STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/19/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: May 12, 13, 14, 15, 16, & 19, 2014 Facility number: 000282 Provider number: 155755 AIM number: 100287520 Survey team: Sue Brooker RD TC Julie Call RN Martha Saull RN Virginia Terveer RN Census bed type: SNF: 4 SNF/NF: 100 Residential: 32 Total: 136 Census payor type: Medicare: 7 Medicaid: 66 Other: 63 Total: 136 Sample: Residential: 7	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/19/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on May 21, 2014 by Randy Fry RN.			
F000311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on interview and record review, the facility failed to ensure a resident was provided adequate opportunity to attempt to attain the restorative goal for participation in a range of motion program for 1 of 3 residents reviewed for rehabilitation. (Resident #38) Findings include: On 5/15/14 at 10 A.M., the clinical	F000311	It is the practice of this facility to ensure that appropriate treatment and services to maintain or improve the resident's abilities. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Nursing, Therapy and Restorative reviewed the current program for Resident #38. Considering the resident's current medical condition and level of pain, it was determined that it would be appropriate for the resident to receive ROM therapy at least four times per week. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? The Restorative Nurse reviewed all restorative program care plans by May 21, 2014 and worked with Therapy to make any revisions. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Therapists will determine goal and write the restorative program. The Restorative nurse will write the care plan according to therapist	06/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	record of Resident #38 was reviewed. Diagnoses included, but were not limited to, the following: Lumbar disc disease, lumbar spinal stenosis, osteoporosis; depression; multiple therapy, chronic pain and anxiety. An MDS (Minimum Data Set assessment) dated 4/4/14 indicated the following: independent cognition; functional status required oversight, encouragement or cueing proved for the following: bed mobility, transfer, walk in room/corridor; walk on and off unit; dressing; eating; toilet use and personal hygiene; no impairment in functional range of motion for upper and lower extremity. On 5/15/14 at 2 P.M., a Weekly skilled therapy review, dated 4/25/14 was reviewed. Included, but not limited to, was the following: "...leans forward over at times d/t (due to) back pain. Pain managed..." On 5/15/14 at 9:20 A.M., the Rehabilitation Manager (RM) was interviewed. She indicated the following: the resident had received PT (physical therapy) and OT (occupational therapy) from 3/9/14 to 4/9/14. The facility mainly treated the resident for her back pain and pain in one shoulder and therapy had been working to restore the resident's physical function back to her prior level.		recommendations. The MDS RN or designee will review the program for its ability to maintain/ restore level of function. A Restorative Assessment Tool (Attachment A) and policy (Attachment B) have been created to capture any decline of participants. The Tool will be used in regularly scheduled weekly meetings between the Restorative Nurse and Restorative Aides to document progress. Therapy will be consulted on how to revise any resident's program flagged by the Restorative Assessment Tool. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The MDS RN or designee will audit the Restorative Assessment Tool to ensure programs are followed and goals are met. The Tool will be audited weekly for four weeks and monthly thereafter. Results will be reported quarterly to QA. The Quality Assurance Committee will determine the necessity of any future systemic changes. 5. By what date the systemic changes will be completed? June 18, 2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The RM indicated the resident's pain was from the resident's poor posture and therapy had been working with the resident to change her posture/body mechanics to improve her function. The RM indicated therapy, PT and OT, had been stopped due to the resident had achieved her maximum benefit and therapy had put her on a maintenance program to maintain her improved level of physical function. The RM indicated the resident was still on a restorative program for ROM (range of motion) both upper and lower extremities. The RM indicated at the time, the facility had two CNAs (certified nursing assistants) who perform the restorative services with the residents. She indicated 3 months after the restorative program begins, residents were reassessed as whether or not to continue with the restorative program and/or put on a "care giver" program. The RM indicated the "care giver" program is where the CNA "kind of incorporates the ROM into the care as opposed to having a special restorative session." The RM indicated this was the second time therapy had provided services for the resident because the resident's pain increased and therapy tried to do pain management without having to utilize more pain medications. The RM indicated therapy performed a quarterly screen on all their residents to assess if			