

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN 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 PERCEDED 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
F0000	<p>This visit was for Investigation of Complaints IN00107197 and IN00108377.</p> <p>Complaint IN00107197- Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00108377- Substantiated, Federal/State deficiency related to the allegations is cited at F241.</p> <p>May 21, 22 and 23, 2012</p> <p>Facility number: 000039 Provider number: 155685 AIM number: 100275130</p> <p>Survey team: Shelly Vice, RN-TC Carol Miller RN (5/22, 5/23, 2012)</p> <p>Census bed type: SNF/NF: 157 Total: 157</p> <p>Census Payor type: Medicare: 14 Medicaid: 113 Other: 30 Total: 157</p> <p>Sample: 7</p>	F0000		

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: 155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELEY 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
	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 25, 2012 by Bev Faulkner, RN</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELEY 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
F0241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observations, record reviews and interviews, the facility failed to ensure residents were provided their meals without an extended waiting period of time. This affected 10 of 11 residents observed in the East Dining room (Residents B,C, D, E, F, G, H, I, J and K) and 1 (Resident M) of 2 residents observed in the main dining room.</p> <p>Findings include:</p> <p>1. On 5/21/12 at 11:00 a.m., upon tour of the facility Residents B, C, D, and E were observed to be sitting in the dayroom/dining area at the end of the East Unit hall.</p> <p>On 5/21/12 at 11:40 a.m., a record review was made of the "Meal Delivery Times." Under the headline titled "Lunch" was noted, "11:30 a.m. East."</p> <p>On 5/21/12 at 12:10 p.m., an observation was made of the East Unit Hall dayroom' dining area. The same residents visualized at 11:00 a.m., were observed to</p>	F0241	<p>Preparation, Submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements</p> <p>The facility is requesting a desk review for considration.</p> <p>F 241</p> <p>1. Residents' B,C,D,E,F,G,H,I,J, AND K were not identified due to the nature of this survey, nor were any of the alleged citations provided to the facility during this survey . There were no adverse outcomes related to the alleged deficient practice.</p> <p>2. Residents' residing at the facility have to potential to be affected by the alleged deficient practice.</p> <p>* A comprehensive review of current meal times, meal delivery and resident dining locations was completed by the Executive Director and Dietary District Manager to ensure meal times and meal</p>	06/22/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>be sitting at the exact same locations. The noon time lunch trays were sitting in a kitchen cart with CNA #1 and LPN#1 assisting with the passing of the trays to the Resident B through E.</p> <p>On 5/21/12 at 12:17 p.m., an observation was made of Resident F being assisted to the East Unit Hall dayroom/dining area. RN#1 arrived to the area and began to assist with the remainder of the lunchtime trays and aided Resident F with his meal set up.</p> <p>On 5/21/12 at 12:20 p.m., Residents B, C, D, and E were observed to be either self assisting themselves to their lunches and or being assisted to eat by the staff.</p> <p>On 5/21/12 at 12:21 p.m., a confidential interview was conducted with a family member of a resident of the East Unit Hall. The family member indicated her visit was to aid with lunchtime due to the facility not being able to "keep up" with providing the residents their meals in a timely manner. The family member indicated her family member was very frail and needed to be encouraged to eat.</p> <p>On 5/21/12 at 12:30 p.m., CNA#1 was observed to be pushing a kitchen plastic 3 (three) shelved rolling cart with 5 (five) trays stored on the shelves. This cart was</p>		<p>deliveries are being completed timely and served to meet the needs of the residents.</p> <p>*Seating charts were updated to ensure tray tickets are arranged according to the seating in the dining areas.</p> <p>3. Dietary Staff have been in-serviced by the Dietary District Manager on nutrition services, food preparation, meal times and meal deliveries to ensure residents are not sitting for long periods of time in- between meal deliveries by June 8, 2012</p> <p>* Nursing staff have be in-serviced on meal deliveries, serving residents together at tables and the importance of assisting residents back to their rooms when meals are completed by June 8, 2012</p> <p>* A food committee will be held weekly for 8 weeks, bi-weekly for 4 weeks and monthly thereafter.</p> <p>* Department Mangers will have dining room assignments in place to cover meals 7 days a week.</p> <p>* The Executive Director and/or designee will complete a resident tray assessment for to ensure food is attractive and palatable. Audits will be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>pushed from the East Unit Hall dayroom/dining area. The cart was observed to hold Residents G, H, I, J and K's lunchtime noon meal. CNA #1 removed a single tray and entered the unit kitchen/ nourishment area. The CNA was then observed to exit the unit kitchen/nourishment area and enter Resident G's room.</p> <p>On 5/21/12 at 12:35 p.m., RN#1 left the East Unit Hall with the rolling cart with 2 (two) noon lunchtime trays on the shelves. These were for Resident J and K. RN#1 proceeded to the kitchen serving window, requested an alternative meal for Resident J and noting that Resident K would be requiring another tray due to their absence from the hall at the lunchtime.</p> <p>On 5/21/12 at 12:45 p.m., RN#1 returned to the East Unit Hall with Resident J's noontime lunch tray. RN#1 entered Resident J's room with the lunchtime tray of food. Resident J was awakened and encouraged to eat.</p> <p>2. On 5/21/12 at 6:20 p.m., an observation was made of the Main Dining area. It was noted that of several tables of 3 (three) residents, only 1(one) resident had been served the main course, while the other 2(two) residents at the table</p>		<p>completed for Lunch and Dinner results of the test tray will be compiled and forwarded to the QA&A committee.</p> <p>4. The results of these audits will be reported by the Dining Services Manager to the QAA committee monthly for 6 months and then quarterly thereafter, until a threshold of 100% is achieved.</p> <p>5. Date of Compliance 6/22/12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN 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 PERCEDED 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>were waiting for their trays.</p> <p>On 5/21/12 at 6:20 p.m., an interview was conducted with Resident L and M and Resident L's family member. Resident L had been served her main course. Resident M had not been served. Resident L's family member noted that the service at the meal times was "never on the times they (the facility) say they will be... we wait along times most evenings...it bothers me to sit here and watch my mom eat when she (Resident M) hasn't even been offered anything... it's bothersome..."</p> <p>On 5/21/12 at 6:20 p.m., an interview was conducted with Resident M. She indicated she was "sick and tired of waiting, waiting and more waiting.... they (the facility) bought those new fangled warming trays to help with the food... and you see where they are (making a non verbal gesture towards a newly constructed steam table service not being used)...it is routine for us (the residents in the main dining room awaiting for dinner service) to wait until the others at our tables are completely finished with their meals to be served..." Resident M also indicated this often affected her willingness to eat at all and often she would request to returned to her room because of her physical tiredness of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELEY 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	
	<p>waiting.</p> <p>This Federal tag relates to Complaint IN00108377.</p> <p>3.1-3(t)</p>				