

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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 0000 Bldg. 00 | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 22, 23, 24, 25, 26 and 29, 2016</p> <p>Facility number: 000045 Provider number: 155109 AIM number: 100291400</p> <p>Census bed type: SNF/NF: 63 Total: 63</p> <p>Census payor type: Medicare: 1 Medicaid: 51 Other: 11 Total: 63</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on March 7, 2016.</p> | F 0000 | <p><u>Disclaimer Statement</u> Submission of the plan correction is not an admission that a deficiency exists or that they were cited correctly. This Plan of Correction is a desire to continuously enhance the quality of care and services provided to our residents and is submitted solely as a requirement of the provision of Federal & State Law.</p> <p>"This Plan of Correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirement."</p> | |
| F 0225 SS=D Bldg. 00 | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS | | | |

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: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|--|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | | | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 | | |
| (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>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure an allegation of misappropriation of resident funds was</p> | F 0225 | <p>1) Resident #74 was interviewed and no ill effects were observed related to the deficient practice. 2) All residents have the potential</p> | 03/25/2016 | |

| | | | | | | | |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 02/29/2016 | |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 | | | |
| (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>reported to the appropriate State Agency and was thoroughly investigated. This deficiency affected 1 of 1 residents reviewed for missing money. (Resident #74).</p> <p>Finding includes:</p> <p>During an interview on 2-23-16 at 3:32 P.M., Resident #74 indicated a few months ago he had \$1300 go missing from his wallet while he was taking a shower in the shower room. Resident #74 indicated he had told the BOM (Business Office Manager) about the missing money.</p> <p>On 2-25-16 at 10:30 A.M., review of a facility "Grievance Form," received from the DON (Director of Nursing) at this time, indicated "...Resident name: [Resident #74]...Today's date: 11-09-15...Grievance heard by: [BOM name]...Statement of Concern: States had \$700 in cash in pocket of pants, laid pants down on bed and went to take a shower, money was missing when he ret'd [returned] to his room...Action Plan: Reinterviewed resident, resident states he is missing \$1500 dollars, or maybe \$1100. Spoke w/ [with] residents POA [Power of Attorney]...Nature of Resolution: Facility applied for rep. [representative] payee per POA request.</p> | | <p>to be affected. An audit of current residents was completed to ensure that no other residents were affected by this practice. Individual adjustments to care plans were made as appropriate/necessary. 3) The facility abuse policy and procedure was reviewed. The Director of Clinical Education/Director of Nursing Services and/or Designee will in-service all staff by 03/11/16 related to allegations of abuse and following facility policy and procedure with any allegation of abuse to prevent potential further abuse while the investigation is in process. The DQI investigation process will be utilized for all allegations of abuse to ensure a thorough and complete investigation is performed. 4) The Director of Nursing Services and/or designee and the Social Services Director will audit progress notes and 24 hour report sheets to ensure allegations of abuse are followed up on according to facility policy and procedure. Audits will be performed at a minimum of at least five times per week for a minimum of at least three months and will continue until no further issues are noted. Issues noted will be reported to the IDT team in morning meeting for review and corrective action as needed. 5) Any concerns will be monitored through the QAPI process for a minimum of three months. If no</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>Explained to resident will need to get funds from facility bank if rep payee occurs...Date of Resolution: 11-10-15...."</p> <p>Review of an attached, undated, statement of the BOM speaking with POA indicated "[POA name] states resident has been going to bank and withdrawing money, she does not want him doing this...Per [POA name], unable to ascertain if resident actually had money or how much, does not know when or if resident went to bank recently...." Facility Grievance form was signed by the BOM, the ED (Executive Director), and the SSD (Social Service Director).</p> <p>On 2-25-16 at 2:35 P.M., an interview with the BOM was conducted. The BOM indicated Resident #74 had come to her and told her he had \$1500 missing. "...I wrote it up in a grievance and went to the ED and told her about it. I did some research but could not validate he had it. The POA said he didn't have that much...." The BOM also indicated Resident #74 had had an outside bank account that he used to walk to and withdraw money.</p> <p>On 2-25-16 at 2:54 P.M., an interview with the ED was conducted via phone. The ED indicated "...I remember the allegation. I had spoken with the POA</p> | | <p>issues are noted after completion of the monthly QAPI process for three months, monitoring will be decreased to an as needed basis as determined by the QAPI committee. If issues continue to be identified, the QAPI committee will continue to monitor the issues identified on a monthly basis until one month has passed with no issues being identified, at which time monitoring will be decreased to an as needed basis as determined by the QAPI committee.</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>and the BOM...I didn't substantiate it because he kept changing his story. I can't tell how much he really had...."</p> <p>On 2-25-16 at 3:15 P.M., an interview with the BOM was conducted. The BOM indicated they did not have an investigation into this allegation of missing money.</p> <p>On 2-26-16 at 9:10 A.M., an interview with the DON was conducted. The DON indicated the facility had not reported the allegation of missing money.</p> <p>On 2-26-16 at 10:13 A.M., an interview with the DON was conducted. The DON indicated "...I am usually involved in investigations like this. I don't know why I wasn't this time. Sometimes the ED just does it herself, usually I am notified...If an allegation comes in and it fits under a category of something that is reportable, we need to report it...."</p> <p>On 2-26-16 at 11:48 A.M., an interview with the SSD was conducted. The SSD indicated "...I would normally be involved in something like this. I was very new at the time...I'm not sure why the ED didn't involve me this time. I had heard about it but wasn't formally notified...."</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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 0226 SS=D Bldg. 00 | <p>On 2-26-16 at 11:55 A.M., review of the current "Reporting Alleged Abuse Violation" policy, dated 1-15-15 and received from the DON on 2-25-16 at 3:48 P.M., indicated "...Any employee who suspects an alleged violation immediately notifies the ED...The ED notifies the appropriate state agency in accordance with state law and the regional vice president...Investigation: The ED or DON conducts all investigations...The investigation includes interviews of employees, visitors or residents who may have knowledge of the alleged incident...The documentation of the investigation is kept in the ED's office in an administrative file...Federal law requires the center to have evidence of investigations of alleged violations...."</p> <p>3.1-28(c) 3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review,</p> | F 0226 | 1) Resident #74 was interviewed and no ill effects were observed | 03/25/2016 |

| | | | | | | | |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/29/2016 | |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 | | | |
