Certification (1) A registered nurse must sign and certify that the assessment is completed.</p> <p>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>(j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</p> <p>(2) Clinical disagreement does not constitute a material and false statement. Based on interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS)</p>			F 0278	F-278		01/04/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155264		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/19/2016	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-GOLDEN RULE				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 STRAIGHT LINE PIKE RICHMOND, IN 47374			
(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>assessment for 1 of 4 residents reviewed for falls. (Resident 81)</p> <p>Findings include:</p> <p>Resident 81's clinical record was reviewed on 12/14/2016 at 1:17 p.m. Her diagnoses included, but were not limited to, dementia. It reported she resides on the secured advanced memory care unit of the facility.</p> <p>In review of a significant change MDS assessment, dated 12/7/16, it specified she had one fall without injury since the prior assessment, an annual assessment, dated 11/9/16.</p> <p>In review of recent falls for Resident 81, the clinical record indicated Resident 81 had one fall on 11/10/16, without injury and one fall on 11/24/16, with an injury of hematoma (contusion with swelling) to above the left eye.</p> <p>In an interview on 12/15/2016 at 11:18 a.m., with MDS Coordinator 1, she shared, "Looks like I marked the fall as no injury from 11/24/16, on the 12/7/16, [significant change] MDS. It should have been coded as a fall with injury. The significant change was triggered by the fall, starting therapy and a decrease in ADL's [activities of</p>				<p>1. Resident 81's MDS was corrected to reflect proper coding and resubmitted on 12/15/16</p> <p>2. All residents who had an MDS completed in the past 30 days were reviewed for accuracy. No other residents were identified to have been affected by this deficient practice.</p> <p>3. The MDS Consultant has completed Training / Education with both MDS Nurses regarding falls and coding. The MDS Consultant also reviewed the RAI Manual for coding with both MDS Nurses. Additionally, the Advanced Clinical Review team reviews MDS's and Physicians orders as scheduled weekly for accuracy.</p> <p>4. The MDS Consultant / DNS / Designee will audit a minimum of 2 submitted MDS a week until we attain 100% accuracy for 3 concurrent months. The audit results will be submitted to monthly Quality Assurance Meeting for</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155264		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/19/2016	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-GOLDEN RULE				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 STRAIGHT LINE PIKE RICHMOND, IN 47374			
(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>daily for Resident 81]."</p> <p>In an interview, on 12/15/16 at 12:15 p.m., with the Director of Nursing, she shared the facility does not have a particular policy in regards to the MDS, but utilizes the Resident Assessment Manual as the facility's guidelines for any issues related to the MDS assessment.</p> <p>The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.13, October 2015, retrieved from the CMS website on 12/16/16, specified in Chapter 3, Section J, "Health Conditions", Item J1900 defined an injury related to a fall as, "Any documented injury that as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall." It further defined an injury, not a major injury, as, " Including skin tears, abrasions, lacerations, superficial bruises, hematoma, and sprains or any fall-related injuries that causes the resident to complaint of pain. "</p> <p>3.1-31(a) 3.1-31(d)</p>			review.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155264		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/19/2016	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-GOLDEN RULE				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 STRAIGHT LINE PIKE RICHMOND, IN 47374			
(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