STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155137	A. BUILDING _____ B. WING _____	**04/08/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement effective supervision in a timely manner to maintain a resident's safety on a locked dementia unit related to an elopement for 1 or 1 incidents reviewed for elopement. (Resident D) Finding includes: Resident D's elopement reportable was reviewed on 4/8/2020 at 9:30 a.m. Per the investigation, Resident D was last observed at 9:30 p.m. on 4/5/2020 laying on his bed by a nurse. At 10:00 p.m. on 4/5/2020, CNA 1 had received report from the previous CNA shift. At approximately 11:50 p.m. on 4/5/2020, CNA 1 had noticed that Resident D was not in his room, and his bed was made. CNA 1 continued to complete her work. At 12:45 a.m. on [DATE]20, CNA 1 had asked LPN 1 when she came back on to the unit if Resident D had been discharged and went home. At 12:50 a.m., the facility had begun to search for Resident D, since he was not discharged from the facility and the Police were called. His responsible party was called at 1:00 a.m. on [DATE]20, and she indicated Resident D was with a friend and he is fine. The resident's Physician was notified of elopement and gave the order to discharge to home with the responsible party if desired. Resident D was later found by the Police at 2:00 a.m. on [DATE]20 at the friend's house and was discharged home with his responsible party at 3:00 a.m. on [DATE]20. The Maintenance Director had found the [MEDICATION NAME] guard was removed from the outside of Resident D's window and the screen had been removed. A statement from CNA 1 from 4/5/2020, indicated she had received a verbal report from the previous shift with no concerns and began her normal work duties. At approximately 11:30 p.m., Resident D was not in his room, CNA 1 thought he was discharged to home, due to that was a plan for him to go home soon. CNA 1 did not clarify with LPN 1 until 12:45 a.m. that Resident D was not discharged , a search was completed, and Resident D was not in the facility. CNA 1 was called via phone on 4/8/2020 at 12:29 p.m., with no response. Resident D's record was reviewed on 4/8/2020 at 9:30 a.m. [DIAGNOSES REDACTED]. The Discharge Minimum Data Set assessment, dated [DATE]20, indicated he was moderately cognitively impaired. Interview with the Administrator on 4/8/2020 at 12:30 p.m., indicated, due to Covid 19, the CNAs were not going room to room for report to limit exposure to residents' rooms. The CNA thought the resident was discharged to his home, so she did not suspect that he was missing. The facility had seen the responsible party at his window around 3/31/2020 and at the kitchen window outside the locked unit. The bedroom windows have [MEDICATION NAME] on the outside of the window and the kitchen window had a screwed in screen from the inside. Since the [MEDICATION NAME] was found off his window outside, it was concluded someone else must have tampered with it in advance. The policy titled, Elopement Guideline, was provided by the Director of Nursing on 4/8/2020. This current policy indicated, .Prevention: Each Living Center had a system of identification of residents. The method is designed to assist law enforcement and others in identifying a resident who has left the facility without staff knowledge This Federal Tag relates to Complaint IN 924. 3.1- 45(a)(2)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation and interview, the facility failed to maintain an infection control program related to a direct care staff not wearing a mask over their face properly while in a resident's room for 1 of 2 random observations. (Resident E) Finding includes: During a random observation on 4/8/2020 at 8:55 a.m., CNA 2 was observed in Resident E's room with a surgical mask under her chin, speaking to Resident E approximately 3 feet away from the resident. The mask was not covering her face and her nose and mouth were exposed. CNA 2 then was observed to place the mask over her face to cover her mouth and nose by touching the outside of the front of the mask with her bare hands to lift the mask into place. Interview with CNA 2 on 4/8/2020 at 12:29 p.m., indicated she had to pull her mask down to speak to the hospice resident because the resident could not hear her. She was inserviced on how to wear a mask, and there should be 6 feet between a resident and staff when not wearing a mask. She indicated she did use the hand sanitizer before exiting the resident's room. Interview with the Administrator and Director of Nursing on 4/8/2020 at 12:31 p.m., indicated CNA 2 was not performing direct care on the resident and therefore did not need to wear a mask. The Administrator could not find the directive or the policy before the exit conference on when to wear a mask. 3.1-18 (b)

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.