| (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>the facility failed to follow their policy and procedure related to reporting and investigating an allegation of missing money. This deficiency affected 1 of 1 residents reviewed. (Resident #74)</p> <p>Finding includes:</p> <p>During an interview on 2-23-16 at 3:32 P.M., Resident #74 indicated a few months ago he had \$1300 go missing from his wallet while he was taking a shower in the shower room. Resident #74 indicated he had told the BOM (Business Office Manager) about the missing money.</p> <p>On 2-25-16 at 10:30 A.M., review of a facility "Grievance Form," received from the DON (Director of Nursing) at this time, indicated "...Resident name: [Resident #74]...Today's date: 11-09-15...Grievance heard by: [BOM name]...Statement of Concern: States had \$700 in cash in pocket of pants, laid pants down on bed and went to take a shower, money was missing when he ret'd [returned] to his room...Action Plan: Reinterviewed resident, resident states he is missing \$1500 dollars, or maybe \$1100. Spoke w/ [with] residents POA [Power of Attorney] ...Nature of Resolution: Facility applied for rep. [representative] payee per POA request.</p> | | <p>related to the deficient practice. 2) All residents have the potential to be affected. An audit of current residents was completed to ensure that no other residents were affected by this practice. Individual adjustments to care plans were made as appropriate/necessary. 3) The facility abuse policy and procedure was reviewed. The Director of Clinical Education/Director of Nursing Services and/or Designee will in-service all staff by 03/11/16 related to allegations of abuse and following facility policy and procedure with any allegation of abuse to prevent potential further abuse while the investigation is in process. The DQI investigation process will be utilized for all allegations of abuse to ensure a thorough and complete investigation is performed. 4) The Director of Nursing Services and/or designee and the Social Services Director will audit progress notes and 24 hour report sheets to ensure allegations of abuse are followed up on according to facility policy and procedure. Audits will be performed at a minimum of at least five times per week for a minimum of at least three months and will continue until no further issues are noted. Issues noted will be reported to the IDT team in morning meeting for review and corrective action as needed. 5) Any concerns will be monitored through the QAPI process for a</p> | | | | |

| | | | | | |
|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/29/2016 |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | | | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 | | |
| (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>Explained to resident will need to get funds from facility bank if rep payee occurs...Date of Resolution: 11-10-15...." Review of an attached, undated, statement of the BOM speaking with POA indicated "[POA name] states resident has been going to bank and withdrawing money, she does not want him doing this...Per [POA name], unable to ascertain if resident actually had money or how much, does not know when or if resident went to bank recently...." Facility Grievance form was signed by the BOM, the ED (Executive Director), and the SSD (Social Service Director).</p> <p>On 2-25-16 at 2:35 P.M., an interview with the BOM was conducted. The BOM indicated Resident #74 had come to her and told her he had \$1500 missing. "...I wrote it up in a grievance and went to the ED [Executive Director] and told her about it. I did some research but could not validate he had it. The POA [Power of Attorney] said he didn't have that much...." The BOM also indicated Resident #74 had had an outside bank account that he used to walk to and withdraw money.</p> <p>On 2-25-16 at 2:54 P.M., an interview with the ED was conducted via phone. The ED indicated "...I remember the</p> | | <p>minimum of three months. If no issues are noted after completion of the monthly QAPI process for three months, monitoring will be decreased to an as needed basis as determined by the QAPI committee. If issues continue to be identified, the QAPI committee will continue to monitor the issues identified on a monthly basis until one month has passed with no issues being identified, at which time monitoring will be decreased to an as needed basis as determined by the QAPI committee.</p> | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>allegation. I had spoken with the POA and the BOM...I didn't substantiate it because he kept changing his story. I can't tell how much he really had...."</p> <p>On 2-25-16 at 3:15 P.M., an interview was conducted with the BOM. The BOM indicated they did not have an investigation into this allegation of missing money.</p> <p>On 2-26-16 at 9:10 A.M., an interview with the DON was conducted. The DON indicated the facility had not reported the allegation of missing money.</p> <p>On 2-26-16 at 10:13 A.M., an interview with the DON was conducted. The DON indicated "...I am usually involved in investigations like this. I don't know why I wasn't this time. Sometimes the ED just does it herself, usually I am notified...If an allegation comes in and it fits under a category of something that is reportable, we need to report it...."</p> <p>On 2-26-16 at 11:48 A.M., an interview with the SSD was conducted. The SSD indicated "...I would normally be involved in something like this. I was very new at the time...I'm not sure why the ED didn't involve me this time. I had heard about it but wasn't formally notified...."</p> | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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 0250 SS=D Bldg. 00 | <p>On 2-26-16 at 11:55 A.M., review of the current "Reporting Alleged Abuse Violation" policy, dated 1-15-15 and received from the DON on 2-25-16 at 3:48 P.M., indicated "...Any employee who suspects an alleged violation immediately notifies the ED...The ED notifies the appropriate state agency in accordance with state law and the regional vice president...Investigation: The ED or DON conducts all investigations...The investigation includes interviews of employees, visitors or residents who may have knowledge of the alleged incident...The documentation of the investigation is kept in the ED's office in an administrative file...Federal law requires the center to have evidence of investigations of alleged violations...."</p> <p>3.1-28(a)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to ensure</p> | F 0250 | 1) Resident #45 was interviewed and no ill effects were observed | 03/25/2016 |

| | | | | | |
|--|---|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 02/29/2016 |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | | | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 | | |
| (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>that dental services were offered upon admission to a resident that was edentulous for 1 of 3 residents reviewed for dental services. (Resident #45)</p> <p>Finding includes:</p> <p>During an interview on 2-25-16 at 12:44 P.M., Resident #45 indicated he does not currently have upper or lower dentures. Resident #45 indicated he had a full set of dentures at one time but his dentures were burned in a house fire and he had not checked into obtaining another set of dentures. The resident denied any chewing problems stating he makes sure he always eats soft food with no whole meat, he further indicated he is used to "gumming" his food. The resident indicated he had not seen a dentist since admission to the facility and did not know if he could afford another set of dentures. The resident was observed to not have natural teeth or dentures at this time.</p> <p>On 2-25-16 at 2:00 P.M., Resident #45's record was reviewed. Resident #45 was admitted to the facility on 6-10-15, with diagnoses including, but not limited to, dysphagia, malnutrition, anemia, CVA (cerebral vascular accident) left side and convulsions.</p> | | <p>related to the deficient practice. Resident #45 signed consent for dental services and an appointment has been scheduled. 2) All residents have the potential to be affected. An audit of current residents was completed to ensure that no other residents were affected by this practice. Individual adjustments to care plans were made as appropriate/necessary. 3) The Resident Rights policy and procedure was reviewed. The Director of Clinical Education/Director of Nursing Services and/or Designee will in-service all management staff by 03/11/16 related to ensuring consent forms regarding ancillary services are completed within 24 hours of admission to the facility. 4) The Director of Nursing Services and/or designee and the Social Services Director will audit charts within 24 hours of admission to the facility to ensure a consent form has been signed. Audits will be performed at a minimum of at least five times per week for a minimum of at least three months and will continue until no further issues are noted. Issues noted will be reported to the IDT team in morning meeting for review and corrective action as needed. 5) Any concerns will be monitored through the QAPI process for a minimum of three months. If no issues are noted after completion of the monthly QAPI process for three months,</p> | | |