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the resident had improved or declined in function. The RM indicated the resident's last quarterly screen had not yet been completed yet as she had just been discharged from therapy in April. On 5/15/14 at 9:40 A.M., Restorative Aide #1 was interviewed. She indicated she currently had Resident #38 on her caseload for restorative services. She indicated the resident gets ROM (range of motion) daily for about 15 minutes in her room and "usually does ok with it." At the time Restorative Aide #1 provided documentation of the resident's restorative care plan. The care plan, dated 4/7/14, included, but was not limited to, the following: following: Problem: "I can still independently ambulate with my walker but have back pain which causes me to become weak and unsteady at times. I would like to start the recommended AROM program for my bue/ble (bilateral upper extremity/bilateral lower extremity) to help increase my strengthening and joint stability." The goal was documented as "I will complete AROM (active range of motion) exercises to ble/bue dly (daily) through next review." Approaches included, but were not limited to, the following: "I will complete ankle...exercises ...I will complete sitting			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	knee flexion/extension...I will perform sitting bilateral hip flexion exercises...I will complete bue rom (range of motion)...may increase to 2# therabar (device used in restorative therapy) if tolerates..." At the time, "Restorative Log and progress notes" for April and May 2014 were reviewed. The program directions indicated "See careplan for instructions." Documentation indicated therapy began on 4/8/14. Documentation was lacking of therapy having been completed on the following dates: 4/11, 4/12, 4/13, 4/18, 4/24, 4/25, 4/26, 4/27, 4/31, 5/2, 5/8, 5/9, 5/10 and 5/11. The Restorative CNA indicated at this time, the resident did not receive restorative services on the above dates as she (the RA) was not working on those days. She also indicated the resident was not in the review period for the MDS. On 5/15/15 at 1:45 P.M., the Restorative CNA (Certified Nursing Assistant) and MDS Coordinator were interviewed. The Restorative CNA indicated on her scheduled days off from working at the facility, the resident did not receive restorative ROM unless the resident was in her review period for the MDS. The MDS coordinator indicated at the time, the resident had an MDS review period in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	March 2014 and the next review period will be in due in June 2014. On 5/15/14 at 2:19 P.M., the DON (Director of Nursing) was interviewed. She indicated the following: the facility had two restorative CNAs. Every day there was a restorative CNA in the building. When residents are in the 7 day window for MDS review, one Restorative CNA will cover the restorative program for the resident's of the other restorative CNA who is not working on a particular day. She stated usually the ROM is written for 5 days a week but she stated they must have missed this one being scheduled daily. The 7 day assessment forms are in a book at the nursing station, the restorative CNAs go through this every morning. The next review would be with the MDS. The DON stated the restorative nurse developed the care plan. She then gives it to the restorative CNAs. On 5/15/14 at 3:45 P.M., the DON (Director of Nursing) provided a copy of the policy and procedure for "Restorative Measures." This policy was dated 4/1/96. The policy included, but was not limited to, the following: "Nursing personnel will help residents to attain and/or maintain their optimum level of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	functioning." On 5/16/14 at 10:24 A.M., the Restorative Nurse was interviewed. At the time, the "Active Range of Motion Strengthening Exercise Program" was reviewed. This form included but was not limited to, the following: program established 4/3/14 by PT and OT and was signed by the COTA and PT. Purpose of the program was to maintain or increase a resident's strength, therapy preserving function and mobility; maintain or increase joint stability and postural base of support, thereby preserving function and mobility; to maintain a resident's appearance, body alignment and health. Resident specific goal was to maintain current level of function. Number of days per week: this area was left blank. Number of weeks: this area was left blank. Documentation was lacking of specification of number or days of week the program was to be performed. The Restorative Nurse indicated she developed the resident's restorative care plan based on this program. She indicated when the "number of days per week" is not specified on the program she assumed it was to be done daily as this was the goal. She indicated the restorative staff performed the program as many times as they can get in their caseload. The Restorative nurse			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated therapy doesn't specify a minimum number of days the program is to be performed. The Restorative Nurse indicated as resident that is in the 7 day review period for the MDS, would receive daily restorative services. At the time, the Restorative nurse was interviewed regarding how the resident would be able to meet her goal of receiving restorative therapy services daily, when she was not provided the opportunity to receive restorative therapy daily. No additional information was provided. 3.1-38(a)(2)(B)			
