STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155685		A. BUILDING	00	COMPLETED 05/07/2014	
		133003	B. WING	The second secon	03/07/2014
NAME OF F	ROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP CODE W HIVELY AVE	
GOLDEN	LIVING CENTER-	ELKHART		HART, IN 46517	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	•	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE CONTRIBUTION
F000000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DET (CLENCT)	DATE
1 - 000000					
	This visit was fo	or the Investigation of	F000000		
		per IN00147521.			
	r				
	Complaint numb	per IN00147521			
	-	ederal/state deficiencies			
		egations are cited at F309			
	and F323.				
	Survey dates: M	Tay 5 and 7, 2014			
	,	•			
	Facility number:	: 000039			
	Provider number				
	AIM number:	100275130			
	Survey team:				
	Christine Fodrea	a, RN, TC			
	Census bed type	::			
	SNF: 142				
	Total: 142				
	Census payor ty	pe:			
	Medicare: 12				
	Medicaid: 110				
	Other: 20				
	Total: 142				
	Sample: 5				
	These deficienci	ies reflect state findings			
	cited in accordan	nce with 410 IAC 16.2.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000039

(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.

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

PRINTED: 05/27/2014 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155685	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/07/2014		
	PROVIDER OR SUPPLIER I LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F000309 SS=D	Quality review completed on May 9, 2014 by Randy Fry RN. 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:	F000309	F309-D Provide Care/Services Highest Well Being1. Resident 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 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 be in-serviced on the new refers form and it's use. Nursing and Administrative staff will also be in-serviced on proper and time documentation of any room changes.4. New ACU placements.	t B s c o I be will wrral e ely		
	On 3-28-2014 at 5:21 AM Resident #B		form will be used going forwar			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VWK811 Facility ID: 000039

If continuation sheet

Page 2 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLI	ETED	
		155685	B. WIN			05/07/2014	
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1001 W HIVELY AVE			
GOLDEN LIVING CENTER-ELKHART			ELKHART, IN 46517				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	·	Ī	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IE	DATE
	was alert, but co	nfused. There was no			for any potential placement on	the	
	-	ndering behavior.			ACU. ED or designee will revie		
		13:01 (1:01 PM)			and approve all referrals for A		
		alert with confusion and			placement for 6 months to ens the proper procedure is	ure	
		ce. The note further			followed.Outcomes of the review	ews	
		nute checks continue and			will be presented to the facility		
					Committee for 6 months.		
	_	vas in place. The was no					
		for the 30 minute checks					
	or the wandergua						
		22:03 (10:03 PM)					
		been transferred from					
	the Primrose uni	t at 1530 (3:30 PM), was					
	alert, but confuse	ed, was looking for her					
	husband all over	the unit, refused supper					
	and vital signs, d	lemanded to be					
	transferred back	to the Primrose unit, and					
	after visiting wit	h family was tearful, but					
		ere was no indication					
	which unit Resident #B had been transferred to or why.						
	A review of Soc	ial Services notes					
	indicated the following						
		ated 3-28-2014 at 16:08					
	1	dent #B was admitted to					
		t on 3-28-2014. the note					
		nt #B was an elopement					
		•					
		ering around the facility					
	and was transfer						
	`	e unit) and has made no					
	_	e. The note did not					
	indicate why the						
		opement risk, nor why					
	the facility chose	e to admit Resident #B to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VWK811 Facility ID: 000039

If continuation sheet Page 3 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	00	COMPLETED	
		155685	B. WIN	G		05/07/2014	
NAME OF B	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
While of TROVIDER OR SOTTELER				1001 W	HIVELY AVE		
	I LIVING CENTER-I			ELKHAI	RT, IN 46517		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)	DATE	
	a locked unit.						
		13:15 (1:15 PM)					
		noted to be walking the					
		r her husband over the					
	weekend and was	s tearful at times. The					
	note further indic	cated Resident #B could					
	go off the unit w	ith her husband who was					
	also a resident at	the facility, as long as					
	she was on the u	nit for meals.					
	In an interview o	on 5-5-2014 at 11:20					
	AM. RN#1 indic	ated the reason Resident					
	*	n the locked unit on					
	•	pecause she had been					
		cility and was off the					
	_	tween 30 minutes and 1					
		f was unable to locate					
		nally located Resident #B					
		RN #1 indicated the					
	_	called and notified. RN					
		ted Resident #B had not					
		r medical changes prior					
	• •	on the unit, but should					
	have been.						
	_	is related to Complaint					
	IN00147521.						
	3.1-37(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VWK811 Facility ID: 000039