| | | | | | |
|--|---|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 02/29/2016 |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | | | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 | | |
| (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>A nursing admission assessment, dated 6-10-15, indicated the resident was edentulous. Hand written on the admission assessment under the condition of teeth section was: no difficulty chewing does not want dentures.</p> <p>The admission Minimum Data Set (MDS) assessment, dated 6-17-15, indicated Resident #45 was edentulous and had no broken or loose fitting full or partial dentures.</p> <p>During an interview on 2-29-16 at 2:10 P.M., the Social Service Director (SSD) indicated when a resident is admitted to the facility there is a consent form in the admission packet that indicates if a resident consents or refuses the use of ancillary providers. The SSD indicated the form is reviewed with the resident or the responsible party at the time of admission and one of the questions is regarding consenting to the use of dental services. The SSD further indicated she was unable to find this form in Resident #45's chart, and then indicated there should be a signed and dated consent form indicating if the resident consented or refused dental services. She further indicated she had not checked with the resident to see if he would like to have a dental consult.</p> | | <p>monitoring will be decreased to an as needed basis as determined by the QAPI committee. If issues continue to be identified, the QAPI committee will continue to monitor the issues identified on a monthly basis until one month has passed with no issues being identified, at which time monitoring will be decreased to an as needed basis as determined by the QAPI committee.</p> | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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 0258 SS=C Bldg. 00 | <p>A policy was requested from the SSD regarding the consent or refusal to use the facility dental services, however one was never received from the facility.</p> <p>3.1-34(a)</p> <p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. Based on observation, interview and record review, the facility failed to ensure comfortable sound levels were maintained in the 100 and 200 Halls, when staff rolled linen barrels through the facility. This deficiency had the potential to affect 63 of 63 residents in the facility.</p> <p>Finding includes:</p> <p>On 2-23-2016 at 3:30 P.M., the Resident Council meeting minutes from September 2015 to February 2016, provided by the DON (Director of Nursing) on 2/23/2016 at 8:00 A.M., were reviewed, with the permission the Resident Council President, given on</p> | F 0258 | <p>1) Resident #23 was assessed and no ill effects were observed related to the deficient practice. New linen/trash carts were put into place 2/29/16 and resident #23 states no longer being disturbed by noise. 2) All residents have the potential to be affected. An audit of current residents was completed to ensure that no other residents were affected by this practice. Individual adjustments to care plans were made as appropriate/necessary. 3) The Resident Rights policy was reviewed. The Director of Clinical Education/Director of Nursing Services will in-service all nursing staff on the need to maintain comfortable sound levels and the use of the new linen/trash carts</p> | 03/25/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | | | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 | | |
| (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>2-22-2016 at 1:45 P.M. Noise levels related to the laundry barrels were mentioned in the minutes on: 10-5-2015, "In resident council today the following nursing issues were identified: ...Noise level related to linen barrels...." On 12-3-2015, "Concerns...barrels making noise...." On 1-5-2016, "Old Business:...Barrels still being noisy at night...." On 2-2016 "...Concerns that continue. Barrels at bedtime making loud noises going down the hallways...."</p> <p>On 2-24-2016 at 11:13 A.M., an interview with the Resident Council President indicated some residents complained at the resident council meeting, regarding the loud noise the laundry barrels made when they were rolled down the halls.</p> <p>On 2-24-2016 at 3:43 P.M., an interview with Resident #23, indicated the volume from the laundry barrels was very loud and disturbing, especially at night around 10:00 to 10:30 P.M. Resident #23 indicated she likes to keep her door open to the hall at night, and the sound of the linen barrels wake her. She indicated the facility recently purchased 2 or 3 new barrels, but the noise had not improved.</p> <p>On 2-25-2016 at 9:44 A.M., an interview with the DON, indicated the barrels were</p> | | <p>by3/11/16. 4) The Director of Nursing Services and/or Designee will audit sound levels to ensure comfortable sound levels are being maintained. Audits will be performed on all shifts at a minimum of at least five times per week for a minimum of at least three months and will continue until no further issues are noted. Issues noted will be reported to the Executive Director and/or Designee and the IDT team in morning meeting for review and corrective action as needed. 5) Any concerns will be monitored through the QAPI process for a minimum of three months. If no issues are noted after completion of the monthly QAPI process for three months, monitoring will be decreased to an as needed basis as determined by the QAPI committee. If issues continue to be identified, the QAPI committee will continue to monitor the issues identified on a monthly basis until one month has passed with no issues being identified, at which time monitoring will be decreased to an as needed basis as determined by the QAPI committee.</p> | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>loud and she had instructed the evening shift not to roll the barrels through the halls in the evenings because residents thought the barrels were too noisy. She indicated some of the staff were continuing to roll the laundry barrels in the halls in the evenings.</p> <p>On 2-25-2016 at 10:43 AM., an interview with the Facility Educator, indicated the facility purchased 2 new laundry barrels about 2 weeks ago and they were more quiet than the previous barrels, but they were still very noisy.</p> <p>On 2-25-2016 at 11:01 A.M., during an observation with the Facility Educator, two CNA (Certified Nursing Assistants), demonstrated the two new laundry barrel as they were rolled down the 200 Hall. As the wheels rolled against the linoleum floor, the noise they made was very loud.</p> <p>During an interview on 2-25-2016 at 11:04 A.M., the Facility Educator indicated the new barrels were still very loud and the facility would need to find something more quiet.</p> <p>During an interview on 2/25/2016 at 1:18 P.M., the DON indicated the laundry barrels were too loud, especially when rolled down the hall fast. She indicated she told the CNAs to roll the carts slower</p> | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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 0272 SS=D Bldg. 00 | <p>so they wouldn't be so loud.</p> <p>3.1-19(f)(5)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information</p> | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview and record review, the facility failed to complete a comprehensive assessment of a contracture for 1 of 3 residents reviewed for range of motion needs. (Resident #43)</p> <p>Findings include:</p> <p>The clinical record for Resident #43 was reviewed on 2-25-16 at 10:03 A.M. Resident #43 was admitted to the facility on 8-3-12 with diagnoses, including but not limited to: Parkinson's disease, dysarthria, short achilles tendon, dementia with Lewy bodies, history of falling, rhabdomyolysis, pain and weakness.</p> <p>Resident #43 was observed, on 2-25-16 at 10:30 A.M., in his room in a lift recliner chair. The resident had a contracted left wrist and contracted fingers on his left hand. His fingers were contracted at the first digit in a flexed position. He indicated his wrist had been broken a couple times from falls. He did not answer when asked if he had a splint</p> | F 0272 | <p>1) Resident #43 was assessed and no ill effects were observed related to the deficient practice. 2) All residents have the potential to be affected. An audit of current residents was completed to ensure that no other residents were affected by this practice. Care plans were audited and individual adjustments to careplans were made as appropriate/necessary. 3) The Contracture policy was reviewed. The Director of Nursing Services/Director of Clinical Education will in-service all nursing staff on the need to routinely assess contractures to identify/prevent worsening of contractures by 3/11/16. 4) The charge nurse/admitting nurse will perform the Range of Motion Assessment and will note any contractures as well as document if any worsening is noted and will notify all appropriate persons if worsening of contracture is noted. The Director of Nursing Services and/or Designee will audit range of motion assessments to ensure contractures are assessed. Audits will be performed at a minimum of at least five times per week for a minimum of at least three months and will continue until no further issues are noted.</p> | 03/25/2016 |