F000323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to ensure hand sanitizers were kept secured from	F000323	It is the practice of this facility to ensure that residents are safe and free from accidents and that residents receive adequate supervision. 1. What corrective actions will be completed for those residents found to have been affected by the deficient practice? The 60 ounce pump bottles of HandClens	06/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	18 of 24 confused, self mobile residents who resided on Community B (Maple Cove and Hickory Ridge, locked Memory Care Units) and 11 of 11 residents who resided on Chestnut Place (A locked Memory Care Unit, part of Community A). Findings include: Throughout the days of the survey, from 5/12/14 through 516/14, a 60 ounce pump bottle of HandClens 2 in 1 Sanitizer and Lotion, a Foaming Sanitizer and Lotion was observed on top of the 4 foot high wall between the main hallways and dining rooms in each of the communities of the facility, providing easy access to residents. The information label on the HandClens bottle indicated the following: "...Warning: Do not use in eyes, ears or mouth. In case of eye contact, flush with water immediately....Keep out of reach of children under 2 years of age...." An Interview with LPN #1 on 5/16/14 at 11:25 a.m., indicated there were 24 Residents who resided on Maple Cove and Hickory Ridge (Community B), locked Memory Care Units. She also indicated 18 of 24 confused residents		were removed from the common areas and locked in the nurses' stations. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents were identified to be potentially at risk. The 60 ounce pump bottles of HandClens were removed from all common on the units. The facility will be providing small refillable bottles HandClens to nursing staff (Attachment C). The small bottles can be stored in secure locations. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The large 60 ounce bottles have been replaced with small refillable bottles. Nursing staff have been educated on proper storage for hand sanitizers(Attachments D, E, F). A policy on hand sanitizer storage was written; refer to Attachment C. 4. How the corrective actions will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into place? The Administrator, the Director of Nursing Services and the Compliance Officer will monitor for compliance on rounds. Education will conducted as violations are noted. Repeat occurrences of violations will be included in the Compliance Officer's report to the Quality Assurance Committee along with recommended correction. 5. By what date the systemic changes will be completed? June 18, 2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were self mobile throughout their community. An Interview with the Administrator on 5/16/13 at 1:55 p.m., indicated she had seen hand sanitizer accessible to the residents in the facility and she realized it could be a potential problem. An Interview with the Administrator on 5/16/13 at 2:10 p.m. indicated Chestnut Place (A locked Memory Care Unit) had 11 residents who resided there and all 11 residents were confused, self mobile and had access to the hand sanitizer. She also indicated the residents had access to the hand sanitizer in all of the dining areas in the facility. A review of the facility's policy, titled Hand Hygiene Policy, with Reference date of December 2002, provided by the Administrator, indicated, "...hand rub products may not be stored on medication or treatment carts, when not observed...." A Material Safety Data Sheet (MSDS) for the HandClens Alcohol Free Hand Sanitizer, provided by the Administrator on 5/16/14 at 2:10 p.m., indicated, "...Eye contact may result in irritation. May cause nausea, vomiting and or diarrhea if consumed....See medical attention if respiratory irritation develops...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/19/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-45(a)(1)			
F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review the facility failed to ensure staff appropriately washed their hands for the recommended amount of time and after touching soiled areas. The facility also failed to ensure staff did not handle resident food with their bare hands and protected beverages from contamination when being transported from a Community kitchen to resident rooms during 3 of 6 meals observed in 3 of 8 facility dining rooms potentially affecting 104 of 104 residents who consumed meals prepared by the facility. (Resident #135, Resident #1, Resident #109,	F000371	It is the practice of this facility that food is stored prepared, distributed and served under sanitary conditions. 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? A. Corrective actions for incidents regarding hand washing, touching the face and touching /serving the resident's food included education (See attachments D, E, F). B. Corrective action regarding the storage of applesauce included removal of applesauce from medication carts and education. