STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 00 B. WING	05/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-ELKHART	1001 W HIVELY AVE ELKHART, IN 46517

(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
F000000	This visit was for the Investigation of Complaint number IN00147521. Complaint number IN00147521 Substantiated. Federal/state deficiencies related to the allegations are cited at F309 and F323. Survey dates: May 5 and 7, 2014 Facility number: 000039 Provider number: 155685 AIM number: 100275130 Survey team: Christine Fodrea, RN, TC Census bed type: SNF: 142 Total: 142 Census payor type: Medicare: 12 Medicaid: 110 Other: 20 Total: 142 Sample: 5 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F000000		

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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	Quality review completed on May 9, 2014 by Randy Fry RN.			
F000309 SS=D	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 interview and record review, the facility failed to assess for condition change prior to intrafacility transfer for 1 of 3 residents reviewed with intrafacility transfers in a sample of 5. (Resident #B) Findings include: Resident #B's record was reviewed 5-7-2014 at 8:50 AM. Resident #B's diagnoses included, but were not limited to, dementia, depression and high blood pressure. A review of Nurse's notes indicated the following: On 3-28-2014 at 5:21 AM Resident #B	F000309	F309-D Provide Care/Services for Highest Well Being1. Resident B was the only resident affected and had no adverse outcomes related to the alleged deficient practice.2. Other residents who may be potentially affected will be properly assessed prior to placement on the ACU.An intra-facility referral form for potential ACU placement has been developed and used for residents who are referred for possible placement.3. Nursing staff and members of the IDT will be in-serviced on the new referral form and it's use. Nursing and Administrative staff will also be in-serviced on proper and timely documentation of any room changes.4. New ACU placement form will be used going forward	06/02/2014

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	was alert, but confused. There was no indication of wandering behavior. On 3-28-2014 at 13:01 (1:01 PM) Resident #B was alert with confusion and refusing assistance. The note further indicated 30 minute checks continue and a wanderguard was in place. The was no reason indicated for the 30 minute checks or the wanderguard. On 3-28-2014 at 22:03 (10:03 PM) Resident #B had been transferred from the Primrose unit at 1530 (3:30 PM), was alert, but confused, was looking for her husband all over the unit, refused supper and vital signs, demanded to be transferred back to the Primrose unit, and after visiting with family was tearful, but went to bed. There was no indication which unit Resident #B had been transferred to or why. A review of Social Services notes indicated the following: In a late entry dated 3-28-2014 at 16:08 (4:08 PM), Resident #B was admitted to the Primrose unit on 3-28-2014. the note indicated Resident #B was an elopement risk due to wandering around the facility and was transferred to the ACU (Alzheimer's care unit) and has made no attempts to leave. The note did not indicate why the wandering was considered an elopement risk, nor why the facility chose to admit Resident #B to		for any potential placement on the ACU. ED or designee will review and approve all referrals for ACU placement for 6 months to ensure the proper procedure is followed.Outcomes of the reviews will be presented to the facility QA Committee for 6 months.	

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	a locked unit. On 3-31-2014 at 13:15 (1:15 PM) Resident #B was noted to be walking the unit searching for her husband over the weekend and was tearful at times. The note further indicated Resident #B could go off the unit with her husband who was also a resident at the facility, as long as she was on the unit for meals. In an interview on 5-5-2014 at 11:20 AM, RN#1 indicated the reason Resident #B was placed on the locked unit on 3-28-2014, was because she had been walking in the facility and was off the Primrose unit between 30 minutes and 1 hour and the staff was unable to locate her. The staff finally located Resident #B on another unit. RN #1 indicated the family had been called and notified. RN #1 further indicated Resident #B had not been assessed for medical changes prior to being placed on the unit, but should have been. This Federal tag is related to Complaint IN00147521. 3.1-37(a)			

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F000323 SS=D	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 interview and record review, the facility failed to supervise a resident known to wander for 1 of 3 residents reviewed for wandering in a sample of 5. (Resident #B) Findings include: Resident #B's record was reviewed 5-7-2014 at 8:50 AM. Resident #B's diagnoses included, but were not limited to, dementia, depression and high blood pressure. A review of Nurse's notes indicated the following: On 3-28-2014 at 5:21 AM Resident #B was alert, but confused. There was no indication of wandering behavior. On 3-28-2014 at 13:01 (1:01 PM) Resident #B was alert with confusion and refusing assistance. The note further indicated 30 minute checks continue and a wanderguard was in place. The was no reason indicated for the 30 minute checks or the wanderguard.	F000323	F323D Free of Accident Hazards/Supervision/Devices1. Resident B was only resident affected and had no adverse outcomes related to the alleged deficient practice.Resident B was assessed by ACU staff and was appropriate for placement on the ACU.2. Other residents who may be potentially affected will be properly assessed prior to placement on the ACU. Our one-on-one policy may be initiated if needed.An intra-facility referral form for potential ACU placement has been developed and will be used for residents who are used for possible placement.3. Nursing staff and members of the IDT will be in-serviced on the new referral form and it's use. Nursing and administrative staff will also be in-serviced on proper and timely documentation of any room changes.4. New ACU placement form will be used going forward for any new potential placement on the ACU. ED or designee will review, approve and monitor all referrals for ACU placement for 6 months to ensure proper procedure is followed.Outcomes of the reviews will be presented to	06/02/2014

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	On 3-28-2014 at 22:03 (10:03 PM) Resident #B had been transferred from the Primrose unit at 1530 (3:30 PM), was alert, but confused, was looking for her husband all over the unit, refused supper and vital signs, demanded to be transferred back to the Primrose unit, and after visiting with family was tearful, but went to bed. There was no indication which unit Resident #B had been transferred to or why. A review of Social Services notes indicated the following: In a late entry dated 3-28-2014 at 16:08 (4:08 PM), Resident #B was admitted to the Primrose unit on 3-28-2014. The note indicated Resident #B was an elopement risk due to wandering around the facility and was transferred to the ACU (Alzheimer's care unit) and has made no attempts to leave. The note did not indicate why the wandering was considered an elopement risk, nor why the facility chose to admit Resident #B to a locked unit. On 3-31-2014 at 13:15 (1:15 PM) Resident #B was noted to be walking the unit searching for her husband over the weekend and was tearful at times. The note further indicated Resident #B could go off the unit with her husband who was also a resident at the facility, as long as she was on the unit for meals.		the facility QA Committee monthly for 6 months.	

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	In an interview on 5-5-2014 at 11:20 AM, RN#1 indicated the reason Resident #B was placed on the locked unit on 3-28-2014, was because she had been walking in the facility and was off the Primrose unit between 30 minutes and 1 hour and the staff was unable to locate her. RN #1 additionally indicated the staff finally located Resident #B on another unit. RN #1 indicated the family had been called and notified. This Federal tag is related to Complaint IN00147521. 3.1-45(a)(2)			