| | | | | | |
|--|---|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/29/2016 |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | | | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 | | |
| (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>for his left fingers.</p> <p>Resident #43 was observed ambulating in the hallway on 2-26-16 at 10:25 A.M. He did not have any splint on his left hand. He was noted to hold his left arm in a flexed position at the elbow and hold his wrist and hand close to his body as he ambulated.</p> <p>A Joint Mobility Assessment, initiated on 8-3-13, indicated the resident had moderate/severe (25 - 50 %) limited joint mobility of his left wrist and left hand and fingers. The assessment had been reviewed quarterly on Join Mobility Assessment form, with the most recent review completed on 2-4-16. The review form indicated the assessor was to evaluate if the resident could do the following: "1. Look from side to side, 2. Touch the back of neck with both hands, 3. Touch opposite shoulder with hand, 4. when lying on back: bring knee to chest, lift leg off the bed, separate legs, and point toes towards and away from head, 5. Make a fist and fully open hands, and 6. Other limitations." The form documented the resident could not perform steps 2, 3, 4a, or 5. "No change in mobility" was handwritten under comments and "Maintained joint mobility" was marked under program effectiveness. During an interview on</p> | | <p>Issues noted will be reported to the Executive Director and/or Designee and the IDT team in morning meeting for review and corrective action as needed. 5) Any concerns will be monitored through the QAPI process for a minimum of three months. If no issues are noted after completion of the monthly QAPI process for three months, monitoring will be decreased to an as needed basis as determined by the QAPI committee. If issues continue to be identified, the QAPI committee will continue to monitor the issues identified on a monthly basis until one month has passed with no issues being identified, at which time monitoring will be decreased to an as needed basis as determined by the QAPI committee.</p> | | |

| | | | | | |
|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/29/2016 |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | | | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 | | |
| (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>2-26-16 at 2:00 P.M., LPN (Licensed Practical Nurse) #30 indicated the form was completed by nursing.</p> <p>The most recent quarterly MDS (Minimum Data Set) assessment, completed on 12-04-15, indicated the resident had limited mobility on one side of his upper extremity. The resident was not documented as having received any range of motion exercises or splint devices.</p> <p>During an interview on 2-25-16 at 2:19 P.M. with COTA (Certified Occupational Therapy Assistant), Employee #30, she indicated she had screened the resident quarterly and she noted he held his left hand in a strange position as he ambulated but she had attributed it to his Parkinson's gait and did not realize he had contractures.</p> <p>During an interview on 2-29-16 at 9:31 A.M., the DON (Director of Nursing) indicated nursing only initiated a restorative plan related to contractures on the direction of the therapy department. She indicated she was not aware of the assessment by therapy of Resident #43's contracture.</p> <p>3.1-31(a)</p> | | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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 0279 SS=E Bldg. 00 | <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and record review, the facility failed to ensure care plans were developed to address behavior management and monitoring needs for 1 of 5 residents reviewed for unnecessary medications (Resident #10), and to address oral needs for 2 of 3 residents reviewed for dental care. (Residents #74 and #11)</p> | F 0279 | <p>1) Resident #10, #74 and #11 were assessed and no ill effects were observed related to the deficient practice. 2) All residents have the potential to be affected. An audit of current residents was completed to ensure that no other residents were affected by this practice. Care plans were audited and individual adjustments to careplans were made as appropriate/necessary. 3) The Care Plan policy was reviewed.</p> | 03/25/2016 |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>Findings include:</p> <p>1. The clinical record for Resident #10 was reviewed on 2-29-16 11:27 A.M. Resident #10 was admitted to the facility on 9-3-14 with diagnoses, including but not limited to: acute and chronic respiratory failure, vitamin D deficiency, chronic obstructive pulmonary disease, obstructive sleep apnea, catatonic schizophrenia, anxiety disorder, dementia with behavioral disturbance, major depressive disorder, pain, heart failure, transischemic attacks, weakness, malaise, shortness of breath, metabolic encephalopathy and wheezing.</p> <p>The current medication orders for Resident #10 included the following psychoactive medications: *Lorazepam (antianxiety) 0.5 mg (milligrams) one tablet at bedtime for anxiety disorder, *Paroxetine (an antidepressant with antianxiety effects) 20 mg per day for sleeplessness and increased paranoid ideation, *Fluphenazine HCL (hydrochloride) (an antipsychotic medication) 5 mg TID (three times a day) for catatonic schizophrenia.</p> <p>The care plans for Resident #10, current through 4-11-16, included a plan to</p> | | <p>The Director of Nursing Services/Director of Clinical Education will in-service all nursing staff and the Social Services Director regarding the need to develop comprehensive care plans which identify pertinent problems and needs, realistic goals to be accomplished and the specific action to be taken in resolution of the problems and/or needs of each resident. In-servicing will be completed by 3/11/16. 4) The Director of Nursing Services and/or Designee and the Social Services Director and/or Designee will audit the care plans to ensure careplans have been developed according to facility policy and procedure. Audits will be performed at a minimum of at least five times per week for a minimum of at least three months and will continue until no further issues are noted. Issues noted will be reported to the Executive Director and/or Designee and the IDT team in morning meeting for review and corrective action as needed. 5) Any concerns will be monitored through the QAPI process for a minimum of three months. If no issues are noted after completion of the monthly QAPI process for three months, monitoring will be decreased to an as needed basis as determined by the QAPI committee. If issues continue to be identified, the QAPI committee will continue to monitor the issues</p> | |

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/29/2016 | |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 | | | |
