

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815
--	---

(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 000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00168833.</p> <p>Complaint IN00168833- Substantiated, Federal/State deficiency cited at F-309</p> <p>Survey Dates: March 12 & 13, 2015</p> <p>Facility number: 000282 Provider number: 155755 AIM number: 100287520</p> <p>Survey team: Angela Strass, RN</p> <p>Census bed type: SNF: 8 SNF/NF: 97 Residential: 41 Total: 146</p> <p>Census payor type: Medicare: 8 Medicaid: 64 Other: 74 Total: 146</p> <p>Sample: 4</p> <p>This deficiency also reflects state</p>	F 000		
-----------------------	---	-------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815
--	---

(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 309 SS=D Bldg. 00	<p>findings in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 16, 2015 by Randy Fry RN.</p> <p>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.</p> <p>Based on record review and interview the facility failed to assess daily 1 resident (B) in a sample of 4 resident records reviewed who was being treated with antibiotics for a urinary tract infection.</p> <p>Finding includes: On 3/12/15 at 10:00 a.m. review of the clinical record for resident(B) indicated she was admitted to the facility on 12/27/14 with diagnoses including but not limited to</p>	F 309	The submission of this plan of correction does not constitute an admission of agreement of the facts alleged in this statement of deficiencies. The plan is submitted due to requirements under state and federal law. It is the practice of this facility to ensure appropriate treatment and services to maintain or improve the resident's abilities.1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The alleged deficient practice cannot be corrected as it occurred in the past.2. How other residents	04/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815
--	---

(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>Alzheimer Disease, Chronic Obstructive Pulmonary Disease and Insomnia.</p> <p>Review of nursing notes on 3/12/15 at 10:10 a.m. indicated the following:</p> <p>3/9/15 at 10:44 a.m. – "Late entry for 3/6/15 went to doctor for appointment/accompanied by (family member). Returned with new order for Cipro (an antibiotic) 500 milligrams twice daily for 7 days for UTI (urinary tract infection)."</p> <p>Review of nursing notes indicated a noted dated 3/4/15 at 3:33 a.m. which indicated "No exit seeking noted today." The next nursing note in the clinical record was dated 3/9/15 at 1:01 a.m. which indicated "Up out of bed, out of room in hall, came to nurse station, knocked on window, waved at writer, tried to explain to go back to bed, time, others sleeping, not redirected well. shoes on, glasses, pajamas, dentures in, asked resident to sit in lounge by nurse station and watch a movie on TV ok verbalized to writer."</p> <p>On 3/13/15 at 10:45 a.m. interview</p>		<p>having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?All residents with a Urinary Tract Infection will be audited to ensure temperatures and proper assessment are being performed at least daily.3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?Documentation guidelines have been established for those residents with a UTI and nurses have been educated.4. How corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?All residents with a Urinary Tract Infection will have documentation reviewed five (5) days a week for four (4) weeks by the Community Nurse Leader, then weekly for six (6) months with results to QA.5. By what date the systemic changes will be completed?The facility is requesting paper compliance and systemic changes will be completed by April 1, 2015.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLIN RD FORT WAYNE, IN 46815
--	--

(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>with the Director of Nursing (DON) indicated the resident had been on an antibiotic for a urinary tract infection which started on 3/6/15. The DON was queried if there was any documentation or assessment of the resident's urine , temperature, or complaints of pain or discomfort. The DON was unable to find any assessment for resident (B) from 3/6/15 until 3/9/15, at 10:56 p.m. at which time nursing staff took the resident's temperature. The DON was queried if the facility had a policy for assessing residents with urinary tract infections, and she indicated they did not.</p> <p>This federal tag is related to complaint IN00168833</p> <p>3.1-37(a)</p>			