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? A. All residents were identified as having the potential to be affected. Corrective actions that will be taken are: education (See attachments D, E, F) and in-services on hand washing to be conducted on each unit,implementing the use of deli tissue wrappers and education on their proper use. B. All residents who receive medication mixed with food items were identified as having the potential to be affected. Corrective actions include re-education on the use of insulated containers (See attachments D, E, F) and the policy re use (See attachment G). The Administrator and DON monitored the units	06/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #63, Resident #12, Resident #4, Resident #106, and Resident #52) The facility further failed to ensure the opened applesauce used for the medication pass for 24 of 63 residents from the 5 of 8 medication carts, was refrigerated after the completion of the medication pass. Findings include: 1. During an observation of the lunch meal in the Birchwood Hills dining room of Community C on 5/15/14, the following was observed: - At 11:00 a.m., Certified Nursing Assistant (CNA) #7, was observed to wash her hands for 10 seconds. She was not observed to use a paper towel as a barrier to turn off the water faucet. She was observed to sit down next to Resident #135, and remove the top of the bun from her hamburger with her bare hands to add ketchup and mayonnaise to the sandwich. She was then observed to place the top of the bun back onto the hamburger with her bare hands and place two of her fingers on top of the bun to hold the sandwich steady while she cut the sandwich in half with a knife. - At 11:13 a.m., CNA #8 , entered dining		to ensure that the containers were in use. 3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A. Sanitation practices of staff serving food will be observed. Corrective action will be initiated through the use of an Improvement Plan (See Attachment H). Hand washing in-services will be conducted on each unit. Food Service policy on in room meal trays has been implemented (See Attachment I). B. Medication carts will be randomly observed for compliance with the use of insulated containers by the Administrator, DON, and Compliance Officer. An Improvement Plan will be initiated for deficiencies. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Any Improvement Plans initiated will be reviewed through the QA Committee. 5. By what date the systemic changes will be completed? June 18, 2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	room and was observed to wash his hands for 8 seconds. He was not observed to lather his hands before rinsing. He then sat down next to Resident #1 to assist her with her meal. 2. During an observation of the breakfast meal in the Birchwood Hills dining room of Community C on 5/16/14, the following was observed: - At 8:10 a.m., CNA #9, was observed to carry glasses of water, orange juice, and milk from the dining room through a common hallway to the room of Resident #109. The glasses of beverages were not covered to protect them from contamination. - At 8:12 a.m., CNA #9, was observed to wash her hands for the appropriate amount of time, but did not use a paper towel as a barrier to turn off the water faucet. She then continued to serve residents in the dining room. - At 8:13 a.m., CNA #7 was observed to wash her hands for 12 seconds. She then continued to pass beverages to residents in the dining room. - At 8:15 a.m., CNA #9 was observed to carry glasses of juice and milk from the dining room through common hallways			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to the room of Resident #63. The glasses of beverages were not covered to protect them from contamination. - At 8:16 a.m., CNA #7 was observed to wash her hands for 8 seconds. She then continued to pass beverages to residents in the dining room. - At 8:17 a.m., CNA #7 was observed to carry a glass of tomato juice from the dining room through common hallways to the room of Resident #12. The glass of tomato juice was not covered to protect it from contamination. - At 8:18 a.m., CNA #7 was observed to wash her hands for 15 seconds. She then continued to pass beverages to residents in the dining room. The Administrator and the Dietary Manager were interviewed on 5/16/14 at 11:46 a.m. During the interview they indicated staff were to wash their hands for 20 seconds and their hands were to be washed out of the stream of water. They also indicated staff were to wash their hands after touching anything soiled and should use a paper towel to turn off the water faucet. They further indicated any food or beverage delivered from the kitchens to resident rooms needed to be covered.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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. 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. 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. 