| (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>address the potential for adverse side effects of all three medications. In addition, there was plan to address the resident's impaired decision making skills and memory which indicated the resident would refuse care and show paranoia and delusions at times often repeating the same set of words over and over. The interventions were to administer a medication to enhance her memory, converse using simple terms and give her time to process, and provide opportunities for the resident to make simple decisions. The interventions were geared towards her memory and decision making impairments and did not give any constructive interventions for staff to apply when she expressed paranoia or delusions and/or repeated the same word set over and over again. There was no plan to address her sleeplessness, anxiety or diagnosis of catatonic schizophrenia.</p> <p>2. On 2-23-16 at 3:38 P.M., Resident #74 indicated he had no teeth, he hadn't had teeth in about 20 years, but occasionally had some trouble chewing certain foods. He indicated, "I left my whole supper the other night." Resident #74 was observed at this time to have no teeth.</p> <p>On 2-25-16 at 2:15 P.M., a review of Resident #74's record was completed. Resident #74 was admitted to the facility,</p> | | <p>identified on a monthly basis until one month has passed with no issues being identified, at which time monitoring will be decreased to an as needed basis as determined by the QAPI committee.</p> | | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>on 9-3-15, with diagnoses including but not limited to: COPD (chronic obstructive pulmonary disease), anemia, dementia, diabetes, and major depressive disorder.</p> <p>An admission nurses note, dated 9-3-15, indicated "...Edentulous, denies any difficulty chewing/swallowing with regular consistency diet, states does not want dentures and has eaten w/o [without] teeth for numerous years...."</p> <p>A Clinical Health Status Assessment, dated 9-3-15, indicated "edentulous."</p> <p>The MDS (Minimum Data Set) assessment, dated 9-10-15, indicated the resident had no natural teeth or tooth fragments (edentulous).</p> <p>Physician's orders indicated Resident #74 is on a consistent carbohydrate diet with no added salt. Resident #74's care plans indicated no documentation of a care plan related to the resident having no teeth or dentures.</p> <p>On 2-25-16 at 3:20 P.M., an interview with the SSD (Social Service Director) was conducted. The SSD indicated she does not see a care plan related to Resident #74's lack of teeth.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>3. During a resident observation on 2-25-2016 at 12:21 P.M., Resident #11 was noted to be without any remaining natural teeth, and was not wearing dentures.</p> <p>On 2-25-2016 at 4:00 P.M., a clinical record review was conducted for Resident #11. The diagnoses included but were not limited to, heart failure, peripheral vascular disease, dementia, anxiety depression, and psychotic disorder and impulsiveness.</p> <p>The most recent MDS (Minimum Data Set) assessment, dated 12-29-2015, indicated the resident's BIMS (Brief Interview for Mental Status) score was 00, indicating severe cognitive impairment.</p> <p>Resident #11's diet order indicated a regular diet of pureed texture.</p> <p>A review of the Social Service Dental Binder, provided by the Social Service Director on 2-25-2016 at 3:55 P.M., indicated Resident #11 "...She has no teeth, and feels she doesn't need dentures...." Dated 7/24/2014.</p> <p>Review of Resident #11's care plans indicated there was no documented plan of care related to the resident's status of</p> | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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 0318 SS=D Bldg. 00 | <p>no natural teeth and no dentures.</p> <p>On 2-29-16 at 9:33 A.M., an interview with the SSD was conducted. The SSD indicated a resident should have a care plan related to having no teeth and not having no dentures.</p> <p>On 2-29-16 at 2:40 P.M., review of the current "Care Plan Policy", dated April 15 and received from the DON (Director of Nursing) on 2-29-16 at 2:03 P.M., indicated "...Care plans should be developed based on completion of the Clinical Health Status Admission form and should be individualized for each resident..."</p> <p>3.1-35(a)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview and record review, the facility failed to ensure</p> | F 0318 | 1) Resident #43 was assessed and no ill effects were observed related to the deficient practice. | 03/25/2016 |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>a contracture of the left upper extremity and hand was assessed and measures implemented to prevent worsening of a contracture for 1 of 3 residents reviewed for limited range of motion needs. (Resident #43)</p> <p>Finding includes:</p> <p>The clinical record for Resident #43 was reviewed on 2-25-16 at 10:03 A.M. Resident #43 was admitted to the facility, on 8-3-12, with diagnoses, including but not limited to: Parkinson's disease, major depressive disorder, dysarthria, short achilles tendon, dementia with Lewy bodies, history of falling, rhabdomyolysis, pain and weakness.</p> <p>Resident #43 was observed on 2-25-16 at 10:30 A.M. in his room in a lift recliner chair. The resident had a contracted, deformed left wrist and contracted fingers on his left hand. His fingers were contracted at the first digit in a flexed position. He indicated his wrist had been broken a couple times from falls. He did not answer when asked if he had a splint for his left fingers.</p> <p>Resident #43 was observed ambulating in the hallway on 2-26-16 at 10:25 A.M. He did not have any splint on his left hand. He was noted to hold his left arm</p> | | <p>2) All residents have the potential to be affected. An audit of current residents was completed to ensure that no other residents were affected by this practice. Care plans and assessments were audited and individual adjustments to careplans and assessments were made as appropriate/necessary. 3) The Contracture policy was reviewed. The Director of Nursing Services/Director of Clinical Education will in-service all nursing staff on the need to develop care plans and appropriately assess residents with contractures to prevent worsening of contractures. In-servicing will be completed by 3/11/16. 4) The Director of Nursing Services and/or Designee will audit the care plans and assessments to ensure careplans have been developed according to facility policy and procedure and contractures are being assessed on a routine basis. Audits will be performed at a minimum of at least five times per week for a minimum of at least three months and will continue until no further issues are noted. Issues noted will be reported to the Executive Director and/or Designee and the IDT team in morning meeting for review and corrective action as needed. 5) Any concerns will be monitored through the QAPI process for a minimum of three months. If no issues are noted</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>in a flexed position at the elbow and hold his wrist and hand close to his body as he ambulated.</p> <p>During an interview conducted on 2-23-16 at 9:43 A.M., the Director of Nursing (DON) indicated Resident #43 had contractures of his left upper extremity and did not receive any range of motion services and did not wear a splint device.</p> <p>The most recent quarterly MDS (Minimum Data Set) assessment, completed on 12-4-15, indicated the resident had limited mobility on one side of his upper extremity. The resident was not documented as having received any range of motion exercises or splint devices.</p> <p>An initial Occupation Therapy Plan of Care, initiated on 8-6-12, when the resident was admitted to the facility indicated the resident had fallen prior to admission to the facility had was being evaluated for weakness, balance deficits, activity tolerance deficits, and impaired ability to perform ADLs (activities of daily living) and functional transfers. The assessment further documented the following under the "Underlying Impairments Other" section of the form: "...l (left) ue (upper extremity) sh</p> | | <p>after completion of the monthly QAPI process for three months, monitoring will be decreased to an as needed basis as determined by the QAPI committee. If issues continue to be identified, the QAPI committee will continue to monitor the issues identified on a monthly basis until one month has passed with no issues being identified, at which time monitoring will be decreased to an as needed basis as determined by the QAPI committee.</p> | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>(shoulder) flexion 0 - 135 end range; elbow 3+/5; supination 0-40; pron (pronation) forearm with pmh compartmental syndrome with contracture wrist and fingers; wrist grossly flexion 30 degrees; fingers contracture flexion; per pt "I have 2 splints but didn't wear them..." The form indicated the resident's right and left elbow strength was being addressed but there was no plan to address the resident's assessed contractures.