If continuation sheet Page 4 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
		155685	B. WIN		 -	05/07/2014	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
GOLDEN LIVING CENTER-ELKHART			1001 W HIVELY AVE ELKHART, IN 46517				
GOLDEN	I LIVING CENTER-I	ELKHARI		ELKHA	R1, IN 40517		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000323	483.25(h)						
SS=D	FREE OF ACCIDE	ENT					
	HAZARDS/SUPER	RVISION/DEVICES					
	•	nsure that the resident					
		ins as free of accident					
		sible; and each resident					
	receives adequate						
	assistance devices	s to prevent accidents.					
			F00	0323	F323D Free of Accident		06/02/2014
	Based on interview	ew and record review,			Hazards/Supervision/Devices1		
	the facility failed	to supervise a resident			Resident B was only resident affected and had no adverse		
	known to wande	r for 1 of 3 residents				4	
		ndering in a sample of 5.			outcomes related to the allege deficient practice.Resident B w		
		idening in a sample of 3.			assessed by ACU staff and wa		
	(Resident #B)				appropriate for placement on t		
					ACU.2. Other residents who m		
	Findings include	:			be potentially affected will be	,	
					properly assessed prior to		
	Resident #B's red	cord was reviewed			placement on the ACU. Our		
	5-7-2014 at 8:50	AM. Resident #B's			one-on-one policy may be		
		ed, but were not limited			initiated if needed.An intra-faci	•	
	_				referral form for potential ACU		
		pression and high blood			placement has been develope		
	pressure.				and will be used for residents vare used for possible	wno	
					placement.3. Nursing staff and	,	
	A review of Nurs	se's notes indicated the			members of the IDT will be	1	
	following:				in-serviced on the new referral		
	_	5:21 AM Resident #B			form and it's use. Nursing and		
					administrative staff will also be	,	
		nfused. There was no			in-serviced on proper and time		
		ndering behavior.			documentation of any room		
		13:01 (1:01 PM)			changes.4. New ACU placeme		
	Resident #B was	alert with confusion and			form will be used going forward		
	refusing assistan	ce. The note further			for any new potential placemen		
	_	ute checks continue and			on the ACU. ED or designee w		
					review, approve and monitor a		
	_	vas in place. The was no			referrals for ACU placement for	1.0	
		for the 30 minute checks			months to ensure proper procedure is followed.Outcome	200	
	or the wandergua	ard.			of the reviews will be presente		
					or the reviews will be presente	u iO	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VWK811 Facility ID: 000039

If continuation sheet

Page 5 of 7

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUI	A. BUILDING COMPLE			ETED	
		155685	B. WIN			05/07/	2014	
NAME OF I	DROVIDED OD SLIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				1001 W HIVELY AVE				
GOLDEN LIVING CENTER-ELKHART			ELKHART, IN 46517					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE	
TAG	,			TAG	the facility QA Committee mon	DATE		
	On 3-28-2014 at 22:03 (10:03 PM) Resident #B had been transferred from				for 6 months.			
		t at 1530 (3:30 PM), was						
		ed, was looking for her						
		the unit, refused supper						
	and vital signs, d							
		to the Primrose unit, and						
	_	h family was tearful, but						
		re was no indication						
	which unit Resid							
	transferred to or	why.						
	A review of Soci	ial Services notes						
	indicated the foll							
		ted 3-28-2014 at 16:08						
	1	dent #B was admitted to						
		t on 3-28-2014. The note						
		nt #B was an elopement						
		ering around the facility						
	and was transfer	•						
		e unit) and has made no						
	•	e. The note did not						
	indicate why the							
	_	opement risk, nor why						
		e to admit Resident #B to						
	a locked unit.	to autilit Nesiuelit #D to						
		12·15 (1·15 DM)						
		13:15 (1:15 PM)						
		noted to be walking the						
	_	or her husband over the						
		s tearful at times. The						
		cated Resident #B could						
	1	ith her husband who was						
		the facility, as long as						
	she was on the u	nit for meals.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VWK811 Facility ID: 000039

If continuation sheet Page 6 of 7

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

PRINTED: 05/27/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
	155685	A. BUILDING B. WING		05/07/2014
	PROVIDER OR SUPPLIER I LIVING CENTER-ELKHART	1001 W	ADDRESS, CITY, STATE, ZIP C I HIVELY AVE RT, IN 46517	ODE
(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 CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION
	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)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VWK811 Facility ID: 000039

If continuation sheet

Page 7 of 7