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 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. Based on observation, interview, and record review, the facility failed to ensure Novolin insulin was not administered after the expiration date for 1 of 2	F000431	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Insulin administered to Resident # 124 was removed and disposed of properly. A new bottle of insulin properly labeled to include expiration date and placed in the cart. 2. How other residents having the potential	06/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/19/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents (Resident #124) who received insulin in 1 of 8 neighborhoods (Red Bud Trail). Findings include: During an observation of the Red Bud Trail medication cart in Community D on 5-16-2014 at 9:20 a.m., a vial of Novolin R 100 units/ml (milliliter) labeled for Resident #124 had an open date of 4-4-2014 written on the label along with an expiration date of 5-2-2014 and was located in the top drawer. A review of the May 2014 physician's recapitulation indicated Resident #124 had a diagnosis of IDDM (Insulin Dependent Diabetes Mellitus). The recapitulation orders indicated "glucoscans (blood sugar checks) before meals and at bedtime" and "Novolin R 100 units/ml (milliliter)" sliding scale coverage as follows: "0-70 = give juice 71-160 = 0 units 161-220 = 2 units 221-260 = 4 units 261-310 = 6 units 311-360 = 8 units >360 = 10 units...." A review of the May 2014 MAR (Medication Administration Record) and		to be affected by the deficient practice will be identified and what corrective actions will be taken? Nursing checked the vials of all residents who receive insulin and all were in compliance. No other resident was at risk. 3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The policy Insulin Administration and Storage (See Attachment J) has been revised so that the Medication Administration Record reflects the expiration date of all insulin vials. 4.How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? All MARs will be audited weekly by the Community Nurse Leader (charge nurse). The Compliance Officer will conduct random audits and check vials on the medication carts to ensure compliance. Deficient findings will be reviewed in the QA meeting along with the initiation of an Improvement Plan. 5. By what dated the systemic changes will be completed? June 18, 2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the Blood Glucose Tacking form for Resident #124 indicated the Novolin R with the expiration date of 5-2-2014 was administered 32 times after it was expired on the following dates/times: 5-3-2014 at 5 p.m. 6 units 5-3-2014 at 8 p.m. initials present but insulin amount not charted (blood sugar was 334 and would have required 8 units) 5-4-2014 at 11 a.m. 4 units 5-4-2014 at 5 p.m. 2 units 5-4-2014 at 8 p.m. initials present but insulin amount not charted (blood sugar was 289 and would have required 6 units) 5-5-2014 at 8 a.m. 2 units 5-5-2014 11 a.m. 4 units 5-5-2014 8 p.m. initials present but insulin amount not charted (blood sugar was 232 and would have required 4 units) 5-6-2014 4 p.m. 4 units 5-6-2014 8 p.m. initials present but insulin amount not charted (blood sugar was 378 and would have required 10 units) 5-7-2014 8 p.m. initials present but insulin amount not charted (blood sugar was 281 and would have required 6 units) 5-8-2014 4 p.m. 6 units 5-8-2014 8 p.m. initials present but insulin amount not charted (blood sugar was 264 and would have required 8 units) 5-9-2014 11 a.m. 2 units 5-9-2014 4 p.m. 2 units 5-9-2014 8 p.m. initials present but			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	insulin amount not charted (blood sugar was 290 and would have required 6 units) 5-10-2014 11 a.m. 4 units 5-10-2014 8 p.m. initials present but insulin amount not charted (blood sugar was 229 and would have required 4 units) 5-11-2014 11 a.m. 4 units 5-11-2014 4 p.m. 2 units 5-11-2014 8 p.m. initials present but insulin amount not charted (blood sugar was 244 and would have required 4 units) 5-12-2014 11 a.m. 2 units 5-12-2014 8 p.m. 2 units 5-13-2014 11 a.m. 2 units 5-13-2014 4 p.m. 4 units 5-13-2014 8 p.m. 6 units 5-14-2014 11 a.m. 4 units 5-14-2014 8 p.m. 6 units 5-15-2014 8 a.m. 2 units 5-15-2014 11 a.m. 2 units 5-15-2014 4 p.m. 6 units 5-15-2014 8 p.m. 6 units An interview with LPN #14 on 5-16-2014 at 9:25 a.m., indicated the vial of Novolin R was expired and disposed of the vial. An interview with the LPN Unit Manager #15 on 5-16-2014 at 9:26 a.m. indicated a nursing staff member was assigned each medication cart to ensure medications were current, cart audits were completed for the medication carts to ensure			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/19/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medications were not expired and the pharmacy technician was just here this month to review the medications in the carts and all of our checks missed the expired Novolin R. An interview with the Interim DON (Director of Nursing) on 5-16-2014 at 1:55 p.m., indicated the nurse was responsible to check the insulin for the expiration date prior to administration of the insulin. A policy "Insulin Administration and Storage" dated 1-4-2014 and provided by the Interim DON on 5-16-2014 at 1:55 p.m., indicated "...Employees Responsible: Licensed Nurses...Date the vial when opened...Insulin expires 28 days from open date...." 3.1-25(o)			
R000000	Golden Years Homestead was found to be in compliance with 410 IAC 16.2-5 in	R000000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN RD FORT WAYNE, IN 46815	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	regard to the State Residential Survey.			