</p> <p>A Joint Mobility Assessment, initiated on 8-3-13, indicated the resident had moderate/severe (25 - 50 %) limited joint mobility of his left wrist and left hand and fingers. The assessment had been reviewed quarterly on Join Mobility Assessment form, with the most recent review completed on 2-4-16. The review form indicated the assessor was to evaluate if the resident could do the following: "1. Look from side to side, 2. Touch the back of neck with both hands, 3. Touch opposite shoulder with hand, 4. when lying on back: bring knee to chest, lift leg off the bed, separate legs, and point toes towards and away from head, 5. Make a fist and fully open hands, and 6. Other limitations." The form documented the resident could not perform steps 2, 3, 4a, or 5. "No change in mobility" was handwritten under</p> | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>comments and "Maintained joint mobility" was marked under program effectiveness. During an interview with LPN (Licensed Practical Nurse) #30, on 2-26-16 at 2:00 P.M. she indicated the form was completed by nursing.</p> <p>A Joint Mobility Assessment, dated 11-5-15, indicated the resident was unable to make a fist and fully open hand, no change in mobility.</p> <p>During an interview on 2-25-16 at 2:19 P.M. with COTA (Certified Occupational Therapy Assistant), Employee #30, she indicated she had screened the resident quarterly and she noted he held his left hand in a strange position as he ambulated but she had attributed it to his Parkinson's gait and did not realize he had contractures.</p> <p>During an interview on 2-25-16 at 2:19 P.M. with COTA (Certified Occupational Therapy Assistant), Employee #30, she indicated she had screened the resident quarterly and she noted he held his left hand in a strange position as he ambulated but she had attributed it to his Parkinson's gait and did not realize he had contractures. Employee #30 looked through the remaining therapy notes since the resident's admission in 2012 and could not locate any documentation</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>addressing the resident's left upper extremity contractures.</p> <p>The current care plans for Resident #43, current through 4-25-16 referred to his limited mobility of his left hand in the problem portion of the plan but there was no interventions to address the resident's limited range of motion or to prevent any potential worsening of the noted contractures.</p> <p>During an interview with the Director of Nursing, on 2-29-16 at 9:31 A.M., she indicated nursing only initiated a restorative plan related to contractures on the direction of the therapy department. She indicated she was not aware of the assessment by therapy of Resident #43's contracture. She confirmed there was no restorative plan to address Resident #43's limited range of motion needs.</p> <p>During an interview with LPN #30, on 2-29-16 at 9:33 A.M., she indicated the resident had been admitted with an old surgical scar on his left arm. She indicated the resident said on admission a physician operated to "fix" his left arm and had further damaged his arm. She indicated she thought at one time he had a splint but she could not really recall anything about it.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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 0329 SS=D Bldg. 00 | <p>The current Restorative Guidelines policy and procedure, dated 2-20-15 and provided by the Director of Nursing on 2-29-16 at 9:00 A.M., included the following procedures: "...Resident/patient selection is made by the Restorative Nurse Coordinator/RNAC with input, if indicated, from therapy representative and other IDT [interdisciplinary team] members. Indicators for selection may include, but are not limited to: identification through transition of care process, decline in ADL function, recent completion of active therapy program, MDS (Full, Quarterly or Significant Change), Recent admission to the center but not receiving active therapy, recent re-admission to the center, restrictions of activity level, a diagnosis that is likely to produce functional decline...."</p> <p>3.1-42(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free</p> | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure the medical symptoms requiring the use of psychoactive medications were monitored for 1 of 5 residents reviewed for unnecessary medications. (Resident #10)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #10 was reviewed on 2-29-16 11:27 A.M. Resident #10 was admitted to the facility, on 9-3-14, with diagnoses, including but not limited to: acute and chronic respiratory failure, vitamin D deficiency,</p> | F 0329 | <p>1) Resident #10 was assessed and no ill effects were observed related to the deficient practice. 2) All residents have the potential to be affected. An audit of current residents was completed to ensure that no other residents were affected by this practice and individual adjustments to careplans and assessments were made as appropriate/necessary. 3) The Medication Monitoring/Management policy was reviewed. The Director of Nursing Services/Director of Clinical Education will in-service all nursing staff and the Social Services Director on the need to monitor/appropriately assess residents receiving psychotropic</p> | 03/25/2016 |

| | | | | | |
|--|---|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 02/29/2016 |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | | | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 | | |
| (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>chronic obstructive pulmonary disease, obstructive sleep apnea, catatonic schizophrenia, anxiety disorder, dementia with behavioral disturbance, major depressive disorder, pain, heart failure, transischemic attacks, shortness of breath, metabolic encephalopathy and wheezing.</p> <p>The current medication orders for Resident #10 included the following psychoactive medications: *Lorazepam (antianxiety) 0.5 mg (milligrams) one tablet at bedtime for anxiety disorder, *Paroxetine (an antidepressant with antianxiety effects) 20 mg per day for sleeplessness and increased paranoid ideation, *Fluphenazine HCL (hydrochloride) (an antipsychotic medication) 5 mg TID (three times a day) for catatonic schizophrenia.</p> <p>The care plans for Resident #10, current through 4-11-16, included a plan to address the potential for adverse side effects of all three medications. In addition, there was plan to address the resident's impaired decision making skills and memory which indicated the resident would refuse care and show paranoia and delusions at times often repeating the same set of words over and over. The</p> | | <p>medications to ensure medications are necessary/effective in behavior management. In-servicing will be completed by 3/11/16. 4) The Director of Nursing Services and/or Designee and Social Services Director and/or Designee will audit care plans and behaviors to ensure psychotropic medications are monitored according to facility policy and procedure on a routine basis. Audits will be performed at a minimum of at least five times per week for a minimum of at least three months and will continue until no further issues are noted. Issues noted will be reported to the Executive Director and/or Designee and the IDT team in morning meeting for review and corrective action as needed. 5) Any concerns will be monitored through the QAPI process for a minimum of three months. If no issues are noted after completion of the monthly QAPI process for three months, monitoring will be decreased to an as needed basis as determined by the QAPI committee. If issues continue to be identified, the QAPI committee will continue to monitor the issues identified on a monthly basis until one month has passed with no issues being identified, at which time monitoring will be decreased to an as needed basis as determined by the QAPI committee.</p> | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>interventions were to administer a medication to enhance her memory, converse using simple terms and give her time to process, and provide opportunities for the resident to make simple decisions. The interventions were geared towards her memory and decision making impairments and did not give any constructive interventions for staff to apply when she expressed paranoia or delusions and/or repeated the same word set over and over again. There was no care plan to address her sleeplessness, anxiety or diagnosis of catatonic schizophrenia.</p> <p>During an interview on 2-29-16 at 2:24 P.M., CNA (Certified Nursing Assistant) #32 indicated she did not know specifically what behaviors were to be monitored for Resident #10. She indicated the resident really just "got needy" at times and did not think she could do anything for herself at those times. She indicated she tried to talk her into being more independent when she got like that. She indicated the behaviors were charted in the Kiosk (an electronic charting system affixed to facility walls) but there were no resident specific information in the system to alert staff of specific behaviors, monitoring plans and specific interventions.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>During an interview on 2-29-16 at 2:25 P.M., CNA #33 indicated Resident #10 got very "needy" and would have repetitive verbalizations of "Help me, Help me." During the interview a voice, identified as Resident #10 by CNA #33, was heard yelling "help me, help me" over and over again. CNA #33 indicated the resident was doing this because her husband had just left the building. She was unaware of any specific interventions to address Resident #10's behaviors of repeated verbalizations. She was also unaware of any other behaviors for which Resident #10 was to be monitored.</p> <p>During an interview on 2-29-16 at 2:48 P.M., the Social Services Director (SSD) indicated the behavior care plan was the side effects care plan. When asked if there was a plan to address what direct care staff were to do when the resident displayed any of the targeted medical symptoms which required the psychoactive medication use, she indicated she would have to investigate it some more. She indicated all behaviors were to be documented in the PCC (electronic chart) and then the tracking was given to the psych nurse practitioners when they visited. Later she indicated she thought there was a behavior book at the nurse's station but she was not sure. She then indicated the facility was going</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>to restart behavior meetings that had ceased after the SSD started working here in October 2015.</p> <p>A Behavior Management Policy and nursing progress notes for the past 3 months was presented by the SSD on 2-29-16 at 3:45 P.M. The nursing progress notes indicated the following:</p> <p>*On 12-17-15, the resident had refused a medication and was yelling paranoid type accusations at the staff member regarding the medication.</p> <p>*On 12-29-15, the resident had been documented as having repetitive health care requests and care and snacks and redirection were attempted.</p> <p>*On 12-30-15, the nurse practitioner increased the resident's antidepressant medication.</p> <p>*On 12-31-15, the resident refused her shower and a medication.</p> <p>*On 1-13-16, the resident was yelling and threatening another resident regarding the volume of a television.</p> <p>*On 2-13-16 and 2-14-16 the resident had behaviors documented as repetitive demands and statements and yelling about a television volume. She was given care, offered care by different staff members and redirected. A urinalysis order was obtained and the resident was treated for a urinary tract infection.</p> | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>During the survey, conducted on 2-22-16 through 2-29-16 the resident was noted to frequently yell out repetitive statements such as "Help me, Help me" and other repetitive phrases. The behavior was not documented in the nursing progress notes.</p> <p>The SSD provided the undated Behavior Management Policy on 2-29-16 at 3:45 P.M., and indicated this was the policy currently used by the facility. The policy indicated the following: "Policy...3. Social Services but not limited to) is responsible for documenting the assessment of the causes of psychological, mood, and/or behavior issues, and directing the care plan process for intervention of mood and behavioral issues, but the responsibility of implementation for this plan belongs to all staff...5. Social Services will provide ongoing assessment of behavioral symptoms via a monthly behavioral summary in an attempt to discern patterns of behaviors, possible precursors to behaviors, interventions attempted and their effectiveness, and recommending and coordinating new approaches to the care plan as needed..." During an interview with the SSD at this time, she indicated she could not locate a behavior book at the nurse's station for Resident #10 and she had not further behavior</p> | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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 0431 SS=D Bldg. 00 | <p>tracking or care plans.</p> <p>3.1-48(a)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976</p> | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 18 insulin pens in use were labeled as to when it was opened and 2 of 18 insulin pens were not outdated. This deficient practice affected 3 of 18 diabetic residents who received insulin via pens in the facility. (Residents #44, 46, and 58)</p> <p>Findings include:</p> <p>An observation of the 200 unit medication cart was conducted on 2-29-16 at 4:00 P.M. with QMA (Qualified Medication Aide) #34. QMA #34 indicated the insulin pens in use for diabetic residents were stored in a purple plastic storage basket. There was a Humalog qwik pen, opened but not dated as to when it had been opened for Resident #58. There was a Novolog pen, dated as opened on 1-25-16 for Resident #44. There was a Humalog qwik pen, opened and dated 1-25-16 for Resident #46. The unit manager, LPN (Licensed Practical Nurse) #35 removed the pens from the purple basket when it was discovered they were not dated and/or were dated more than 28 days prior.</p> | F 0431 | <p>1) Resident #58, #44 and #46 were assessed and no ill effects were observed related to the deficient practice. 2) All residents have the potential to be affected. An audit of current residents was completed to ensure that no other residents were affected by this practice and individual adjustments to careplans and assessments were made as appropriate/necessary. 3) The Expired Insulin policy was reviewed. The Director of Nursing Services/Director of Clinical Education will in-service all nursing staff on the need to date/label/dispose of insulins per facility policy. In-servicing will be completed by 3/11/16. 4) The Director of Nursing Services and/or Designee will audit medication carts to ensure insulins are dated/labeled/disposed of according to facility policy and procedure on a routine basis. Audits will be performed at a minimum of at least five times per week for a minimum of at least three months and will continue until no further issues are noted. Issues noted will be reported to the Executive Director and/or Designee and the IDT team in morning meeting for review and corrective action as needed. 5)</p> | 03/25/2016 |

| | | | | | | | |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 02/29/2016 | |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 | | | |
| (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 0458 SS=E Bldg. 00 | <p>During an interview on 2-29-16 at 4:20 P.M., RN (Registered Nurse) #3 indicated the facility should have disposed of all insulin pens 28 days after the opened date. However, RN #3 indicated they utilized the 28 day time frame just to be safe for all types of unrefrigerated insulin.</p> <p>3.1-25(o)</p> <p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.</p> <p>Based on observation and interview, the facility failed to provide at least 80 square feet per resident in 22 multiple occupancy resident rooms for 2 of 2 units (100 and 200). (Rooms, 100, 101, 103, 104, 108, 109, 110, 111, 112, 114, 116, 118, 204, 205, 206, 207, 211, 213, 215 and 226). In addition, the facility failed to ensure 100 square feet per resident in single resident room. (Rooms 105 and 107)</p> | F 0458 | <p>Any concerns will be monitored through the QAPI process for a minimum of three months. If no issues are noted after completion of the monthly QAPI process for three months, monitoring will be decreased to an as needed basis as determined by the QAPI committee. If issues continue to be identified, the QAPI committee will continue to monitor the issues identified on a monthly basis until one month has passed with no issues being identified, at which time monitoring will be decreased to an as needed basis as determined by the QAPI committee.</p> <p>1) All residents have the potential to be affected. An audit of current residents was completed to ensure that no residents were affected by this practice. 2) The facility has applied for a waiver related to room size for identified rooms:100, 101, 103, 104, 108, 109,110, 111, 112, 114, 116, 118, 204, 205, 206, 207, 211, 213, 215, 226, 105 and 107.</p> | 03/25/2016 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>Findings include:</p> <p>1. During an environmental tour on 2/29/2016 at 10:00 A.M., the following multiple rooms were observed to contain less than 80 square feet per resident. The following rooms were certified SNF/NF (Skilled Nursing Facility / Nursing Facility) for three beds and measured from 70.5 to 72 square feet per resident.</p> <p>*Room 100, 2 beds, 211.5 total square feet. 105.75 square feet per resident.</p> <p>*Room 104, 2 beds, 216 total square feet. 108 square feet per resident.</p> <p>*Room 108, 2 beds, 216 total square feet. 108 square feet per resident.</p> <p>*Room 110, 2 beds, 216 total square feet. 108 square feet per resident.</p> <p>*Room 112, 2 beds, 216 total square feet. 108 square feet per resident.</p> <p>*Room 114, 2 beds, 216 total square feet. 108 square feet per resident.</p> <p>*Room 116, 2 beds, 216 total square feet. 108 square feet per resident.</p> <p>*Room 118, 2 beds, 211.5 total square feet. 105.75 square feet per resident.</p> | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>*Room 204, 2 beds, 216 total square feet. 108 square feet per resident.</p> <p>*Room 205, 2 beds, 212.9 total square feet. 106.45 square feet per resident.</p> <p>*Room 206, 2 beds, 215.3 total square feet. 107.65 square feet per resident.</p> <p>*Room 207, 2 beds, 213.6 total square feet. 106.8 square feet per resident.</p> <p>*Room 211, 2 beds, 213.6 total square feet. 106.8 square feet per resident.</p> <p>*Room 213, 2 beds, 213.6 total square feet. 106.8 square feet per resident.</p> <p>*Room 215, 2 beds, 213.6 total square feet. 106.8 square feet per resident.</p> <p>*Room 226, 2 beds, 216 total square feet. 108 square feet per resident.</p> <p>2. The following resident rooms were certified SNF/NF for 2 beds and measured between 70.5 and 71.5 square feet per resident.</p> <p>*Room 101, 1 bed, 141 total square feet. 141 square feet per resident.</p> <p>*Room 103, 1 bed 144 total square feet.</p> | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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 0465 SS=F Bldg. 00 | <p>144 square feet per resident.</p> <p>*Room 109, 1 bed, 143 total square feet. 143 square feet per resident.</p> <p>*Room 111, 1 bed, 143 total square feet. 143 square feet per resident.</p> <p>3. The following resident rooms were certified SNF/NF for one bed and measured less than 100 square feet.</p> <p>*Room 105, 1 bed 91.6 total square feet. 91.6 square feet per resident.</p> <p>*Room 107, 1 bed 91.6 total square feet. 91.6 square feet per resident.</p> <p>3.1-19(1)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe, clean, and comfortable environment in regard to a malfunctioning call light, resident rooms with broken tiles, marred walls, broken conduit, broken dressers, and a cracked bathroom wall. This deficiency affected 2 of 2 halls observed (100 and 200</p> | F 0465 | <p>1) All residents have the potential to be affected. An audit of current residents was completed to ensure that no residents were affected by this practice. 2) The emergency call light for the bathroom of 120 not lighting at the call panel is being repaired. The broken conduit in room 104-1 and the gouged wall behind the</p> | 03/25/2016 |

| | | | | | |
|--|--|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 02/29/2016 |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | | | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 | | |
| (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>Halls).</p> <p>Findings include:</p> <p>1. On 2-22-2016 at 4:06 P.M., during a resident room observation, (Room 120), the emergency call light system check, in the resident's bathroom did not light up on the call panel at the 100 Hall Nurse's Station.</p> <p>On 2-23-2014 at 9:48 A.M., an interview with the DON (Director of Nursing), indicated the bathroom call light in room 120 was not functioning at the 100 Hall Nurse's Station, and they brought in a contractor to work with the Maintenance Supervisor the determine the cause of the malfunction and to try to repair the call light to function as it was supposed to.</p> <p>On 2-23-2014 at 10:22 A.M., an interview with the Maintenance Supervisor, indicated the bathroom call lights should light up outside the resident's rooms, and at the nurse's station.</p> <p>2. On 2-29-2016 from 2:10 P.M. to 2:55 P.M., an environmental tour of the facility was conducted with the Maintenance Supervisor, Employee #2 and the House Keeping Supervisor. During the tour the following was</p> | | <p>bed have been repaired. The marred/scratched wall between beds 2 and 3 in room 104 has been repaired. The dressers in rooms 100-1, 101, 102-1, 102-2,103, 104-1, 104-2, 105, 106-1, 108-1, 108-2, 105,109, 110-1, 112-1, 112-2, 116-1, 118-1, 118-2, 120-1,200-2, 203-1, 204-1, 211-1, 211-2, 213-1, 21 and 222 are being replaced. The floor tiles on both sides of the threshold in rooms 106, 207, 215 and 230 have been repaired/replaced. The crack on the bedroom wall in room 226 and the marred wall behind bed 226-3 have been repaired. 3) The Guardian Angel Program policy was reviewed. The Director of Nursing Services/Director of Clinical Education will in-service all management staff on the need to utilize the revised Guardian Angel form to note any issues with walls, dressers floor tiles, conduit or other environmental issues and report any noted issues to the Executive Director and Director of Maintenance. In-servicing will be completed by 3/11/16. 4) The Executive Director and/or Designee will audit Guardian Angel Round forms and facility environment to ensure noted environmental issues are addressed. Audits will be performed at a minimum of at least five times per week for a minimum of at least three months and will continue until no further issues are noted. Issues noted</p> | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|--|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | | | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 | | |
| (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>observed:</p> <p>Room 104 had broken conduit hanging loosely under the window and behind resident bed 1. The wall behind bed 1 was gouged in an 8 inch area. The wall between beds 2 and 3 was marred and scratched approximately 5 feet up from the floor in an area of approximately 12 inches circumference.</p> <p>Multiple rooms were observed to have broken 3 drawer dressers, with one or more of the following concerns: peeling veneers, worn finish, missing particle base board, drawers that did not close properly, broken drawer handles, miss-matched drawer handles, warn and exposed edges, (rooms 100-1, 101, 102-1,102-2, 103, 104-1, 104-2, 105, 106-1, 108-1, 108-2, 105, 109, 110-1, 112-1, 112-2, 116-1, 118-1, 118-2, 120-1, 200-2, 203-1, 204-1, 211-1, 211-2, 213-1, 216, and 222).</p> <p>Floor tiles were observed broken or missing from both side of the threshold corners of four rooms, (106, 207, 215, and 230).</p> <p>Room 226 had 2 large cracks in the bathroom on the wall opposite the toilet. Each crack ran from the top corner frame of the resident's room door to the ceiling,</p> | | <p>will be reported to the Maintenance Director for follow up and to the IDT team in morning meeting for review and corrective action as needed. 5) Any concerns will be monitored through the QAPI process for a minimum of three months. If no issues are noted after completion of the monthly QAPI process for three months, monitoring will be decreased to an as needed basis as determined by the QAPI committee. If issues continue to be identified, the QAPI committee will continue to monitor the issues identified on a monthly basis until one month has passed with no issues being identified, at which time monitoring will be decreased to an as needed basis as determined by the QAPI committee.</p> | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/29/2016 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544 |
|--|---|

| (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>and gapped from a slight crack to 1/4 inch wide. The wall an 8 inch area that was marred behind bed 3.</p> <p>During an interview at the conclusion of the tour, the Maintenance Supervisor indicated he was not aware of the broken conduit, and it should not be hanging loosely. He was aware the conduit was not holding up and was in the process of replacing all the conduit in resident rooms. He indicated the walls in the resident rooms should not be gouged, marred, nor cracked. The Maintenance Supervisor indicated broken and missing tiles at the resident room thresholds should not be broken or missing, and should be repaired.</p> <p>During an interview at the conclusion of the tour, Employee # 2 indicated the broken and ill repaired 3 drawer dressers should be replaced and the facility had already replaced several dressers.</p> <p>3.1-19(f)</p> | | | |